Vaccines and Global Health: The Week in Review
30 May 2015
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 8,000 entries.*

Comments and suggestions should be directed to
David R. Curry, MS
Editor and
Executive Director
Center for Vaccine Ethics & Policy
david.r.curry@centerforvaccineethicsandpolicy.org

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Sixty-eighth World Health Assembly [full documentation]

Editor's Note:
The World Health Assembly concluded with a number high-level actions summarized in news releases as below. We focus below on action around immunization and include the full text of the WHA Global Vaccine Action Plan (GVAP) resolution. We note the aggressive call in the resolution for action on vaccine pricing transparency.

Delegates discuss progress towards global immunization goals
25 May 2015 - Fifty-two speakers, including 46 delegates of Member States, one observer (Chinese Taipei), four civil society organizations and GAVI, the Vaccine Alliance took the floor during the discussion on the Global Vaccine Action Plan.

Delegates welcomed the GVAP assessment report, and commended the WHO Strategic Advisory Group of Experts (SAGE) on immunization on the recommendations in the report.

Delegates took note and expressed concern that the progress with the implementation of GVAP was patchy and slow and "far off-track" for achieving five out of six targets for 2014 and 2015.

WHO's fundamental role in facilitating the implementation of the GVAP was acknowledged, stressing the important and leading role that WHO should play to:
:: Improve vaccine price transparency and build mechanisms that promote healthy and competitive vaccine markets, tackle the problems faced by middle income countries to secure sustainable supplies of vaccines at affordable prices, particularly for the newer vaccines.
:: Work to enhance awareness of the value of vaccines to increase acceptance of immunization and to mitigate the risks posed by misinformation leading to vaccine hesitancy and refusal.
:: Analyse the causes of vaccine stock out and develop tools to respond immediately to any supply shortfalls.
:: Regularly convene countries that remain off-track to assist with diagnosing the problems and finding solutions.
:: Support countries to improve the quality of data and to use data for informing decisions and for improving programme performance.
:: Expand the existing guidance for vaccination in humanitarian emergencies to also include guidance on sustaining routine immunization during periods of conflict and crisis, including outbreaks of disease, such as the current Ebola epidemic in west Africa.

Delegates acknowledged that countries and particularly national governments, play a leading role in making the needed investments in immunization. Governments are accountable for the progress as well as the monitoring of their own immunization programme performance.

The Health Assembly adopted a resolution tabled by Libya that specifically addresses the issue of access to sustainable supplies of affordable vaccines for low and middle income countries, including the promotion of vaccine price transparency, support for pooled procurement mechanisms and for increased capacity for the manufacture of vaccines of assured quality to foster competition for a healthy vaccine market.

Note: List of Member States that made interventions during the GVAP discussion: Libya, Iceland, Panama, Chile, Australia, Brazil, Iran, Japan, Ethiopia, Morocco, Egypt, Republic of Korea, China, Ecuador, Pakistan, Lebanon, Brunei Darussalam, United Sates of America, Russians Federation, United Kingdom, Cape Verde, Thailand, Philippines, Tanzania, Nigeria, South Africa, Canada, Colombia, Bangladesh, Maldives, Jamaica, Bahamas, Bahrain, Saudi Arabia, Qatar, Malaysia, Argentina, Kuwait, Gabon, India, Venezuela, Latvia, Iraq, Senegal, Algeria, Greece

Note: List of civil society organizations that made interventions during the GVAP discussion: Save the Children, Médecins Sans Frontières, Medicus Mundi, International Pharmaceutical Federation

World Health Assembly addresses antimicrobial resistance, immunization gaps and malnutrition
25 May 2015
News release
Excerpt
…Immunization
The Assembly agreed a resolution to improve access to sustainable supplies of affordable vaccines – a key issue for low- and middle-income countries aiming to extend immunization to the entire population. In 2012, the Assembly endorsed the Global Vaccine Action Plan, a commitment to ensure that no one misses out on vital immunization by 2020. A report from WHO's Strategic Advisory Group of Experts on immunization, warns, however, that progress towards the Action Plan's targets is slow and patchy.

The resolution calls on WHO to coordinate efforts to address gaps in progress. It urges Member States to increase transparency around vaccine pricing and explore pooling the procurement of vaccines. It requests the WHO Secretariat to report on barriers that may undermine robust competition that can enable price reductions for new vaccines, and to address any other factors that might adversely affect the availability of vaccines. The resolution also highlighted that immunization is a highly cost-effective public health interventions, playing a major role in reducing child deaths and improving health. It recommends scaling up advocacy efforts to improve understanding of the value of vaccines and to allay fears leading to vaccine hesitancy.

Last week, on the margins of the Health Assembly, the Secretariat brought together high-level representatives of 34 countries with low immunization coverage to discuss challenges and explore solutions to overcome them…

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WHA Resolution - Global vaccine action plan
A68/73 26 May 2015
The Sixty-eighth World Health Assembly,
Having considered the report on the global vaccine action plan A68/30;

Emphasizing the importance of immunization as one of the most effective interventions in public health and access to immunization as a key step towards access to health and universal health coverage;

Acknowledging the progress made in global immunization and the commitment under the 2011–2020 Decade of Vaccines to achieve immunization goals and milestones;

Recalling resolutions WHA58.15 and WHA61.15 on the global immunization strategy, resolution WHA65.17 on the global vaccine action plan, resolution WHA61.21 on the global strategy and plan of action on public health, innovation and intellectual property, resolution WHA54.11 on the WHO medicines strategy and resolution WHA67.20 on regulatory system strengthening for medical products;

Noting with concern that globally immunization coverage has increased only marginally since the late 2000s; and that in 2013 more than 21 million children under one year of age did not complete the three-dose series of diphtheria-tetanus-pertussis (DTP) vaccine;

Recognizing that the availability of new vaccines against important causes of vaccine preventable diseases such as pneumonia, diarrhoea and cervical cancer can prevent leading causes of childhood and women's death;

Acknowledging that successful national immunization programmes require sustainable political and financial support of Member States;

Appreciating the contributions of WHO, UNICEF, the Gavi Alliance, and all partners in their efforts to support the introduction of new vaccines in developing countries and strengthen immunization services;

Concerned that inequities between Member States are growing, inter alia, due to the increased financial burden of new vaccines and based upon those that are eligible or ineligible for financial and technical support from global partners;

Concerned that many low- and middle-income countries may not have the opportunity to access newer and improved vaccines, particularly because of the costs related to the procurement and introduction of these vaccines; and concerned at the increase of costs of overall immunization programmes because of increase in price of the WHO-recommended vaccines;

Recognizing that publicly available data on vaccine prices are scarce, and that the availability of price information is important for facilitating Member States' efforts towards introduction of new vaccines;

Recalling many Member States' interventions on the Health Assembly's immunization agenda item each year, expressing concern over the unaffordable cost of new vaccines and appealing to the global community to support strategies that will reduce prices;

Recalling the WHO global framework for expanding access to essential drugs, and its four components: the rational selection and use of medicines, reliable health and supply systems, sustainable financing, and affordable prices;

Taking into account the importance of competition to reduce prices and the need to expand the number of manufacturers, particularly in developing countries, that can produce WHO-prequalified vaccines and create a competitive market;

Stressing the critical life-saving role of vaccines and immunization programmes and striving to make immunization available to all;

Noting with concern the global shortage of certain traditional routine vaccines, for example BCG vaccine and combined measles-rubella vaccine;

Acknowledging that shortages of vaccines are quite often an important cause of disruption of vaccination schedules and that therefore the establishment of effective and sustainable vaccine

production, supply, procurement and delivery systems is essential to ensure access to all the necessary vaccines of assured quality at the right time;

Concerned that scepticism against vaccination is continuing to grow in society despite the proven efficacy and safety of modern vaccines, and that many children do not receive life-saving vaccines as a result of insufficient information to parents or health care workers or even of active anti-vaccination propaganda,

1. URGES Member States [And, where applicable, regional economic integration organizations]
(1) to allocate adequate financial and human resources for the introduction of vaccines into national immunization schedules and for sustaining strong immunization programmes in accordance with national priorities;

(2) to strengthen efforts, as and where appropriate, for pooling vaccine procurement volumes in regional and interregional or other groupings, as appropriate, that will increase affordability by leveraging economies of scale;

(3) to provide, where possible and available, timely vaccine price data to WHO for publication, with the goal of increasing affordability through improved price transparency, particularly for the new vaccines;

(4) to seek opportunities for establishing national and regional vaccine manufacturing capacity, in accordance with national priorities, that can produce to national regulatory standards, including WHO-prequalification;

(5) to create mechanisms to increase the availability of comparable information on government funding for vaccine development and work towards strategies that enhance public health benefit from government investments in vaccine development;

(6) to support the ongoing efforts of various partners coordinated by WHO to design and implement the strategies to address the vaccine and immunization gaps faced by the low- and middle-income countries that request assistance;

(7) to improve and sustain vaccine purchasing and delivery systems in order to promote the uninterrupted and affordable safe supply of all the necessary vaccines and their availability to all immunization service providers;

(8) to strengthen immunization advocacy and provide training to health professionals and information to the public regarding immunization issues to achieve a clear understanding of the benefits and risks of immunization;

2. REQUESTS the Director-General:
(1) to explore ways to mobilize funding to fully support collaborative efforts with international partners, donors, and vaccine manufacturers to support low- and middle-income countries in accessing affordable vaccines of assured quality in adequate supply;

(2) to continue developing and adequately managing publicly available vaccine price databases, like the WHO Vaccine Product, Price and Procurement project, working with Member States to increase availability of price information;

(3) to monitor vaccine prices through annual reporting of the global vaccine action plan;

(4) to provide technical support and facilitate financial resources for establishing pooled procurement mechanisms, where appropriate, for use by Member States;

(5) to strengthen the WHO prequalification programme and provide technical assistance to support developing countries in capacity building for research and development, technology transfer, and other upstream to downstream vaccine development and manufacturing strategies that foster proper competition for a healthy vaccine market;

(6) to report upon technical, procedural and legal barriers that may undermine robust competition that can enable price reductions for new vaccines, and address other factors that can adversely affect the availability of vaccines;

(7) to assist in mobilizing resources for countries that request assistance in the introduction of new vaccines in line with the global vaccine action plan and in accordance with national priorities;

(8) to continue to assist Member States to improve and sustain their vaccine delivery systems and to continue to provide technical support to Member States to strengthen the knowledge and skills of their health care professionals in vaccination programmes;

(9) to report back on progress in implementing this resolution to the Health Assembly through the Executive Board in the annual report on the global vaccine action plan.

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WHA68 Side Meeting on Immunization

"Achieving the Global Vaccine Action Plan Objective for Routine Coverage: What can be done to get back on track?"

20 May 2015 ¦ Geneva - During the WHA68, a side meeting on immunization with delegates from Member States with DTP3 coverage below 80% was convened by WHO. The objectives were to discuss the challenges faced by countries to reach global vaccination targets for 2015 and explore solutions to overcome them. Lead agencies in the Decade of Vaccines Collaboration and other development partners were given the opportunity to reiterate their commitments to support countries to achieve this important goal.

The WHA side meeting was co-sponsored by Thailand, the Democratic Republic of Congo and the United States of America and was chaired by Dr Flavia Bustreo, Assistant Director General, Family, Women's and Children's Health. Dr Margaret Chan, the Director-General of WHO, was in attendance. Representatives of agencies comprising the Global Vaccine Action Plan (GVAP) Secretariat, namely Gavi, the Vaccine Alliance, UNICEF and the Bill & Melinda Gates Foundation were present, as well as representatives from Civil Society Organizations.

Member States highlighted critical operational needs and challenges to ensure wider vaccination and delivery on the ground to reach every last child especially those living in remote and inaccessible areas, the need to strengthen vaccine supply chains, the challenges posed by conflict, natural disasters and vaccine stock out and the importance of mechanisms to secure sustainable supplies of vaccines at affordable prices.

