

WHO Region	International Staff	National Staff	Total
African	151	946	1097
American	1	5	6
Eastern Mediterranean	96	839	935
European	4	6	10
South East Asian	25	1167	1192
Western Pacific	2	1	3
Total	279	2964	3243

Data are from the WHO Polio Eradication Initiative.

Table: Poliomyelitis eradication staff supported by Global Polio Eradication Initiative

wider support to the influenza-laboratory network. Should there be a need for rapid and effective social mobilisation and distribution of antiviral drugs or eventually vaccines, the capacity of the poliomyelitis eradication officers to ensure access is proven.

External support for national poliomyelitis surveillance is presently borne entirely by GPEI, with about US\$100 million in annual funding from donor countries, multilateral institutions, foundations, and Rotary International. Broadening the funding base for this

unique international public-health surveillance and laboratory network could maintain its geographical distribution and ensure a stronger response capacity for any national or international pandemic of influenza. To ignore this dividend of the 20-year international investment in poliomyelitis eradication will increase vulnerability to avian influenza in countries where health systems are weakest and least able to detect and respond.

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We declare that we have no conflict of interest.

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A new global immunisation vision and strategy

The widespread establishment of immunisation programmes over the past 30 years has provided remarkable achievements. Smallpox was eradicated, the worldwide incidence of poliomyelitis has dropped 99% since 1988,¹ and more than 2 million children’s deaths from diphtheria, tetanus, pertussis, and measles are prevented each year (figure).^{2,3} Hepatitis B vaccination could annually prevent an additional 600 000 future deaths (from liver cirrhosis and hepatoma).⁴ More than 75% of children younger than 1 year of age receive three doses of diphtheria, tetanus, and pertussis, and at least one dose of measles vaccine.⁵

Despite such success, serious challenges remain. In 2002, an estimated 1.4 million children—13% of the 10.5 million children who die each year (2000–03)⁶—died of diseases preventable with widely available vaccines for pertussis, measles, tetanus, *Haemophilus influenzae* type b, poliomyelitis, diphtheria, and yellow fever.⁷ More efforts are needed to immunise the un-immunised and save lives.

Immunisation can substantially contribute to achieving the Millennium Development Goals,⁸ especially

Goal 4, which calls for a reduction by two-thirds of under-5 mortality by 2015.⁸ Improving services to deliver traditional vaccines will reduce the 13% of child deaths mentioned above. Introducing new vaccines will help to prevent some of the 1.1 million (10%) child deaths attributed to pneumococcal disease, meningococcal disease, and rotavirus.⁷ In 72 of the world’s poorest countries—those with income per head of less than US\$1000—reaching more children and introducing new vaccines will require more resources, as immunisation costs rise from \$2.5 billion a year in 2005 to more than \$4 billion a year by 2015. More than 40 million deaths can be prevented over the next decade, at a cost of under \$1000 a life saved.

Against this background, WHO and UNICEF are joining forces, and have developed the Global Immunization Vision and Strategy 2006–2015 (GIVS).⁹ Both the World Health Assembly,¹⁰ and UNICEF’s Executive Board¹¹ recently welcomed the GIVS document as the framework for strengthening national immunisation programmes in the next decade. GIVS outlines four major strategic areas; we discuss each in turn.

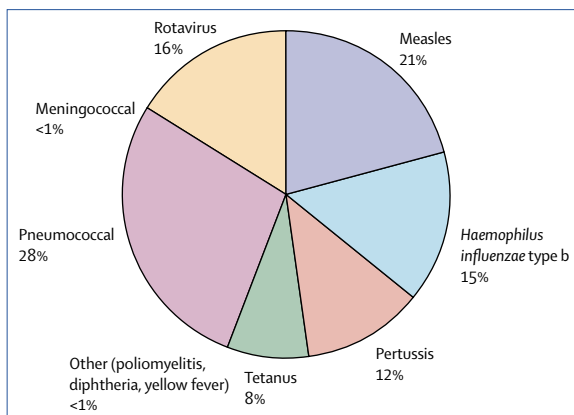


Figure: Distribution by cause of 2.5 million child deaths preventable through immunisation (2002)³

