Irrational Vaccine push and irrational solutions

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Analysis

Rethinking global access to vaccines

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http://www.bmj.com/rapid-response/2011/11/01/irrational-vaccine-push-and-irrational-solutions

Dear Sir,

The paper,[1] is a thought provoking one and raises issues that need further debate. The vaccine push has incapacitated the ability of the poor and the developing countries to think in terms of their own requirements, priorities and the needs to acquire capacities for producing vaccines well beyond a point when the developed countries think them to be obsolete. Instead they are forced to have vaccines the thinkers in the west would say as cost effective given their population.

The Vaccine Push is spearheaded by GAVI and WHO and surprisingly these organizations are forgetting to make available essential vaccines to the underdeveloped and developing countries and foster a co-operation amongst them in producing basic vaccines.

India is still struggling to immunize its children against six vaccine preventable diseases. In some states of India like in Bihar's Kishanganj district the routine immunization is only 8.5%[2] and in Gonda district of Jharkhand it is 10.4%2.

In India there are more than 50% districts (321/593) where the vaccine coverage for six vaccine preventable diseases is less than 50% and the routine immunization has shown a declining trend over the years, some citing the reason as fatigue of the health worker in specific and the system in general due to repeated Pulse Polio Vaccine rounds and also polio putting a drain on the already strained health budgets as now promised funding for it has stopped and the third world countries are being asked to bear the burnt of polio eradication though the idea and the ultimate cost-benefit is for the rich countries for eradication of the polio. Now India would be spending around $44 Million on polio eradication this year while the routine immunization would get only around $14 Million.

So while the paper advocates access to vaccines like Hepatitis-b and Hib, we are concerned about the access to essential cost-effective vaccines in India so the disease burden due to conventional vaccine preventable diseases (Tetanus, tuberculosis, diphtheria, pertusis, measles)

is reduced before we move towards the latest vaccines.(Table:1)[3]. Newer vaccines are being foisted on poor countries in an effort to reduce the cost of the vaccines in the West, therefore helping the developed countries themselves rather than helping the poor countries!

I agree with the contention of the authors that " local logistic hurdles must be overcome to achieve equitable access", but the question is how can the logistic hurdles be removed without putting up a "Functional Vaccine Delivery Mechanism" in place. In the absence of such a mechanism where we are unable to deliver essential routine vaccines, how can we think of introducing other vaccines when we would not be able to make them reach to the intended and so called poor!

Here lies the trick of pentavalent vaccine that makes it more costly putting a drain on already strained health systems of third world countries. Regarding the cost effective analysis as per the table number 20.6 of the book[4] the cost of pentavalent vaccines for Asia comes out to be $15.24 per person vaccinated and it is only $11.58 per person vaccinated for all the vaccines as for as the traditional EPI is concerned. The old EPI costs about $1 in India (not USA prices) for all the vaccines.

The newer GMP mechanism put by WHO have already forced the stoppage of production of essential vaccines in India[5] giving another blow to self sufficiency and creating dependence on private manufacturers as the anti-snake venom and vaccines like yellow fever, DPT,BCG and Measles are now out of stocks in many states of the country!.

So the priorities need to be seen as the ground reality in the respective countries and not in the contest of making vaccines cheaper by producing in bulk or giving assurances to the vaccine producers of using the vaccine in bulk irrespective of the need for it by the countries where they are intended to be put to use.

The vaccine manufacturers are keen for getting assurances for their supplies but are reluctant to compensate the damage by their product, this double talk need to be corrected and the poor need not be taken for guaranteed.

We strongly agree that we need to develop a mechanism whereas where relaxation in TRIPS is given to enable global distribution of vaccines as almost all trial of vaccine efficacy are done in Third world countries. This would be a just and fair trade as the trial countries are feeling alienated for not getting the benefits and are given meager compensation for the trials. Also the suggestion to build local capacity to scale up vaccine programmes and scale up production needs a serious thought.

In India many people are dying with snake bites (Table-1), but nobody is advocating for the easy availability of anti-snake venom but all the talk is only of introducing Hepatitis-b and pentavalent vaccines!

So the argument by the authors for "wider global availability" needs thinking in the context of the ground situation in the respective countries and not the availability of vaccines in developed countries.

Table-1. The cases and deaths3 due to vaccine/ antisera /antitoxin preventable diseases, India, 2006

Condition/Disease	Cases	Deaths
Snake Bite	55490	1086
Japanese Encephalitis (J.E.)	2832	658
Typhoid	726484	651
Tetanus (other than neonatal)	2803	365
Rabies	361	361
Measles	63515	99
Neonatal Tetanus	620	80
Diphtheria	2745	66
Pertusis	23935	17
Polio		

REFERENCES:-

[1] Choaski DA, Kesselheim AS. Thinking global access to Vaccines, BMJ 336;2008;750-753

[2]. International Institute for Population Sciences, Mumbai. District Level Household Survey on Reproductive and Child Health DLHS-RCH, INDIA, 2002-04: http://www.rchindia.org/sr_india.htm [2007, April 7]
[3] National Health Profile, India – 2006. Central Bureau of Health Intelligence, Dte.General of Health Services, Ministry of Health & Family Welfare, Govt. of India.2006

[4] Logan Brenzel, Lara J. Wolfson, Julia Fox-Rushby, Mark Miller, and Neal A. Halsey. Vaccine-Preventable Diseases in Breman JG, Jamison D T (Ed) Disease Control Priorities in Developing Countries. The World Bank 2006 (2nd Ed). Oxford University Press 165 Madison Avenue New York NY 10016: 389-412.

[5] Ramachandran R. Vaccine worries. Frontline. Apr. 11, 2008 25(07): http://www.frontlineonnet.com/stories/20080411250700400.htm

Competing interests:
None declared