Dr Chan highlighted several areas that require attention, including the need to address vaccine hesitancy and refusal, improve communications to create greater awareness of the importance of immunization and the science behind vaccines, the need for collective actions and the importance of private public partnerships to come up with new funding mechanisms. She emphasized the need to build on the lessons learned from the polio eradication initiative.

Notable achievements have been made with the help of Gavi, the Vaccine Alliance to enhance access and the roll out of new vaccines. It was acknowledged that problems remain with reaching the "5th child". UNICEF is working hand-in-hand with WHO and partners to address the issues impeding the achievement of high coverage and plays an important role in strengthening supply chains.

Dr Elias highlighted that a collective effort was required and encouraged each in the room, international agencies, development partners and national governments "to challenge ourselves to find new solutions to address the remaining barriers to universal access to immunization".

"The fifth child is often part of undocumented migrant or urban populations or living in remote or insecure areas. Hence, the strategies to reach them cannot be a continuation of what we have done till now"
Dr Chris Elias, President of the Global Development Programme, the Bill & Melinda Gates Foundation

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WHA 68: Press Releases Summary
:: World Health Assembly closes, passing resolutions on air pollution and epilepsy
26 May 2015 *New release*

:: World Health Assembly addresses antimicrobial resistance, immunization gaps and malnutrition
25 May 2015
New release
25 MAY 2015 ¦ GENEVA - The World Health Assembly today agreed resolutions to tackle antimicrobial resistance; improve access to affordable vaccines and address over- and under-nutrition.
Tackling antimicrobial drug resistance
Delegates at the World Health Assembly endorsed a global action plan to tackle antimicrobial resistance - including antibiotic resistance, the most urgent drug resistance trend. Antimicrobial resistance is occurring everywhere in the world, compromising our ability to treat infectious diseases, as well as undermining many other advances in health and medicine.
The plan sets out 5 objectives:
:: improve awareness and understanding of antimicrobial resistance;

:: strengthen surveillance and research;
:: reduce the incidence of infection;
:: optimize the use of antimicrobial medicines;
:: ensure sustainable investment in countering antimicrobial resistance.

The resolution urges Member States to put the plan into action, adapting it to their national priorities and specific contexts and mobilizing additional resources for its implementation.

Through adoption of the global plan, governments all committed to have in place, by May 2017, a national action plan on antimicrobial resistance that is aligned with the global action plan. It needs to cover the use of antimicrobial medicines in animal health and agriculture, as well as for human health. WHO will work with countries to support the development and implementation of their national plans, and will report progress to the Health Assembly in 2017.

World Health Assembly gives WHO green light to reform emergency and response progamme
23 May 2015

WHA reaches agreement on polio, International Health Regulations and strengthening surgical care
22 May 2015

World Health Assembly agrees Global Malaria Strategy and Programme Budget 2016-17
20 May 2015

WHA 68: Selected Conference Papers
:: A68/A/CONF./4 Rev.2
Global vaccine action plan

:: A68/A/CONF./5
2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on Ebola

:: A68/B/CONF./1 Rev.1
Global strategy and plan of action on public health, innovation and intellectual property

:: A68/A/CONF./1 Rev.1
Global action plan on antimicrobial resistance

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The Weekly Epidemiological Record (WER) 29 May 2015, vol. 90, 22 (pp. 261–280) includes:
…Monthly report on dracunculiasis cases, January– April 2015
…Meeting of the Strategic Advisory Group of Experts on immunization, April 2015: conclusions and recommendations
[Meeting Report Sections and Editor's Excerpts]
Report from the WHO Department of Immunization, Vaccines and Biologicals

The report focused on: the implementation of the Global Vaccine Action Plan (GVAP) and the related discussions during meetings of the WHO Governing Bodies at global and regional levels; the programmatic priorities to close the immunization gap; an update on implementation of selected SAGE recommendations; and agenda items on the horizon for future meetings.

The report stressed that reaching the GVAP goals is resource intensive (human and financial) and emphasized the urgent need for adequate investments and focus in order to increase routine immunization coverage which has been almost static, at global level, since 2009 and below the expected 90% coverage.

The report noted the current global shortage of bacille Calmette–Guérin (BCG) vaccine and proposed interim solutions while stressing the need for the global community to pay more attention and take measures to avoid future shortages of other recommended vaccines.

SAGE took note of regional progress and commended the work carried out to advance regional vaccine action plans and promote activities to strengthen routine immunization.

SAGE stressed that additional disaggregation was needed in the analysis of the progress achieved on the ground, and in identifying bottlenecks for progress, and recommended that reports display disparities observed at subnational levels.

In view of weak infrastructure in some countries with a related inability to deliver vaccines, SAGE called for new politically supported initiatives to mobilize partners and resources to apply technological know-how in fragile countries and find ways to build infrastructure in fragile systems. SAGE reaffirmed the need for solutions that simplify operations on the ground, including delivery technologies such as compact pre-filled auto-disable injection technology. In this context SAGE also acknowledged the importance of the polio infrastructure and noted how it had been critical in helping to deal with the Ebola situation, particularly in Nigeria.

SAGE stressed the importance of applying rigour and science in implementation programme design and evaluation of delivery of vaccines, in order to maximize the impact of current and future vaccines and delivery technologies.

SAGE also stressed the need to draw lessons from the Ebola epidemic regarding mobilization of communities as well as the encouragement of countries and partners to mobilize the private sector.

SAGE supported WHO's plan to expand guidance beyond the current framework on the use of vaccines in humanitarian emergencies to include guidance on how to re-establish routine vaccination in those settings.

At the January 2015 WHO Executive Board meeting, Member States endorsed a resolution for pre-emptive development of vaccines against emerging infectious diseases such as Ebola virus disease. WHO was asked to provide leadership in supporting a prioritized research agenda. A framework for action in relation to vaccine development was proposed, which would include public health criteria, technical feasibility, regulatory pathways, and economic considerations. The issues will be reviewed by SAGE, the Product Development for Vaccines Advisory

Committee (PDVAC), the Expert Committee on Biological Standardization (ECBS) and other forums, with the aim of reaching an agreement within a year.

A SAGE Working Group on Dengue Vaccine was established in March 2015.
Subject to the completion and conclusions of the vaccine assessment by the European Medicines Agency, it is planned that SAGE and the Malaria Programme Advisory Committee will issue policy recommendations on the use of RTS,S malaria vaccine during a joint session in October 2015.
..1 See http://www.who.int/immunization/sage/en
..2 The complete set of presentations and background materials used for the SAGE meeting of 14-16 April 2015 together with the list of SAGE members and the summarized declarations of interests provided by SAGE members are available at http://www.who.int/immunization/sage/meetings/2015/april/en

Report from Gavi, the Vaccine Alliance
Report of the Global Advisory Committee on Vaccine Safety (GACVS)
Report of the Product Development for Vaccines Advisory Committee (PDVAC)

Polio eradication
SAGE reviewed progress towards eradication of wild poliovirus (WPV) and elimination of persistent circulating vaccine-derived poliovirus type 2 (cVDPV2) as well as the plans, preparedness and timeline for withdrawal of type 2 oral polio vaccine (OPV2).

SAGE noted that the programme had made substantial progress since the previous SAGE meeting. No WPV case has been reported in the Middle East or Africa since April 2014 and August 2014, respectively. In polio-endemic countries there were definite improvements in the quality of supplementary immunization activities (SIAs), increasing access to children in conflict-affected areas of Pakistan, improvements in AFP surveillance and expansion of environmental surveillance…

…SAGE concluded that progress towards elimination of persistent cVDPV2 is on track. SAGE recommended that all countries and GPEI should plan firmly for April 2016 as the designated date for withdrawal of OPV2. SAGE will consider delaying OPV2 withdrawal only if the WG reports in October 2015 that the assessed risk of continued cVDPV2 transmission is high. SAGE requested the polio WG to continue monitoring progress towards cVDPV2 elimination and ensuring that remaining challenges are addressed including contingencies for vaccine supplies (IPV, bOPV and tOPV), registration of bOPV for routine use, surveillance sensitivity, and reaching inaccessible children. The Working Group will make a full report to SAGE in October 2015, when SAGE may reconfirm April 2016 as the definite date for OPV2 withdrawal.

SAGE endorsed the proposed approach to verification of compliance of poliovirus containment in essential facilities. Under the WHO Global Action Plan (GAP III), facilities planning to handle or store type 2 poliovirus are requested to implement containment measures and appropriately manage associated biorisks. National Regulatory Authorities for containment (NRAcs) are expected to certify facilities according to GAP III. Certification reports are submitted to Regional Certification Commissions (RCCs) for evaluation. In support of this process, RCCs, NRAcs or concerned facilities may request that WHO verify compliance of certified facilities in keeping

with GAP III. SAGE requested that the programme consider mechanisms to address the risks associated with research and therapeutic uses of live polioviruses.

Administration of multiple injectable vaccines in a single visit

…SAGE supported the following Good Practice Statement on multiple vaccine injections in a single visit, recognizing that the country context is an important determinant of success and acceptability among caregivers and providers: National vaccination schedules recommending administration of multiple injections in the same visit are widely used and provide benefits insofar as they support timely and efficient vaccination of children. Where studies have evaluated the immunogenicity and safety of co-administered vaccines, these practices are encouraged based on the benefits they confer.

SAGE concluded that countries should not make modifications to recommended immunization schedules with the aim of preventing multiple injections during the same visit when such modifications are not evidence-based…

Reducing pain and distress at the time of vaccination

Sustainable access to vaccines in middle-income countries (MICs): report of the WHO-convened MIC Task Force

The MIC Task Force, a group of 9 immunization partners, presented a proposed strategy for coordinated action to enhance sustainable access to vaccines in MICs. Over the past decade, access to vaccines in MICs has been much debated, fuelled by the fact that the majority of poor people are now in MICs and concern that this group of countries may be missing out on opportunities to introduce new vaccines, as donors focus on low-income countries. In view of this situation and at the request of SAGE, in June 2014 WHO convened the MIC Task Force to develop a coordinated strategy and plan of action.

A comprehensive review of MICs' performance shows that they are far from attaining the GVAP targets. While 40 MICs are well supported by Gavi, 63 do not benefit from a unified international strategy for action. In these countries, vaccine-preventable disease burden and numbers of unvaccinated children are relatively low compared to the Gavi-supported MICs, but nonetheless substantial and unacceptable. Many of these countries have strong health systems and potential for rapid gains if key barriers are removed. The MIC strategy, aligned with the GVAP time frame (2016–2020), proposes a way forward for non-Gavi countries. Importantly, solutions and platforms set up as part of the strategy would also benefit countries that graduate from Gavi support over time, ensuring sustainability of current investments…

…SAGE acknowledged that the strategy represents a strong proposal for a coordinated and comprehensive approach to the MIC situation. SAGE concurred with the general direction of the strategy and valued the menu of options as an approach to tailoring activities to the individual needs of a heterogeneous group of countries. SAGE appreciated that the strategy builds upon lessons learnt and existing activities as the most efficient way to use resources and achieve impact.

SAGE called on partners to support implementation of the strategy and on countries to take advantage of the proposed solutions.

SAGE noted that prompt implementation of the MIC strategy is particularly important given the impending graduation of several large Gavi countries, which will require long-term solutions to be put in place…

Ebola vaccines and vaccination

…In parallel with the vaccine trials, WHO and partners, including the 3 most affected countries, have established a framework to develop guidelines to support planning, implementing and monitoring vaccination once a vaccine becomes available for use, according to SAGE recommendations.

A proposed framework for making recommendations was presented, which aims to adopt a scenario-based approach, while also taking account of a number of programmatic, socio-cultural and other factors. Considerations guiding the use of the framework are: specific scenario relating to the epidemiology and the type of authorization for vaccine use; objectives for vaccination (primary – stopping transmission, secondary – individual protection); prioritization of target populations; and additional considerations which would inform SAGE's recommendations. The framework would be adjusted based on evolution of the current epidemic, the type of regulatory or emergency use authorization given for a vaccine, and on the data that become available from the clinical trials.