Immunisation needs to fully exploit its potential to protect more people. In 2003, an estimated 27 million infants and 40 million pregnant women remained in need of immunisation.⁷ Reaching the unreached with immunisation services—especially, hard-to-reach populations—is not only a matter of equity, but is also essential to achieving required levels of population immunity to control communicable diseases.¹² Innovative approaches, such as taking advantage of improving school attendance¹³ to introduce school-based immunisation, will be required to immunise more people and to boost waning immunity.

Protection against disease can be expanded with increasing availability and affordability of new vaccines and technologies. Recent partnerships, such as the Global Alliance for Vaccines and Immunization (GAVI Alliance), have shown a capability to lend support to countries to introduce expensive vaccines, such as those for hepatitis B and *Haemophilus influenzae* type b, and have highlighted the importance of long-term planning and country ownership. Forward planning is required by countries for informed decision-making about the introduction of new vaccines.

Health-system barriers, such as absence of qualified human resources or poor infrastructure, hamper immunisation. Immunisation will, more than ever, require stronger health systems and guidance by surveillance and monitoring activities. But immunisation services can also be used to provide other life-saving interventions, such as administration of anthelmintic drugs or distribution of insecticide-treated bednets, particularly in areas where few other services exist.

With globalisation, entire populations are becoming more interdependent. Epidemics can threaten populations living far beyond countries' borders. Cross-border collaboration and coordination must be strengthened to ensure a reliable supply of reliable vaccine, sustained financing of vaccination, epidemic preparedness, and accurate and consistent immunisation information.

The GIVS document, which describes these four strategic areas in detail, aims to provide new ideas and innovative approaches. With the political commitment now obtained to take immunisation to a new level, countries will adopt those strategies proposed in the GIVS report that are most suited to their national needs. The development of national multiyear plans, inspired by GIVS, will identify the best ways to better protect more people within their country's health systems. A global collective effort will be needed to lend support to countries in turning the ideas of GIVS into plans and actions, resulting in immunising the vulnerable children of the world.

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A secretary by any other name

Medical secretaries and personal assistants are vital to the functioning of the UK’s National Health Service (NHS), and for doctors working in private practice. Yet they are often overlooked, overworked, and feel devalued.

Secretarial support is one of the top concerns for doctors.¹ With average pay for a secretary of £14 000 a year, there is a shortfall of some 5000 secretaries from a workforce of 30 000.¹ Mark Davies, Primary Care Medical Director, National Choose and Book Team, states that “medical secretaries are the linchpins of the NHS.”²

There is a huge skill shortage, which will get worse as the current generation of medical secretaries retire. If the number of experienced medical secretaries continues to decline, consultants will have to rely on a secretarial pool or, as is already happening, medical transcription will be outsourced abroad. This outsourcing would inevitably mean delay and even poorer communication between hospitals, family doctors, and patients. Wolverhampton’s New Cross Hospital has announced that it aims to cut its annual medical secretary bill by half by sending work to India.³

The unique role of the medical secretary has evolved over decades and should be preserved and developed. However, without proper financial rewards and career development, young recruits of sufficient calibre will not come forward. Medical secretaries have an indispensable part in health-care delivery and they need to be properly integrated into the medical team.

A doctor’s professional life is underpinned by medical secretaries who give not only the doctor but also the patients all those aspects of efficiency and personal communication, which the large bureaucratic machine

of the NHS cannot deliver. In the private sector many secretaries do not have a formal job description or contract. Some NHS secretaries also work in a personal capacity for their doctor in private practice, which is a grey area and open to abuse.

The British Society of Medical Secretaries (BSMS) was founded in 1983 and seeks to promote and support medical secretaries. The Society is trying to redress the balance and help to preserve the secretarial role as an indispensable part of health-care delivery in the UK.

