Indian J Med Res 132, August 2010, pp 228-229

Correspondence

Policy Document: Evidence-based national vaccine policy

Sir,

The "policy document: evidence-based national vaccine policy" is the report of a workshop (4-5 June 2009), as clarified by footnote[1]. Participants were from academic institutions, registered societies, governmental and non-governmental organizations and private company. It states no endorsement by the Immunisation Division (ID) of the Government of India (GoI), the agency empowered to draft national vaccination policy or by participant's organizations such as the Indian Council of Medical Research. However, the journal has done well to open a forum for discussions on GoI policies pertaining to health.

The term 'policy' as applied to the national universal immunization program (UIP) has more implications than mere choice of vaccines. Policy must apply to programme design, implementation, monitoring and evaluation. The workshop report offers no help for critical assessment of current policy, if any. The section "policy measures" comes close to potential policy elements, but it is a list of 24 items most of which are neither new nor pertaining to policy. Improving vaccination schedule and inclusion of additional vaccines are technical matters; the current policy is to obtain advice from a technical group of experts -- Immunisation Technical Advisory Group (TAG), as is the practice in most other countries. Its framework and rules of procedure are administrative details. Its recommendations ought to be based (as is currently done) on scientific evidence on safety and efficacy of specific vaccines, on the epidemiological need and ethics.

The economic issues are complex and vastly more than the cost of vaccines. The loss to national economy and to families due to not preventing vaccine-preventable diseases and measures of economic benefit due to their prevention are to be addressed, for which quality data on disease burdens and expertise in health economics are essential, but wanting in ID. When estimated, I believe that funds spent on UIP will be understood as wise economic investment, instead of the current thinking that these are unavoidable expenditure to satisfy international norms.

The idea of vaccine-manufacturing under public sector ought to come under a broader GoI policy on healthcare-financing. If the GoI fully funds a vaccine manufacturing unit, UIP should get its products at no further payment. When examining the price of a vaccine available from public sector, the total investments for capital assets, salaries, pension and running costs should all be calculated to arrive at the actual cost to the GoI. We need to know the unit cost of vaccine made in the public sector (already paid for by the State) and the selling price of out-sourced product, before judging which of the two is economically less expensive to the exchequer. The need of the day is a national policy on healthcare-financing, particularly pertaining to UIP.

In my opinion, the following issues are examples of important items for articulating statements of national policy on UIP through appropriate channels and processes.

Currently UIP is centrally sponsored (vertical) and implemented by States. Implementation is satisfactory in a few States that have demonstrated 'ownership' but is unsatisfactory in a number of other States. The policy framework of sharing responsibilities as sponsor and implementer deserves to be reviewed so that all States are compelled to own up the program for optimal performance.

Major deficiencies of UIP are lack of definition of its outcome and lack of a system to monitor it[2]. Other

vertical programmes against tuberculosis, malaria and AIDS have their own built-in outcome monitoring methods – albeit of variable quality/reliability. Since India does not practice 'public health surveillance' should not UIP design and implement a disease surveillance programme for vaccine-preventable diseases? A policy is urgently needed.

Should UIP provide free vaccinations to all children or only to those below a specified income level? Although UIP budgets for 100 per cent coverage, some 20-30 per cent of population, mostly urban, use private sector and pay out-of-pocket for vaccinating children even with vaccines in the UIP schedule. Since neither healthcare nor healthcare expenses are provided by GoI for all citizens, clear policy on what expenses the GoI and State Governments are responsible for, needs to be enunciated.

Vaccinations under UIP are given by health workers with various levels of training, mostly unsupervised by medical officers at the point of delivery. In Tamil Nadu, by Government Order, vaccination has to be directly supervised by a medical officer for the purposes of maintaining quality and preventing errors. Implementing a policy on 'good vaccination practices' will help in preventing serious adverse reactions due to program errors. A beginning had been made several years ago to ensure that each injection is given by a new, non-reusable set of syringe and needle.

The above list is not exhaustive. On August 31, 2009 the Ministry of Health and Family Welfare convened a meeting chaired by the Additional Secretary & Director of National Rural Health Mission, specifically to address various elements in UIP design and implementation (captured in the phrase, 're-engineering'). Follow up action is still awaited. The failures of UIP are less due to the lack of clear policies (and goals and objectives), but more due to deficiencies in implementation. Such deficiencies have been clearly identified by the TAG but ID is so thinly staffed and supervised that they are understandable. This is not to accept status quo, but merely to sympathize with the incumbent officials. The UIP system is in urgent need of re-engineering.

T. Jacob John
439 Civil Supplies Godown Lane,
Kamalakshipuram, Vellore, TN, 632 002, India
tjacobjohn@yahoo.co.in

References

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