In the discussion that followed, it was noted that the quality of the reported disease data had limitations and that the data on cultural and other factors that may have contributed to differences in the epidemic patterns were not fully captured in the national databases. However, there was confidence that the available data correctly reflected the epidemic patterns and the relative incidence of disease in different age groups.

SAGE members expressed concern about the likelihood that efficacy estimates may not be generated from the phase 3 trials, given the declining number of cases in all 3 countries and felt that the trials must also contribute additional data (including those related to programmatic aspects) that could inform recommendations. Noting WHO's unique position to coordinate the development of Ebola vaccines, SAGE stressed the importance of transparent and prompt sharing of information on the trial protocols and data from the phase 3 clinical trials, and the need for a greater role for WHO in facilitating the sharing of information so that results between studies will generate the greatest benefit for policy decision-making.

SAGE supported the proposed framework for making recommendations, but asked that it be made explicit that the identification and prioritization of target populations for vaccination will be based on a thorough assessment of risks (from disease as well as from vaccination) and benefits. It was recognized that the final recommendations would be driven by the evolution of the current epidemic, the conditions laid down in the regulatory authorization for use of vaccines and social and cultural considerations.

SAGE recommended that the further development of the Emergency Use Assessment and Listing procedure being developed by WHO, which would allow use of a vaccine in the context of a Public Health Emergency of International Concern, be done in close consultation with relevant regulatory authorities, including those of the affected countries.

SAGE again noted the probability that efficacy data for any of the Ebola vaccines may not be available by the end of the current outbreak, and therefore recommended that future use of unproven Ebola vaccines should be in the context of studies that would generate safety and effectiveness data.

Maternal vaccination during pregnancy

SAGE encouraged WHO to promote more implementation research to generate generalizable data on the best ways to integrate maternal immunization into routine antenatal care in low resource settings. SAGE also encouraged the Regional Office for the Americas to document the successful regional experience of delivering influenza vaccine to pregnant women.

It was considered unnecessary to establish a SAGE working group to review maternal influenza immunization at present, given that substantial data still being generated will not be available until late 2015–2016. SAGE emphasized the importance of the maternal immunization platform, in general, and called upon WHO to affirm its commitment to building the evidence base to strengthen vaccine delivery during pregnancy, as it has great potential for infection prevention in high-risk groups worldwide.

Pertussis vaccination schedules

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Nepal earthquake 2015 - Grade 3 emergency

:: **Health situation report No. 19pdf, 317kb** - 26 May 2015 2015

KEY HIGHLIGHTS

:: The repeated earthquakes and aftershocks since 25 April 2015 have had a major public health consequences, with a total 1085 health facilities (402 completely and 683 partially) damaged.

:: A total of 2088 people have undergone major surgeries and 26,160 have received psychosocial support in the highly affected 14 districts.

:: Nepal's Ministry of Health and Population (MOHP) identifies 429 patients in Bhaktapur, Kathmandu and Lalitpur who require longer term treatment support.

:: 42 Foreign Medical teams (FMTs) are operating in the country with a total 802 persons including 264 doctors and 236 nurses.

:: Currently there are over 100 beds available for patients requiring ongoing rehabilitation or nursing care within the Kathmandu valley.

:: **Health Cluster Bulletin No. 4 pdf, 1.83Mb** 27 May 2015

Situation update

Up to 26 May, just a little over a month after the first earthquake of 7.8 on the Richter scale struck Nepal on 25 April, followed by a 7.3 magnitude on 12 May and numerous aftershocks, the MoHP is reporting that there has been 8673 earthquake-related deaths and 21952 injuries. Of this amount, eight health workers and 10 FCHVs have lost their lives, 75 have been injured and two remain missing.

The Ministry of Health and Population's (MoHP) Early Warning and Response System for epidemic-prone diseases (EWARS) show a generally stabilizing trend in numbers of outbreak prone diseases in the 14 severely affected districts. No major outbreaks have been reported to date…

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EBOLA/EVD [to 30 May 2015]
Public Health Emergency of International Concern (PHEIC); "Threat to international peace and security" (UN Security Council)

WHO: Ebola Situation Report - 27 May 2015
[Excerpts]
SUMMARY
:: There were 12 confirmed cases of Ebola virus disease (EVD) reported in the week to 24 May: 9 from Guinea and 3 from Sierra Leone. A total of 5 districts (3 in Guinea, 2 in Sierra Leone) reported at least one confirmed case, compared with 6 districts the previous week. The west-Guinean prefecture of Forecariah reported the most cases of any one district, and continues to present the greatest challenge in terms of response, with multiple chains of transmission over a wide geographical area (4 sub-prefectures), and the continued occurrence of cases from unknown sources of infection.

COUNTRIES WITH WIDESPREAD AND INTENSE TRANSMISSION
:: There have been a total of 27,013 reported confirmed, probable, and suspected cases of EVD in Guinea, Liberia and Sierra Leone (figure 1, table 1), with 11,134 reported deaths (this total includes reported deaths among probable and suspected cases, although outcomes for many cases are unknown). A total of 9 new confirmed cases were reported in Guinea and 3 in Sierra Leone in the 7 days to 24 May. The outbreak in Liberia was declared over on 9 May.

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POLIO [to 30 May 2015]
Public Health Emergency of International Concern (PHEIC)

GPEI Update: Polio this week - *As of 27 May 2015*
Global Polio Eradication Initiative
[Editor's Excerpt and text bolding]
Full report: http://www.polioeradication.org/Dataandmonitoring/Poliothisweek.aspx
:: Ministers of Health from around the world adopted a landmark resolution to end polio once and for all at the World Health Assembly in Geneva last week. The discussions were informed by a status report prepared by the Global Polio Eradication Initiative. Draft 3rd report of the Committee A , WHO news release from 22 May 2015
:: Polio staff continue to offer support to the humanitarian response to the devastating earth quakes in Nepal. Read more.
:: The 11th IMB report was published last week, reporting on progress towards polio eradication and making recommendations
Selected excerpts from Country-specific Reports [No new polio cases reported]
Afghanistan
:: One new case of wild poliovirus type 1 (WPV1) has been reported in the past week in Gulestan district of Farah province. This most recent case had onset of paralysis on 5 May. The total number of WPV1 cases for 2015 is now 2, and remains 28 for 2014. Most of the cases from 2014 were linked with cross-border transmission from neighbouring Pakistan.
:: Environmental sampling in the country continues to find wild poliovirus (most recently in Hilmand). Such sampling is invaluable to improved surveillance for the virus.

:: Subnational Immunization Days (SNIDs) are planned from 14 – 16 June across the south and east using bivalent OPV. National Immunization Days are scheduled on 16 to 18 Augus

Pakistan

:: Two new environmental samples positive for WPV1 were reported this week from Quetta district of Balochistan and from Jacobabad district of Sindh.
:: Currently, the focus of the polio eradication programme in Pakistan is on known infected areas and on areas deemed to be high-risk but which have not reported polio cases.
:: Environmental surveillance indicates widespread circulation of polioviruses – WPV as well as VDPV – not just in known infected areas but also in areas without cases. Environmental surveillance is proving to be an instrumental supplemental surveillance tool enabling a clearer epidemiological picture.

WHO and UNICEF launch vaccination campaign to keep Iraq polio free

Baghdad | Erbil, 26 May 2015 – A mass polio vaccination campaign, aiming to target 5.7 million children under the age of 5, began in Iraq on 24 May. The campaign will be conducted in all governorates to maintain the country's polio-free status. The last case of polio was reported on 7 April 2014; a 34-month-old girl from the Rasafa district of Baghdad.

Iraq's response to combating polio aligns with a multi-country response plan developed following the outbreak of polio in Syria in 2013. Multiple vaccination rounds held in country since then have helped to protect Iraqi children from the paralysis caused by this incurable disease. Despite ongoing conflict, mass population displacement and a complex and unpredictable security situation, only 2 cases of polio were confirmed in Iraq during the regional outbreak in early 2014.

WHO Country Representative to Iraq Dr Syed Jaffar Hussain said, "Despite the civil unrest that engulfs over a third of the country, polio campaigns have continued to reach up to 90% of children through collaborative efforts with multiple line-ministries and local partners." He paid tribute to polio vaccination team members and parents and appealed to the international community and partners for their continued financial and technical support over the next 12 months for an additional 4 nationwide vaccination campaigns. "Community efforts were well acknowledged by the Independent Monitoring Board for the Global Polio Eradication Initiative during their recent meeting. However, significant risks continue to exist and thus there is no room for complacency," Dr Hussain added.

UNICEF Country Representative to Iraq Phillippe Heffinck added, "The polio effort in Iraq has been successful despite tremendous challenges. The collaboration and leadership of the Ministries of Health and strong collaboration with partners, such as WHO, have established community ownership for polio campaigns, and created a strong platform for rolling out strong routine immunization services. Both of these achievements are not only remarkable, but essential to keep Iraq polio free and improve the health of all Iraqi children."…

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WHO & Regionals [to 30 May 2015]

Egypt: increase in H5N1 human and poultry cases but no change in transmission pattern of infection

May 2015 -- The recent increase in the number of people affected by the avian influenza virus H5N1 in Egypt is not related to virus mutations but rather to more people becoming exposed to infected poultry. Since November 2014 to 30 April 2015, the period analysed by the international mission, a total of 165 cases, including 48 deaths were reported.

WHO recommends 10 measurements for HIV

May 2015 -- WHO released new guidelines recommending simplified indicators to measure the reach of HIV services, and the impact achieved at both the national and global levels.

Global Alert and Response (GAR) – Disease Outbreak News (DONs)

30 May 2015 - Middle East respiratory syndrome coronavirus (MERS-CoV) – China
30 May 2015 - Middle East respiratory syndrome coronavirus (MERS-CoV) – Republic of Korea
28 May 2015 - Lassa Fever – United States of America
25 May 2015 - Middle East Respiratory Syndrome coronavirus (MERS-CoV) – Saudi Arabia
24 May 2015 - Middle East respiratory syndrome coronavirus (MERS-CoV) – United Arab Emirates

:: WHO Regional Offices

WHO African Region AFRO

:: Cholera crisis in Tanzania improving despite high transmission risk

Kagunga, 26 May 2015 – The ongoing cholera outbreak in western Tanzania appears to be improving thanks to intensive national and international efforts, but the risk of transmission remains high due to limited access to shelter, toilets, water and essential medical care. As of 25 May, the total number of cases diagnosed and treated was 4408 and no deaths have been reported between 21-24 May.

WHO Region of the Americas PAHO

:: PAHO urges member countries to ratify new protocol on illicit tobacco (05/29/2015)

WHO South-East Asia Region SEARO

:: Stop illicit trade of tobacco products 29 May 2015

WHO European Region EURO

:: Final day of the World Health Assembly: highlights for the European Region 28-05-2015
:: World No Tobacco Day awards 2015 27-05-2015
:: Days 5 to 7 of the World Health Assembly: highlights for the European Region 27-05-2015

WHO Eastern Mediterranean Region EMRO

:: Urgent funding needed to prevent imminent closure of health care projects in Iraq

Cairo, 27 May 2015 – If urgently needed funds are not secured by the end of June 2015, more than 84% of health care projects serving populations in need in Iraq will be forced to close. If this happens, more than 3 million refugees, internally displaced persons and host communities will not have access to the treatment and care that these projects provide. WHO is coordinating the response of health cluster partners to optimize the use of available resources and calls on donors to provide financial support to prevent further avoidable death and additional suffering for millions of the most vulnerable people in Iraq.

:: WHO statement on the situation in Yemen by WHO Director-General Dr Margaret Chan 27 May 2015
:: WHO and UNICEF launch vaccination campaign to keep Iraq polio free 26 May 2015
:: WHO partners with MENTOR Initiative to control leishmaniasis in Aleppo and Deir ez-Zor 26 May 2015

WHO Western Pacific Region
No new digest content identified.

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GAVI Watch [to 30 May 2015]
http://www.gavialliance.org/library/news/press-releases/
:: **Oman commits US$ 3 million to support childhood immunisation**
28 May 2015
First time pledge will enable Gavi to reach children with life-saving vaccines.
Geneva, 28 May 2015 – The Government of the Sultanate of Oman today committed US$ 3 million to Gavi, the Vaccine Alliance - the first time Oman has provided funds to help Gavi reach children with vaccines in the world's poorest countries.
"Oman is joining the global drive to protect children from potentially-fatal diseases," said Dr Seth Berkley, Gavi CEO. "This new contribution will help us achieve our goal of supporting developing countries to immunise 300 million more children between 2016 and 2020, saving up to six million more lives."
Oman's contribution comes days after the World Health Assembly agreed on a resolution to improve access to sustainable supplies of affordable vaccines and highlighted the important role immunisation plays in reducing child deaths while also being a highly cost-effective public health intervention…

MSF/Médecins Sans Frontières [to 30 May 2015]
http://www.doctorswithoutborders.org/news-stories/press/press-releases
Press Releases
Governments Take Decisive Step Towards More Affordable Vaccines
May 26, 2015
GENEVA—Governments meeting in Geneva for the annual World Health Assembly raised the alarm today on the exorbitant rise in the price to vaccinate a child, and took a decisive step towards addressing the problem by passing a resolution that called for more affordable vaccines and greater transparency of vaccine prices…

DoD Launches Review of Lab Procedures Involving Anthrax
WASHINGTON, May 29, 2015 – The Defense Department is launching a comprehensive review of its laboratory procedures, processes, and protocols associated with inactivating spore-forming anthrax…Deputy Defense Secretary Bob Work today ordered the review after consulting with Defense Secretary Ash Carter…
No Risk to the General Public

There is no known risk to the general public and an extremely low risk to lab workers from the department's inadvertent shipments of inactivated samples containing small numbers of live anthrax to several laboratories, according to the release.

As of now, 24 laboratories in 11 states and two foreign countries are believed to have received suspect samples, the release said.

The department is working closely with the Centers for Disease Control and Prevention, who is leading the ongoing investigation pursuit to its statutory authorities, the release said.

Monitoring the Situation

The department will continue to monitor the situation and provide updates to the public, the release said.

In addition to the CDC review, Work ordered all DoD laboratories that have these materials to test all previously inactivated spore-forming anthrax in the inventory, the release said.

DoD also is advising labs that received inactive anthrax from the department to stop working with those samples until further instruction from the DoD and CDC…

CDC/MMWR/ACIP Watch [to 30 May 2015]
http://www.cdc.gov/media/index.html

CDC investigating unintentional DoD shipment of anthrax

Media Statement

CDC is investigating the unintentional transfer of anthrax from the U.S. Department of Defense (DOD) to labs in multiple states and overseas. At this time we do not suspect any risk to the general public.

The CDC investigation was started after a request for technical consultation from a private commercial lab. The lab was working as part of a DOD effort to develop a new diagnostic test to identify biological threats. Although an inactivated agent was expected, the lab reported they were able to grow live Bacillus anthracis.

CDC is working in conjunction with DoD and other federal and state partners to conduct an investigation with all the labs that received samples from the DoD. The ongoing investigation includes determining if the labs also received other live samples, epidemiologic consultation, worker safety review, laboratory analysis, and handling of laboratory waste.

All samples involved in the investigation are being securely transferred to CDC or Laboratory Response Network (LRN) laboratories for further testing. CDC has sent officials from the CDC Federal Select Agent Program to the DOD labs to conduct onsite investigations.

Updates will continue to be provided as the investigation progresses.

ACIP

:: February 2015 ACIP Minutes [2.16 MB, 72 pages]
:: Next ACIP Meeting - June 24-25, 2015
ACIP June 2015 Draft Meeting Agenda [2 pages]
Register for upcoming June ACIP meeting
(Wednesday - Thursday)
Deadline for registration:
- Non-US Citizens: June 3, 2015
- US Citizens: June 10, 2015

NIH Watch [to 30 May 2015]

http://www.nih.gov/news/releases.htm
Starting antiretroviral treatment early improves outcomes for HIV-infected individuals
May 27, 2015 — NIH-funded trial results likely will impact global treatment guidelines.

European Medicines Agency Watch [to 30 May 2015]
http://www.ema.europa.eu/ema/
Regulatory information – Update of EMA recommendations for 2015/2016 seasonal flu vaccine composition
27/05/2015
Update completes previous recommendations issued in March 2015 ...

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BMGF (Gates Foundation) [to 30 May 2015]
http://www.gatesfoundation.org/Media-Center/Press-Releases
No new digest content identified.

Global Fund [to 30 May 2015]
http://www.theglobalfund.org/en/mediacenter/newsreleases/
No new digest content identified.

PATH [to 30 May 2015]
http://www.path.org/news/
No new digest content identified

FDA Watch [to 30 May 2015]
http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/default.htm
No new digest content identified

European Vaccine Initiative [to 30 May 2015]
http://www.euvaccine.eu/news-events
No new digest content identified

International AIDS Vaccine Initiative Watch [to 30 May 2015]
http://www.iavi.org/
No new digest content identified.

IVI Watch [to 30 May 2015]
http://www.ivi.org/web/www/home
No new digest content identified.

Sabin Vaccine Institute Watch [to 30 May 2015]
http://www.sabin.org/updates/pressreleases
No new digest content identified.

DCVMN / PhRMA / EFPIA / IFPMA / BIO Watch [to 30 May 2015]

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

No new content identified.

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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 15, Issue 5, 2015
http://www.tandfonline.com/toc/uajb20/current
[Reviewed earlier]

American Journal of Infection Control
June 2015 Volume 43, Issue 6, p547-662
http://www.ajicjournal.org/current

What can we learn about the Ebola outbreak from tweets?
Michelle Odlum, Sunmoo Yoon
p563–571
Preview
Twitter can address the challenges of the current Ebola outbreak surveillance. The aims of this study are to demonstrate the use of Twitter as a real-time method of Ebola outbreak surveillance to monitor information spread, capture early epidemic detection, and examine content of public knowledge and attitudes.

Healthcare worker influenza declination form program

Sherri L. LaVela, PhD, MPH, MBA, Jennifer N. Hill, MA, Bridget M. Smith, PhD, Charlesnika T. Evans, PhD, MPH, Barry Goldstein, MD, PhD, Richard Martinello, MD
Published Online: March 20, 2015
DOI: http://dx.doi.org/10.1016/j.ajic.2015.02.013
Highlights
:: The declination form program was compatible, flexible, easy to use, and supported by leadership.
:: Declination form program facilitators included complementary ongoing strategies and leadership engagement.
:: One-on-one attention and education at the time of vaccination led to health care worker accountability.
:: An influenza declination form program is of minimal cost, but it requires some dedicated staff and resources.
:: Vaccination rate improved from 53.5% to 77.4% pre- to postdeclination form program implementation.
Abstract
Background
Health care worker (HCW) vaccination rates have been low for many years (approximately 50%). Our goal was to implement an influenza declination form program (DFP) to assess feasibility, participation, HCW vaccination, and costs.
Methods
This was a prospective interventional pilot study using mixed methods to evaluate the DFP implementation processes and outcomes. We conducted a formative evaluation and interviews; data were transcribed and coded into themes. Secondary outcomes included self-reported HCW influenza vaccine uptake (pre-/postsurvey) and program costs; data were evaluated using descriptive and bivariate analyses.
Results
The DFP was compatible with ongoing strategies and unit culture. Barriers included multiple hospital shifts and competing demands. Facilitators included complementary ongoing strategies and leadership engagement. HCW vaccination rates were higher post- versus preimplementation (77.4% vs 53.5%, P =.01). To implement the DFP at site 1, using a mobile flu cart, 100% of declination forms were completed in 42.5 staff hours over <2 months. At site 2, using a vaccination table on all staff meeting days, 49% of forms were completed in 26.5 staff hours over 4.5 months. Average cost of staff time was $2,093 per site.
Conclusion
DFP implementation required limited resources and resulted in increased HCW influenza vaccine rates; this may have positive clinical implications for influenza infection control/prevention.
Increased reports of measles in a low endemic region during a rubella outbreak in adult populations
Takako Kurata, Daiki Kanbayashi, Hiroshi Nishimura, Jun Komano, Tetsuo Kase, Kazuo Takahashi
p653–655
Published online: April 1, 2015
Preview
In 2013, a rubella outbreak was observed in Japan, Romania, and Poland. The outbreak in Japan was accompanied by an increase of measles reports, especially from a region where measles is highly controlled. This was attributed to the adult populations affected by this rubella outbreak, similarity of clinical signs between rubella and measles, sufficiently small impact of

measles outbreaks from neighboring nations, and elimination levels of measles endemicity. Current and future concerns for measles control are discussed.

American Journal of Preventive Medicine
June 2015 Volume 48, Issue 6, p647-770, e11-e30
http://www.ajpmonline.org/current

Impact of Health Insurance Status on Vaccination Coverage Among Adult Populations

Peng-jun Lu, MD, PhD, Alissa O'Halloran, MSPH, Walter W. Williams, MD, MPH
Immunization Services Division, National Center for Immunization and Respiratory Diseases, CDC, Atlanta, Georgia
Published Online: April 15, 2015
DOI: http://dx.doi.org/10.1016/j.amepre.2014.12.008
Abstract
Introduction
Underinsurance is a barrier to vaccination among children. Information on vaccination among adults aged ≥18 years by insurance status is limited. This study assesses vaccination coverage among adults aged ≥18 years in the U.S. in 2012 by health insurance status and access to care characteristics.
Methods
The 2012 National Health Interview Survey data were analyzed in 2014 to estimate vaccination coverage among adults aged ≥18 years by health insurance status for seven routinely recommended vaccines.
Results
Influenza vaccination coverage among adults aged ≥18 years without or with health insurance was 14.4% versus 44.3%, respectively; pneumococcal vaccination coverage among adults aged 18–64 years with high-risk conditions was 9.8% versus 23.0%; tetanus and diphtheria toxoid (Td) coverage (age ≥18 years) was 53.2% versus 64.5%; tetanus, diphtheria, and acellular pertussis (Tdap) coverage (age ≥18 years) was 8.4% versus 15.7%; hepatitis A (HepA) coverage (age 18–49 years) was 16.6% versus 19.8%; hepatitis B (HepB) coverage (age 18–49 years) was 27.5% versus 38.0%; shingles coverage (age ≥60 years) was 6.1% versus 20.8%; and human papillomavirus (HPV) coverage (women aged 18–26 years) was 20.9% versus 39.8%. In addition, vaccination coverage differed by insurance type, whether respondents had a regular physician, and number of physician contacts.
Conclusions
Overall, vaccination coverage among adults aged ≥18 years is lower among uninsured populations. Implementation of effective strategies is needed to help improve vaccination coverage among adults aged ≥18 years, especially those without health insurance

American Journal of Public Health
Volume 105, Issue 6 (June 2015)
http://ajph.aphapublications.org/toc/ajph/current

Long-Term Effectiveness of Accelerated Hepatitis B Vaccination Schedule in Drug Users

Dimpy P. Shah, Carolyn Z. Grimes, Anh T. Nguyen, Dejian Lai, Lu-Yu Hwang
American Journal of Public Health: June 2015, Vol. 105, No. 6: e36–e43.

ABSTRACT
Objectives. We demonstrated the effectiveness of an accelerated hepatitis B vaccination schedule in drug users.
Methods. We compared the long-term effectiveness of accelerated (0–1–2 months) and standard (0–1–6 months) hepatitis B vaccination schedules in preventing hepatitis B virus (HBV) infections and anti-hepatitis B (anti-HBs) antibody loss during 2-year follow-up in 707 drug users (HIV and HBV negative at enrollment and completed 3 vaccine doses) from February 2004 to October 2009.
Results. Drug users in the accelerated schedule group had significantly lower HBV infection rates, but had a similar rate of anti-HBs antibody loss compared with the standard schedule group over 2 years of follow-up. No chronic HBV infections were observed. Hepatitis C positivity at enrollment and age younger than 40 years were independent risk factors for HBV infection and antibody loss, respectively.
Conclusions. An accelerated vaccination schedule was more preferable than a standard vaccination schedule in preventing HBV infections in drug users. To overcome the disadvantages of a standard vaccination schedule, an accelerated vaccination schedule should be considered in drug users with low adherence. Our study should be repeated in different cohorts to validate our findings and establish the role of an accelerated schedule in hepatitis B vaccination guidelines for drug users.

American Journal of Tropical Medicine and Hygiene
May 2015; 92 (5)
http://www.ajtmh.org/content/current
[Reviewed earlier]

Annals of Internal Medicine
19 May 2015, Vol. 162. No. 10
http://annals.org/issue.aspx
[Reviewed earlier]

BMC Health Services Research
http://www.biomedcentral.com/bmchealthservres/content
(Accessed 30 May 2015)
Research article
Making health insurance pro-poor: evidence from a household panel in rural China
Mateusz Filipski, Yumei Zhang, Kevin Chen BMC Health Services Research 2015, 15:210 (29 May 2015)
Abstract
Background
In 2002, China launched the largest public health insurance scheme in the world, the New Cooperative Medical Scheme (NCMS). It is intended to enable rural populations to access health care services, and to curb medical impoverishment. Whether the scheme can reach its equity goals depends on how it is used, and by whom. Our goal is to shed light on whether and how income levels affect the ability of members to reap insurance benefits.
Methods

We exploit primary panel data consisting of a complete census (over 3500 individuals) in three villages in Puding County, Guizhou province, collected in 2004, 2006, 2009 and 2011. Data was collected during in-person interviews with household member(s). The data include yearly gross and net medical expenses for all individuals, and socio-economic information. We apply probit, ordinary least squares, and tobit multivariate regression analyses to the three waves in which NCMS was active (2006, 2009 and 2011). Explained variables include obtainment, levels and rates of NCMS reimbursement. Household income is the main explanatory variable, with household- and individual-level controls. We restrict samples to rule out self-selection, and exploit the 2009 NCMS reform to highlight equity-enhancing features of insurance.
Results
Prior to 2009 reforms, higher income in our sample was statistically significantly related to higher probability of obtaining reimbursement, as well as higher levels and rates of reimbursement. These relations all disappear after the reform, suggesting lower-income households were better able to reap insurance benefits after the scheme was reformed. Regression results suggest this is partly explained by reimbursement for chronic diseases.
Conclusions
The post-reform NCMS distributed benefits more equitably in our study area. Making health insurance pro-poor may require a focus on outpatient costs, credit constraints and chronic diseases, rather than catastrophic illnesses.

BMC Infectious Diseases
http://www.biomedcentral.com/bmcinfectdis/content
(Accessed 30 May 2015)
[No new relevant content identified]

BMC Medical Ethics
http://www.biomedcentral.com/bmcmedethics/content
(Accessed 30 May 2015)
Debate
Research partnerships between high and low-income countries: are international partnerships always a good thing?
John D Chetwood, Nimzing G Ladep, Simon D Taylor-Robinson BMC Medical Ethics 2015, 16:36 (28 May 2015)
Abstract
Background
International partnerships in research are receiving ever greater attention, given that technology has diminished the restriction of geographical barriers with the effects of globalisation becoming more evident, and populations increasingly more mobile.
Discussion
In this article, we examine the merits and risks of such collaboration even when strict universal ethical guidelines are maintained. There has been widespread examples of outcomes beneficial and detrimental for both high and low –income countries which are often initially unintended.
Summary
The authors feel that extreme care and forethought should be exercised by all involved parties, despite the fact that many implications from such international work can be extremely hard to

predict. However ultimately the benefits gained by enhancing medical research and philanthropy are too extensive to be ignored

BMC Pregnancy and Childbirth
http://www.biomedcentral.com/bmcpregnancychildbirth/content
(Accessed 30 May 2015)
[No new relevant content identified]

BMC Public Health
http://www.biomedcentral.com/bmcpublichealth/content
(Accessed 30 May 2015)
[No new relevant content identified]

BMC Research Notes
http://www.biomedcentral.com/bmcresnotes/content
(Accessed 30 May 2015)
[No new relevant content identified]

BMJ Open
2015, Volume 5, Issue 5
http://bmjopen.bmj.com/content/current
[No new relevant content identified]

British Medical Journal
30 May 2015(vol 350, issue 8010)
http://www.bmj.com/content/350/8010
[New issue; Ne relevant content identified]

Bulletin of the World Health Organization
Volume 93, Number 5, May 2015, 285-360
http://www.who.int/bulletin/volumes/93/5/en/
[Reviewed earlier]

Clinical Infectious Diseases (CID)
Volume 60 Issue 12 June 15, 2015
http://cid.oxfordjournals.org/content/current
[New issue; No relevant content]

Clinical Therapeutics
April 2015 Volume 37, Issue 4, p687-924

http://www.clinicaltherapeutics.com/current
[Reviewed earlier]

Complexity
May/June 2015 Volume 20, Issue 5 Pages C1–C1, 1–76
http://onlinelibrary.wiley.com/doi/10.1002/cplx.v20.5/issuetoc
[Reviewed earlier]

Conflict and Health
[Accessed 30 May 2015]
http://www.conflictandhealth.com/
[No new relevant content identified]

Contemporary Clinical Trials
Volume 42, In Progress (May 2015)
http://www.sciencedirect.com/science/journal/15517144/42
[Reviewed earlier]

Cost Effectiveness and Resource Allocation
http://www.resource-allocation.com/
(Accessed 30 May 2015)
[No new relevant content identified]

Current Opinion in Infectious Diseases
June 2015 - Volume 28 - Issue 3 pp: v-v,199-282
http://journals.lww.com/co-infectiousdiseases/pages/currenttoc.aspx
[Reviewed earlier]

Developing World Bioethics
April 2015 Volume 15, Issue 1 Pages ii–iii, 1–57
http://onlinelibrary.wiley.com/doi/10.1111/dewb.2015.15.issue-1/issuetoc
[Reviewed earlier]

Development in Practice
Volume 25, Issue 4, 2015
http://www.tandfonline.com/toc/cdip20/current
[Reviewed earlier]

Emerging Infectious Diseases
Volume 21, Number 6—June 2015

http://wwwnc.cdc.gov/eid/
[Reviewed earlier]

Epidemics
Volume 11, In Progress (June 2015)
http://www.sciencedirect.com/science/journal/17554365
[Reviewed earlier]

Epidemiology and Infection
Volume 143 - Issue 08 - June 2015
http://journals.cambridge.org/action/displayIssue?jid=HYG&tab=currentissue
[New issue; No relevant content identified]

The European Journal of Public Health
Volume 25, Issue 3, 01 June 2015
http://eurpub.oxfordjournals.org/content/25/3
[Reviewed earlier]

Eurosurveillance
Volume 20, Issue 21, 28 May 2015
http://www.eurosurveillance.org/Public/Articles/Archives.aspx?PublicationId=11678
[New issue: No new relevant content]

Global Health: Science and Practice (GHSP)
March 2015 | Volume 3 | Issue 1
http://www.ghspjournal.org/content/current
[Reviewed earlier]

Global Health Governance
http://blogs.shu.edu/ghg/category/complete-issues/spring-autumn-2014/
[Accessed 30 May 2015]
[No new relevant content]

Global Public Health
Volume 10, Issue 5-6, 2015
http://www.tandfonline.com/toc/rgph20/current
Special Issue: Circumcision and HIV prevention: Emerging debates in science, policies and programs
[Reviewed earlier]

Globalization and Health
http://www.globalizationandhealth.com/
[Accessed 30 May 2015]
Research
Tracking Global Fund HIV/AIDS resources used for sexual and reproductive health service integration: case study from Ethiopia
Mookherji S, Ski S and Huntington D Globalization and Health 2015, 11:21 (27 May 2015)
Abstract (provisional)
Objective/Background
The Global Fund to Fight AIDS, Tuberculosis & Malaria (GF) strives for high value for money, encouraging countries to integrate synergistic services and systems strengthening to maximize investments. The GF needs to show how, and how much, its grants support more than just HIV/AIDS, TB and malaria. Sexual and Reproductive Health (SRH) has been part of HIV/AIDS grants since 2007. Previous studies showed the GF PBF system does not allow resource tracking for SRH integration within HIV/AIDS grants. We present findings from a resource tracking case study using primary data collected at country level.
Methods
Ethiopia was the study site. We reviewed data from four HIV/AIDS grants from January 2009-June 2011 and categorized SDAs and activities as directly, indirectly, or not related to SRH integration. Data included: GF PBF data; financial, performance, in-depth interview and facility observation data from Ethiopia.
Results
All HIV/AIDS grants in Ethiopia support SRH integration activities (12-100%). Using activities within SDAs, expenditures directly supporting SRH integration increased from 25% to 66% for the largest HIV/AIDS grant, and from 21% to 34% for the smaller PMTCT-focused grant. Using SDAs to categorize expenditures underestimated direct investments in SRH integration; activity-based categorization is more accurate. The important finding is that primary data collection could not resolve the limitations in using GF GPR data for resource tracking. The remedy is to require existing activity-based budgets and expenditure reports as part of PBF reporting requirements, and make them available in the grant portfolio database. The GF should do this quickly, as it is a serious shortfall in the GF guiding principle of transparency.
Conclusions
Showing high value for money is important for maximizing impact and replenishments. The Global Fund should routinely track HIV/AIDs grant expenditures to disease control, service integration, and overall health systems strengthening. The current PBF system will not allow this. Real-time expenditure analysis could be achieved by integrating existing activity-based financial data into the routine PBF system. The GF's New Funding Model and the 2012-2016 strategy present good opportunities for over-hauling the PBF system to improve transparency and allow the GF to monitor and maximize value for money.

Health Affairs
May 2015; Volume 34, Issue 5
http://content.healthaffairs.org/content/current
[Reviewed earlier]

Health and Human Rights

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

Health Economics, Policy and Law
Volume 10 - Issue 03 - July 2015
http://journals.cambridge.org/action/displayIssue?jid=HEP&tab=currentissue
The impact of Universal Health Coverage on health care consumption and risky behaviours: evidence from Thailand
Simone Ghislandi, Wanwiphang Manachotphong and Viviana M.E. Perego
Health Economics, Policy and Law / Volume 10 / Issue 03 / July 2015, pp 251 - 266
Abstract
Thailand is among the first non-OECD countries to have introduced a form of Universal Health Coverage (UHC). This policy represents a natural experiment to evaluate the effects of public health insurance on health behaviours. In this paper, we examine the impact of Thailand's UHC programme on preventive activities, unhealthy or risky behaviours and health care consumption using data from the Thai Health and Welfare Survey. We use doubly robust estimators that combine propensity scores and linear regressions to estimate differences-in-differences (DD) and differences-in-DD models. Our results offer important insights. First, UHC increases individuals' likelihood of having an annual check-up, especially among women. Regarding health care consumption, we observe that UHC increases hospital admissions by over 2% and increases outpatient visits by 13%. However, there is no evidence that UHC leads to an increase in unhealthy behaviours or a reduction of preventive efforts. In other words, we find no evidence of ex ante moral hazard. Overall, these findings suggest positive health impacts among the Thai population covered by UHC.

Health Policy and Planning
Volume 30 Issue 5 June 2015
http://heapol.oxfordjournals.org/content/current
[Reviewed earlier]

Health Research Policy and Systems
http://www.health-policy-systems.com/content
[Accessed 30 May 2015]
[No new relevant content]

Human Vaccines & Immunotherapeutics (formerly Human Vaccines)
Volume 11, Issue 4, 2015
http://www.tandfonline.com/toc/khvi20/current
[Reviewed earlier]

Infectious Agents and Cancer

http://www.infectagentscancer.com/content
[Accessed 30 May 2015]
[No new relevant content]

Infectious Diseases of Poverty
http://www.idpjournal.com/content
[Accessed 30 May 2015]
[No new relevant content]

International Health
Volume 7 Issue 3 May 2015
http://inthealth.oxfordjournals.org/content/current
[Reviewed earlier]

International Journal of Epidemiology
Volume 44 Issue 1 February 2015
http://ije.oxfordjournals.org/content/current
[Reviewed earlier]

International Journal of Infectious Diseases
June 2015 Volume 35, p1
http://www.ijidonline.com/current
[Reviewed earlier]

JAMA
May 26, 2015, Vol 313, No. 20
http://jama.jamanetwork.com/issue.aspx
Principles and Challenges in Access to Experimental Medicines
Michael Rosenblatt, MD; Bruce Kuhlik, JD
Excerpt
Efforts by patients to obtain early access to experimental medicines have increased as novel therapies provide new evidence of their potential to treat or cure life-threatening diseases. As drug discovery efforts, particularly for cancer and orphan diseases, are increasingly based on molecular targets, success rates improve, generating further interest in early access to experimental drugs. Devising "expanded access programs" (EAPs), however, presents challenges.1,2 Fairness and ethical issues need to be addressed as do practical matters, such as efficient conduct of clinical trials, adequate drug supply, finances, and geography. The complexity of crafting EAPs is compounded by early, rapid, and broad communication by traditional and social media. This Viewpoint outlines general principles to help balance the competing interests of individuals facing life-threatening illness with practical concerns and broader societal interests in knowing which drugs do or do not work and making them generally available through expeditious regulatory approval…

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May 2015, Vol 169, No. 5
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[Reviewed earlier]

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Volume 40, Issue 3, June 2015
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[Reviewed earlier]

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June 2015, Volume 69, Issue 6
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[New issue; No relevant content identified]

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Volume 11, Issue 1, 2015
http://www.tandfonline.com/toc/rjge20/.U2V-Elf4L0I#.VAJEj2N4WF8
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[Reviewed earlier]

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April-June 2015 Volume 7 | Issue 2 Page Nos. 53-94
http://www.jgid.org/currentissue.asp?sabs=n
[Reviewed earlier]

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Volume 26, Number 2, May 2015 Supplement
https://muse.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/toc/hpu.26.2A.html
SUPPLEMENT FOCUS: Shining the Light on Asian American, Native Hawaiian, and Pacific Islander Health
[Reviewed earlier]

Journal of Immigrant and Minority Health
Volume 17, Issue 3 – June 2015
http://link.springer.com/journal/10903/17/2/page/1
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[New issue; No relevant content]

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Volume 13, Issue 1, 2015
http://www.tandfonline.com/toc/wimm20/current#.VQS0KOFnBhW
[Reviewed earlier]

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Volume 211 Issue 11 June 1, 2015
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Spring 2015 Volume 43, Issue 1 Pages 6–166
http://onlinelibrary.wiley.com/doi/10.1111/jlme.2015.43.issue-1/issuetoc
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June 2015, Volume 41, Issue 6
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Vol 17, No 5 (2015): May
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[New issue; No relevant content identified]

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April 2015; 64 (Pt 4)
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[Reviewed earlier]

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Volume 2, Issue 2 (2015)
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[Reviewed earlier]

Journal of the Pediatric Infectious Diseases Society (JPIDS)
Volume 4 Issue 2 June 2015
http://jpids.oxfordjournals.org/content/current
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June 2015 Volume 166, Issue 6, p1329-1550
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Volume 36, Issue 2 (May 2015)
http://www.palgrave-journals.com/jphp/journal/v36/n2/index.html
[Reviewed earlier]

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06 May 2015; volume 12, issue 106
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June 2015, volume 89, issue 12
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The Lancet
May 30, 2015 Volume 385 Number 9983 p2121-2222
http://www.thelancet.com/journals/lancet/issue/current
Comment
African health leaders: claiming the future
Agnes Binagwaho, Nigel Crisp
DOI: http://dx.doi.org/10.1016/S0140-6736(15)60934-5
Improving health in Africa is a team effort that involves many people from different backgrounds. The health gains made in recent years would not have been possible without the contribution of these people, national and global political will, and the support of development partners. All too often, however, the part played by Africans themselves has been overlooked or downplayed internationally in policy making and publications.
Comment
Offline: An irreversible change in global health governance
Richard Horton
DOI: http://dx.doi.org/10.1016/S0140-6736(15)60997-7
"We should have reacted sooner", was Angela Merkel's conclusion in her address to the World Health Assembly last week. She was speaking about Ebola, and she gave a sharp and public rebuke to WHO for its diffident performance. WHO's decentralised structure can be a powerful advantage, she said, but it "can also impede decision-making and hinder good functioning". Still, despite its weaknesses, "WHO is the only international organisation that enjoys universal political legitimacy on global health matters." It should be supported. Her assessment was backed by the Ebola Interim Assessment Panel, chaired by Barbara Stocking and whose first report was debated by WHO's member states the next day. Stocking and her team, which

included, among others, Ilona Kickbusch and Julio Frenk, listed their concerns with compelling clarity. They expressed surprise that it took WHO so long to recognise what it would take to bring Ebola transmission under control. Why did repeated early warnings from May to July, 2014, fail to trigger the declaration of a Public Health Emergency of International Concern before Aug 8, 2014, the date when an emergency was finally announced? Why was WHO unable "to engage in a high-level media response with greater command over the narrative"? Why did WHO fail to seek appropriate support from other UN agencies and humanitarian organisations? Why did WHO fail to ensure it had the operational capacity and culture to manage a public health emergency response? Donors were not spared: WHO "suffers from a lack of political and financial commitment by its Member States". The Panel commented that "this [is] a defining moment for the work of WHO…'Business as usual' or 'more of the same' is not an option." Stocking concluded that, "Now is the historic political moment for world leaders to give WHO new relevance and empower it to lead in global health."

Understandably, the Panel preferred to place responsibility on structures, not individuals. This is entirely correct. But structures are made up of individuals, and it is individuals who make decisions. There needs to be some serious soul-searching within the agency about who did what, when, and why it went wrong. The Lancet has felt resistance to these questions, in sometimes acutely hostile terms from WHO staff members. If WHO diagnoses the international response to Ebola as a collective failure and not as a failure of its own processes, procedures, and people, it risks sustaining the conditions that have led to this public health catastrophe for millions of west Africans. For example, it is surreal for WHO to say, as it did last week, that it has now heard what the world expects from the agency. Does this statement mean it was only when Ebola swept across west Africa that WHO woke up to an understanding of its global role? When WHO says that it will strengthen its command and control systems, does this statement mean that after six decades of experience in responding to health crises it needed Ebola to make the agency realise the importance of leadership? And can anyone take the statement that Ebola has accelerated reforms to the organisation seriously when the recent "WHO reform" programme is widely judged (internally and externally) to have delivered few tangible benefits to the agency's work?

Debates about Ebola and WHO's response (and future) certainly overwhelmed discussions in Geneva last week. But the most exciting moment was not in the Assembly Hall or Committees. Instead, it was in a small room in the Palais des Nations, and after hours too. For the first time in the history of WHO and its Assembly, a civil-society led forum was held to strengthen political accountability for global health—specifically, for women's and children's health. The White Ribbon Alliance, together with the Governments of Bangladesh and Sweden, convened the first Global Dialogue between Citizens and Governments. It was an historic moment. It built on National Citizen's Hearings held in over 20 countries. Examples from Indonesia and Tanzania were presented with informed passion. Indonesian and Namibian Ministers of Health spoke. This Global Dialogue signalled the beginning of a very different World Health Assembly. What took place last week was an irreversible change in the governance of global health—one in which civil society assumed a legitimate place in shaping the future of health. While WHO reflected (sometimes painfully) on its role and purpose, civil society found its voice. Mark this moment.

The Lancet Global Health

Jun 2015 Volume 3 Number 6 e297-e340
http://www.thelancet.com/journals/langlo/issue/current
Comment
Global access to surgical care: moving forward
Evan G Wong, Dan L Deckelbaum, Tarek Razek
Open Access
DOI: http://dx.doi.org/10.1016/S2214-109X(15)00004-2
Summary
Global surgical care is gaining ground on the public health platform. Throughout 2015–16, the World Bank is publishing the long-anticipated third edition of its Disease Control Priorities (DCP3). First published in 1993,1 these reports aim to systematically identify effective interventions to address the disease burden in low-income and middle-income countries. For the first time since its inception, the DCP now includes a distinct volume on the value of surgical care. Volume 1—Essential Surgery2—focuses on the benefits of surgical care, including its potential to substantially decrease mortality while being exceptionally cost-effective; the issues of access to life-saving surgery, perioperative safety, and the inclusion of surgery in universal health coverage are also specifically addressed.
Comment
Health and sustainable development: a call for papers
Richard Horton, Zoë Mullan
Published Online: 30 April 2015
Open Access
DOI: http://dx.doi.org/10.1016/S2214-109X(15)00002-9
Summary
In just under 5 months' time, the aspiration for the next 15 years of development efforts will be signed off at the UN General Assembly in New York, USA. These Sustainable Development Goals (SDGs) are already at an advanced stage of drafting—17 ambitious goals and 169 targets (panel), which have been criticised even by the UN General Secretary for being too voluminous.1 Amid this multitude of outcomes, those pertaining to health are reduced from three Millennium Development Goals to one SDG. What does this mean for global health research?
Articles
Global access to surgical care: a modelling study
Blake C Alkire, MD*, Dr Nakul P Raykar, MD*, Mark G Shrime, MD, Thomas G Weiser, MD, Prof Stephen W Bickler, MD, John A Rose, MD, Cameron T Nutt, BA, Sarah L M Greenberg, MD, Meera Kotagal, MD, Johanna N Riesel, MD, Micaela Esquivel, MD, Tarsicio Uribe-Leitz, MD, George Molina, MD, Prof Nobhojit Roy, MD, John G Meara, MD, Prof Paul E Farmer, MD, *
Published Online: 26 April 2015
Open Access
DOI: http://dx.doi.org/10.1016/S2214-109X(15)70115-4
Summary
Background
More than 2 billion people are unable to receive surgical care based on operating theatre density alone. The vision of the Lancet Commission on Global Surgery is universal access to safe, affordable surgical and anaesthesia care when needed. We aimed to estimate the number of individuals worldwide without access to surgical services as defined by the Commission's vision.
Methods

We modelled access to surgical services in 196 countries with respect to four dimensions: timeliness, surgical capacity, safety, and affordability. We built a chance tree for each country to model the probability of surgical access with respect to each dimension, and from this we constructed a statistical model to estimate the proportion of the population in each country that does not have access to surgical services. We accounted for uncertainty with one-way sensitivity analyses, multiple imputation for missing data, and probabilistic sensitivity analysis.
Findings
At least 4·8 billion people (95% posterior credible interval 4·6–5·0 [67%, 64–70]) of the world's population do not have access to surgery. The proportion of the population without access varied widely when stratified by epidemiological region: greater than 95% of the population in south Asia and central, eastern, and western sub-Saharan Africa do not have access to care, whereas less than 5% of the population in Australasia, high-income North America, and western Europe lack access.
Interpretation
Most of the world's population does not have access to surgical care, and access is inequitably distributed. The near absence of access in many low-income and middle-income countries represents a crisis, and as the global health community continues to support the advancement of universal health coverage, increasing access to surgical services will play a central role in ensuring health care for all.
Funding
None.

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May 2015 Volume 15 Number 5 p487-614
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[Reviewed earlier]

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Volume 19, Issue 5, May 2015
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May 2015; 35 (4)
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March 2015 Volume 93, Issue 1 Pages 1–222
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[Reviewed earlier]

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Volume 521 Number 7553 pp394-556 28 May 2015
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[New issue; No relevant content identified]

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May 2015, Volume 21 No 5 pp415-537
http://www.nature.com/nm/journal/v21/n5/index.html
[New issue; No relevant content identified]

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May 2015 Vol 15 No 5
http://www.nature.com/nri/journal/v15/n5/index.html
[Reviewed earlier]

New England Journal of Medicine
May 28, 2015 Vol. 372 No. 22
http://www.nejm.org/toc/nejm/medical-journal
Original Article
Efficacy of an Adjuvanted Herpes Zoster Subunit Vaccine in Older Adults
Himal Lal, M.D., Anthony L. Cunningham, M.B., B.S., M.D., Olivier Godeaux, M.D., Roman Chlibek, M.D., Ph.D., Javier Diez-Domingo, M.D., Ph.D., Shinn-Jang Hwang, M.D., Myron J. Levin, M.D., Janet E. McElhaney, M.D., Airi Poder, M.D., Joan Puig-Barberà, M.D., M.P.H., Ph.D., Timo Vesikari, M.D., Ph.D., Daisuke Watanabe, M.D., Ph.D., Lily Weckx, M.D., Ph.D., Toufik Zahaf, Ph.D., and Thomas C. Heineman, M.D., Ph.D. for the ZOE-50 Study Group
N Engl J Med 2015; 372:2087-2096 May 28, 2015 DOI: 10.1056/NEJMoa1501184
Abstract
Background
In previous phase 1–2 clinical trials involving older adults, a subunit vaccine containing varicella–zoster virus glycoprotein E and the AS01B adjuvant system (called HZ/su) had a clinically acceptable safety profile and elicited a robust immune response.
Methods
We conducted a randomized, placebo-controlled, phase 3 study in 18 countries to evaluate the efficacy and safety of HZ/su in older adults (≥50 years of age), stratified according to age group (50 to 59, 60 to 69, and ≥70 years). Participants received two intramuscular doses of the vaccine or placebo 2 months apart. The primary objective was to assess the efficacy of the vaccine, as compared with placebo, in reducing the risk of herpes zoster in older adults.
Results
A total of 15,411 participants who could be evaluated received either the vaccine (7698 participants) or placebo (7713 participants). During a mean follow-up of 3.2 years, herpes zoster was confirmed in 6 participants in the vaccine group and in 210 participants in the placebo group (incidence rate, 0.3 vs. 9.1 per 1000 person-years) in the modified vaccinated cohort. Overall vaccine efficacy against herpes zoster was 97.2% (95% confidence interval [CI], 93.7 to 99.0; P<0.001). Vaccine efficacy was between 96.6% and 97.9% for all age groups. Solicited reports of injection-site and systemic reactions within 7 days after vaccination were

more frequent in the vaccine group. There were solicited or unsolicited reports of grade 3 symptoms in 17.0% of vaccine recipients and 3.2% of placebo recipients. The proportions of participants who had serious adverse events or potential immune-mediated diseases or who died were similar in the two groups.
Conclusions
The HZ/su vaccine significantly reduced the risk of herpes zoster in adults who were 50 years of age or older. Vaccine efficacy in adults who were 70 years of age or older was similar to that in the other two age groups. (Funded by GlaxoSmithKline Biologicals; ZOE-50 ClinicalTrials.gov number, NCT01165177.)
Editorial
A New Vaccine to Prevent Herpes Zoster
Jeffrey I. Cohen, M.D.
N Engl J Med 2015; 372:2149-2150 May 28, 2015 DOI: 10.1056/NEJMe1505050

Pediatrics
May 2015, VOLUME 135 / ISSUE 5
http://pediatrics.aappublications.org/current.shtml
[Reviewed earlier]

Pharmaceutics
Volume 7, Issue 2 (June 2015), Pages 10-
http://www.mdpi.com/1999-4923/7/2
[Reviewed earlier]

Pharmacoeconomics
Volume 33, Issue 5, May 2015
http://link.springer.com/journal/40273/33/5/page/1
[Reviewed earlier]

PLoS Currents: Outbreaks
http://currents.plos.org/outbreaks/
(Accessed 30 May 2015)
Surveillance of Acute Respiratory Infections Using Community-Submitted Symptoms and Specimens for Molecular Diagnostic Testing
May 27, 2015 · Research
Participatory systems for surveillance of acute respiratory infection give real-time information about infections circulating in the community, yet to-date are limited to self-reported syndromic information only and lacking methods of linking symptom reports to infection types. We developed the GoViral platform to evaluate whether a cohort of lay volunteers could, and would find it useful to, contribute self-reported symptoms online and to compare specimen types for self-collected diagnostic information of sufficient quality for respiratory infection surveillance. Volunteers were recruited, given a kit (collection materials and customized instructions), instructed to report their symptoms weekly, and when sick with cold or flu-like symptoms, requested to collect specimens (saliva and nasal swab). We compared specimen types for

respiratory virus detection sensitivity (via polymerase-chain-reaction) and ease of collection. Participants were surveyed to determine receptivity to participating when sick, to receiving information on the type of pathogen causing their infection and types circulating near them. Between December 1 2013 and March 1 2014, 295 participants enrolled in the study and received a kit. Of those who reported symptoms, half (71) collected and sent specimens for analysis. Participants submitted kits on average 2.30 days (95 CI: 1.65 to 2.96) after symptoms began. We found good concordance between nasal and saliva specimens for multiple pathogens, with few discrepancies. Individuals report that saliva collection is easiest and report that receiving information about what pathogen they, and those near them, have is valued and can shape public health behaviors. Community-submitted specimens can be used for the detection of acute respiratory infection with individuals showing receptivity for participating and interest in a real-time picture of respiratory pathogens near them.

PLoS Medicine

http://www.plosmedicine.org/

(Accessed 30 May 2015)

Seasonal Influenza Vaccination for Children in Thailand: A Cost-Effectiveness Analysis

Aronrag Meeyai, Naiyana Praditsitthikorn, Surachai Kotirum, Wantanee Kulpeng, Weerasak Putthasri, Ben S. Cooper, Yot Teerawattananon

Research Article | published 26 May 2015 | PLOS Medicine 10.1371/journal.pmed.1001829

Abstract

Background

Seasonal influenza is a major cause of mortality worldwide. Routine immunization of children has the potential to reduce this mortality through both direct and indirect protection, but has not been adopted by any low- or middle-income countries. We developed a framework to evaluate the cost-effectiveness of influenza vaccination policies in developing countries and used it to consider annual vaccination of school- and preschool-aged children with either trivalent inactivated influenza vaccine (TIV) or trivalent live-attenuated influenza vaccine (LAIV) in Thailand. We also compared these approaches with a policy of expanding TIV coverage in the elderly.

Methods and Findings

We developed an age-structured model to evaluate the cost-effectiveness of eight vaccination policies parameterized using country-level data from Thailand. For policies using LAIV, we considered five different age groups of children to vaccinate. We adopted a Bayesian evidence-synthesis framework, expressing uncertainty in parameters through probability distributions derived by fitting the model to prospectively collected laboratory-confirmed influenza data from 2005-2009, by meta-analysis of clinical trial data, and by using prior probability distributions derived from literature review and elicitation of expert opinion. We performed sensitivity analyses using alternative assumptions about prior immunity, contact patterns between age groups, the proportion of infections that are symptomatic, cost per unit vaccine, and vaccine effectiveness. Vaccination of children with LAIV was found to be highly cost-effective, with incremental cost-effectiveness ratios between about 2,000 and 5,000 international dollars per disability-adjusted life year averted, and was consistently preferred to TIV-based policies. These findings were robust to extensive sensitivity analyses. The optimal age group to vaccinate with LAIV, however, was sensitive both to the willingness to pay for health benefits and to assumptions about contact patterns between age groups.

Conclusions
Vaccinating school-aged children with LAIV is likely to be cost-effective in Thailand in the short term, though the long-term consequences of such a policy cannot be reliably predicted given current knowledge of influenza epidemiology and immunology. Our work provides a coherent framework that can be used for similar analyses in other low- and middle-income countries.

PLoS Neglected Tropical Diseases
http://www.plosntds.org/
(Accessed 30 May 2015)
Harnessing Case Isolation and Ring Vaccination to Control Ebola
Chad Wells, Dan Yamin, Martial L. Ndeffo-Mbah, Natasha Wenzel, Stephen G. Gaffney, Jeffrey P. Townsend, Lauren Ancel Meyers, Mosoka Fallah, Tolbert G. Nyenswah, Frederick L. Altice, Katherine E. Atkins, Alison P. Galvani
Research Article | published 29 May 2015 | PLOS Neglected Tropical Diseases
10.1371/journal.pntd.0003794
Abstract
As a devastating Ebola outbreak in West Africa continues, non-pharmaceutical control measures including contact tracing, quarantine, and case isolation are being implemented. In addition, public health agencies are scaling up efforts to test and deploy candidate vaccines. Given the experimental nature and limited initial supplies of vaccines, a mass vaccination campaign might not be feasible. However, ring vaccination of likely case contacts could provide an effective alternative in distributing the vaccine. To evaluate ring vaccination as a strategy for eliminating Ebola, we developed a pair approximation model of Ebola transmission, parameterized by confirmed incidence data from June 2014 to January 2015 in Liberia and Sierra Leone. Our results suggest that if a combined intervention of case isolation and ring vaccination had been initiated in the early fall of 2014, up to an additional 126 cases in Liberia and 560 cases in Sierra Leone could have been averted beyond case isolation alone. The marginal benefit of ring vaccination is predicted to be greatest in settings where there are more contacts per individual, greater clustering among individuals, when contact tracing has low efficacy or vaccination confers post-exposure protection. In such settings, ring vaccination can avert up to an additional 8% of Ebola cases. Accordingly, ring vaccination is predicted to offer a moderately beneficial supplement to ongoing non-pharmaceutical Ebola control efforts.
Author Summary
Public health efforts for controlling the 2014–2015 Ebola outbreak in West Africa have focused on contact tracing and isolation of symptomatic individuals. In addition, substantial resources have been committed to scaling up the production of experimental vaccines. Ring vaccination—the vaccination of the contacts of an infected individual—was successfully implemented to achieve smallpox eradication. Ring vaccination is particularly feasible and effective in settings where the supply of vaccines is limited and disease incidence is low. Using a disease transmission model, we evaluated the benefit of adding ring vaccination to case isolation in Liberia and Sierra Leone. We found that ring vaccination could have averted up to 126 cases in Liberia and 560 cases in Sierra Leone, thereby saving lives and intervention resources.
Hepatitis B Vaccines and HPV Vaccines Have Been Hailed as Major Public Health Achievements in Preventing Cancer—Could a Schistosomiasis Vaccine be the Third?
Michael H. Hsieh, Julia M. L. Brotherton, Afzal A. Siddiqui
Editorial | published 28 May 2015 | PLOS Neglected Tropical Diseases
10.1371/journal.pntd.0003598

PLoS One
[Accessed 30 May 2015]
http://www.plosone.org/
Cluster Survey Evaluation of a Measles Vaccination Campaign in Jharkhand, India, 2012
Heather M. Scobie, Arindam Ray, Satyabrata Routray, Anindya Bose, Sunil Bahl, Stephen Sosler, Kathleen Wannemuehler, Rakesh Kumar, Pradeep Haldar, Abhijeet Anand
Research Article | published 26 May 2015 | PLOS ONE 10.1371/journal.pone.0127105
Abstract
Introduction
India was the last country in the world to implement a two-dose strategy for measles-containing vaccine (MCV) in 2010. As part of measles second-dose introduction, phased measles vaccination campaigns were conducted during 2010–2013, targeting 131 million children 9 months to <10 years of age. We performed a post-campaign coverage survey to estimate measles vaccination coverage in Jharkhand state.
Methods
A multi-stage cluster survey was conducted 2 months after the phase 2 measles campaign occurred in 19 of 24 districts of Jharkhand during November 2011–March 2012. Vaccination status of children 9 months to <10 years of age was documented based on vaccination card or mother's recall. Coverage estimates and 95% confidence intervals (95% CI) for 1,018 children were calculated using survey methods.
Results
In the Jharkhand phase 2 campaign, MCV coverage among children aged 9 months to <10 years was 61.0% (95% CI: 54.4–67.7%). Significant differences in coverage were observed between rural (65.0%; 95% CI: 56.8–73.2%) and urban areas (45.6%; 95% CI: 37.3–53.9%). Campaign awareness among mothers was low (51.5%), and the most commonly reported reason for non-vaccination was being unaware of the campaign (69.4%). At the end of the campaign, 53.7% (95% CI: 46.5–60.9%) of children 12 months to <10 years of age received ≥2 MCV doses, while a large proportion of children remained under-vaccinated (34.0%, 95% CI: 28.0–40.0%) or unvaccinated (12.3%, 95% CI: 9.3–16.2%).
Conclusions
Implementation of the national measles campaign was a significant achievement towards measles elimination in India. In Jharkhand, campaign performance was below the target coverage of ≥90% set by the Government of India, and challenges in disseminating campaign messages were identified. Efforts towards increasing two-dose MCV coverage are needed to achieve the recently adopted measles elimination goal in India and the South-East Asia region

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Vol 6 (2015)
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[Reviewed earlier]

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07 May 2015; volume 282, issue 1806
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[Reviewed earlier]

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Volume 8 Issue 1 April 2015
http://phe.oxfordjournals.org/content/current
[Reviewed earlier]

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May 2015; 25 (5)
http://qhr.sagepub.com/content/current
[Reviewed earlier]

Revista Panamericana de Salud Pública/Pan American Journal of Public Health (RPSP/PAJPH)
February 2015 Vol. 37, No. 2
[Reviewed earlier]

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April 2015 Volume 35, Issue 4 Pages 555–758
http://onlinelibrary.wiley.com/doi/10.1111/risa.2015.35.issue-3/issuetoc
[New issue; No relevant content]

Science
29 May 2015 vol 348, issue 6238, pages 941-1052

http://www.sciencemag.org/current.dtl
Feature
Is measles next?
Leslie Roberts
Before the polio virus is even in the grave, a small cadre of disease fighters is itching to set the next global eradication target: measles. The case is compelling. Measles killed 145,000 children last year in poor countries and left many more blind, deaf, or disabled. A cheap and effective vaccine has long been on the shelves; numerous expert panels have deemed measles eradication feasible, although daunting—it is the most contagious virus on Earth. But the biggest obstacle to measles eradication is polio, which hasn't disappeared as it was supposed to do in 2000. Skeptics question whether a measles initiative would fall down the same rabbit hole as did the polio effort, which has spent billions of dollars and nearly 3 decades chasing the last few cases, only to see them disappear around the corner. Maybe it is time, they say, to settle for keeping measles cases really low but not trying to get to zero…
Feature
In Vietnam, an anatomy of a measles outbreak
Leslie Roberts
Routine immunization is one of the great public health success stories in Vietnam, where rates of vaccine-preventable diseases have plummeted. But the measles outbreak last year was another story, with 60,000 reported cases and nearly 150 deaths in children under age 2. Experts trace the epidemic to the public's loss of faith in the government-led vaccination program, following reports of adverse events associated in time with another vaccine. Many parents stopped vaccinating their children, leaving them susceptible to measles. When the virus swept in from the north and hit Hanoi, it exploded. Panicked parents rushed their children to the hospital, which was quickly overburdened. With poor infection control, the hospital became a hub of measles transmission, and children who weren't already infected caught the virus there.

Social Science & Medicine
Volume 132, Pages 1-286 (May 2015)
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[Reviewed earlier]

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Vol. 43(2015) No. 2
https://www.jstage.jst.go.jp/browse/tmh/43/0/_contents
[Reviewed earlier]

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May 2015 Volume 20, Issue 5 Pages 553–680
http://onlinelibrary.wiley.com/doi/10.1111/tmi.2015.20.issue-5/issuetoc
[Reviewed earlier]

Vaccine

Volume 33, Issue 25, Pages 2851-2954 (9 June 2015)
http://www.sciencedirect.com/science/journal/0264410X/33
[Reviewed earlier]

Vaccines — Open Access Journal
(Accessed 30 May 2015)
http://www.mdpi.com/journal/vaccines
Review: Emerging Vaccine Technologies
by Rebecca J. Loomis and Philip R. Johnson
Vaccines 2015, 3(2), 429-447; doi:10.3390/vaccines3020429 - published 26 May 2015
Abstract
Vaccination has proven to be an invaluable means of preventing infectious diseases by reducing both incidence of disease and mortality. However, vaccines have not been effectively developed for many diseases including HIV-1, hepatitis C virus (HCV), tuberculosis and malaria, among others. The emergence of new technologies with a growing understanding of host-pathogen interactions and immunity may lead to efficacious vaccines against pathogens, previously thought impossible.

Value in Health
May 2015 Volume 18, Issue 3
http://www.valueinhealthjournal.com/current
[Reviewed earlier]

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

No new content identified.

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Media/Policy Watch

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

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

Al Jazeera
http://america.aljazeera.com/search.html?q=vaccine
Accessed 30 May 2015
[No new, unique, relevant content]

The Atlantic
http://www.theatlantic.com/magazine/
Accessed 30 May 201
[No new, unique, relevant content]

BBC
http://www.bbc.co.uk/
Accessed 30 May 2015
[No new, unique, relevant content]

Brookings
http://www.brookings.edu/
Accessed 30 May 2015
[No new, unique, relevant content]

Center for Global Development
http://www.cgdev.org/
Accessed 30 May 2015
[No new, unique, relevant content]

Council on Foreign Relations
http://www.cfr.org/
Accessed 30 May 2015
[No new, unique, relevant content]

The Economist
http://www.economist.com/
Accessed 30 May 2015
Development aid
It's not what you spend
How to make aid to poor countries work better
May 23rd 2015 The Economist | 30 May 2015

FOR decades rich countries have sought to foster global development with aid. But all too often there is little to show for their spending, now over $135 billion a year and rising. Success depends on political will in recipient countries, says Erik Solheim of the Development Assistance Committee of the OECD, a club of mostly rich countries that includes the biggest donors. And that may well be lacking.

What donors will pay for may not be what recipients deem a priority. So poor countries' governments say what they must to get cash, and often fail to keep their side of the deal. Aid to build schools may be used to give fat contracts to allies, and the schools left empty. Ambulances bought by donors may rust on the kerb, waiting for spare parts.

Now donors are trying a new approach: handing over aid only if outcomes improve. "Cash on delivery" sees donors and recipients set targets, for example to cut child mortality rates or

increase the number of girls who finish school, and agree on how much will be paid if they are met. Conventional approaches still account for the lion's share of international aid. But several countries, including Britain and Norway, and big private donors, including the Bill and Melinda Gates Foundation, are experimenting with cash-on-deliver…

Financial Times
http://www.ft.com/hme/uk
[No new, unique, relevant content]

Forbes
http://www.forbes.com/
Accessed 30 May 2015
Can New Research Break The Anti-Vaccine Fever? Probably Not
Todd Essig, Contributor May 26, 2015
May has been a good month for health and well-being, at least for the science of preventing preventible illnesses. Here's why: two new research studies appeared with powerful support for vaccines and two states made legislative progress towards ending so-called "philosophical exemptions" in which parents opt-out of vaccination programs on the basis of fear and misinformation. Unfortunately, the anti-vaccine fear-trepreneurs and celebrities, like Jenny McCarthy and Robert F. Kennedy Jr., have fomented a movement impervious to data.
Both of the new studies shift the risk-reward calculation even more towards the benefits vaccines provide, a calculation already so heavily dominated by reward it should not be a question for otherwise healthy individuals…

Foreign Affairs
http://www.foreignaffairs.com/
Accessed 30 May 2015
[No new, unique, relevant content]

Foreign Policy
http://foreignpolicy.com/
Accessed 30 May 2015
[No new, unique, relevant content]

The Guardian
http://www.guardiannews.com/
Accessed 30 May 2015
[No new, unique, relevant content]

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

Mail & Guardian
http://mg.co.za/
Accessed 30 May 2015
[No new, unique, relevant content]

New Yorker
http://www.newyorker.com/
Accessed 30 May 2015
News Desk
May 29, 2015
Vermont Says No to the Anti-Vaccine Movement
By Michael Specter

Just a year after Vermont became the first state to require labels for products made with genetically modified organisms, Governor Peter Shumlin on Thursday signed an equally controversial but very different kind of legislation: the state has now become the first to remove philosophical exemptions from its vaccination law.

The two issues are both emotional and highly contested. But Vermont's decisions could hardly be less alike: the G.M.O. bill, which has enormous popular support, has been widely criticized by scientists—largely because no credible evidence exists suggesting that G.M.O.s are dangerous. The vaccine law, however, opposed by many people, is the strongest possible endorsement of the data that shows that vaccines are the world's most effective public-health tool.

Perhaps because the debate over removing the philosophical exemption has been rancorous and long, the governor first opposed the legislation. More recently, he suggested that he was neutral. On Thursday, possibly sensing the political peril involved in siding with the anti-vaccine movement, Shumlin signed the bill without much publicity. Rather than hold a news conference, as he did when signing the G.M.O. legislation last year, he simply released a statement.

"Vaccines work and parents should get their kids vaccinated," he said. "I know there are strong feelings on both sides of this issue. I wish the legislation passed three years ago had worked to sufficiently increase vaccination rates. However we're not where we need to be to protect our kids from dangerous diseases, and I hope this legislation will have the effect of increasing vaccination rates."

The previous legislation, which required parents to review educational materials before claiming the exemption, was an attempt to balance individual rights with the need to protect children from childhood diseases. Nobody has yet figured out how to do that. During the current debate, the Vermont State Health department reported that fewer than eighty-eight per cent of children entering the state's kindergartens were fully vaccinated. Like most states, Vermont currently offers parents an exemption for medical conditions and one for religious beliefs. It has been one of about twenty states that allow for philosophical exemptions, and the majority of exemptions in Vermont have been for philosophical reasons.

Meanwhile, outbreaks of measles, like the one earlier this year at Disneyland, as well as other childhood diseases, have been increasingly difficult for politicians to ignore. Public-health experts say that ninety-five per cent of a student population needs to be vaccinated to provide adequate protection against measles, the world's most contagious disease. Measles remains one of the world's leading causes of death among children under five, according to the World Health Organization. In 2013, the disease killed nearly a hundred and fifty thousand people; before vaccines became available, millions died.

"There is something deep in the core of my being," Representative Warren Kitzmiller, of Montpelier, said during the debate over the philosophical objection. "And it simply will not allow me to vote to remove a parent's right to make this serious decision on what is in the best interest of their child."

That is a reasonable position, and many people hold it. According to a 2014 Pew Research Center survey, only sixty-eight per cent of Americans believe that childhood vaccinations should be required. Among younger parents, the percentage who object is even higher.

Data and science are obviously not the only issues that matter in this debate. But it's hard to see how all rights can be equal: if parents want their children to remain unprotected from vaccinations, perhaps they should have that right. But should those children then be allowed near other students, in public places like playgrounds, or anywhere else where they could infect people with weakened immune systems? By removing the philosophical objection, at least one state has begun to say no.

New York Times
http://www.nytimes.com/
Accessed 30 May 2015
U.S. Military Orders Review as Anthrax Mishap Widens
By REUTERSMAY 30, 2015, 1:34 A.M. E.D.T.

WASHINGTON — The U.S. military said on Friday it discovered even more suspected shipments of live anthrax than previously thought, both in the United States and abroad, and ordered a sweeping review of practices meant to inactivate the bacteria…

Wall Street Journal
http://online.wsj.com/home-page?_wsjregion=na,us&_homepage=/home/us
Accessed 30 May 2015
[No new, unique, relevant content]

Washington Post
http://www.washingtonpost.com/
Accessed 30 May 2015
[No new, unique, relevant content]

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