Non-availability of Vaccines and Program Ownership

Raoot, *et al*. [1] , in the recent issue of *Indian Pediatrics*, reported the success of Delhi in introducing newer vaccines. Given the fact that health is a state subject, the proactive role of Delhi is noteworthy. It is encouraging that individual state/ Union Territory takes lead for providing extra vaccines to its children. However, typhoid vaccine being out of stock in Delhi since November 2016 and MMR vaccine since December 2016 (till April, 2017), we would like to point out the other side of 'walking the extra mile'.

As expected, policy makers and doctors know the difference between National Immunization Schedule and the schedule followed by individual states. From their point of view, this newer initiative is remarkable. On the other hand, for common parents attending immunization sessions for their children, stock-out means a breach of trust. After returning without getting vaccine twice/thrice over a period of six months, we really do not know what trust on vaccination program they are left with. When a vaccine scheduled for their children is not available and health worker is not able say any probable date for the next availability of that particular vaccine, the whole immunization program suffers a setback.

With such examples of failure in supply chain management, we need to introspect the reasons of such discontinuity in vaccine availability. An exploratory study on this is probably the need of the hour. Nevertheless, if we consider the fact that even with irregular supply, we protected a number of children (as evident from reduced case load) in a way better than other states, we should take pride and look forward to consolidate the gain we have achieved so far.

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Optimizing Antibiotic Therapy for Necrotizing Enterocolitis – Need of the Hour

In last three decades, our understanding about pathophysiology of Necrotizing enterocolitis (NEC) has improved. There is a high degree of variability in the antibiotic regimen for the treatment of NEC, even within a single treating unit, with no regimen appearing superior over another. A recent study by Blackwood, *et al.* [1] documented that 22 different pre-operative antibiotic regimens were used with average duration of 10.6 d (mode 14 d). The 15 different post-operative antibiotic regimens had an average duration of 6.6 d (mode 2 d) [1].

An international survey done by Zani, *et al*. [2] on the management of NEC documented that most (67%) surgeons use a combination of two (51%) or three (48%) antibiotics for more than 7 days, and keep patients nil-by-mouth for 7 (41%) or 10 (49%) days. Currently, there is no consensus in the literature about the antibiotic regimen for neonates with NEC [2].

The Cochrane review by Shah, *et al*. [3] concluded that there is insufficient evidence to recommend a particular antibiotic regimen for NEC. There has been no randomized trial in this area since late 1980s. As prolonged antibiotics usage is associated with dysbiosis and affects neonatal outcomes, there is urgent need to optimize antibiotic therapy.

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A Plea for Fair Pricing of Vaccines

Over the last decade, there has been an upsurge of new vaccines in the Indian market. The Indian Academy of Pediatrics Committee on Immunization (IAPCOI) recommends vaccination schedule for 'office practice' annually, which serves as a guideline for pediatricians across the country. From 'optional' to 'one is to one discussion with parents' there has been a major shift to 'routine vaccines' and 'special circumstances' vaccination. This has led to a vertical split between the public- and the private-sector vaccination program.

It has been our observation that a new vaccine is usually launched at a higher price, that is then slashed within months once another manufacturer steps in. Further, by altering or adding another component to the vaccine, the cost of such combination far exceeds the cost when given individually. This is aptly being reflected in the newly launched six-in-one combinations. Also it is observed that individual vaccine by the same company goes out of market once a new vaccine is launched but continues to be available in combination (eg, Inactivated polio vaccine). This leads to an unjustified increase in the overall cost of vaccination, thus pinching the pockets of the parents.

The vaccine pricing recently has created headlines in national print media holding the pediatricians responsible. This is unfortunate as it has led to a growing mistrust between the doctor and the parents. It is very clear that doctors have no say in the pricing of the vaccine, and 'MRP' is decided by the vaccine manufacturer.

Cardiology stents and orthopedic implants have come under radar for over-pricing. Government of India has recently introduced regulation for fair pricing for essential drugs. This should be extended to the vaccine sector to curb the growing price menace. It is indeed tragic that the vaccination has become a 'privilege' rather than an essential right of the child. Parents feel guilty of not affording the newer vaccines and pediatricians usually have to take the blame little realizing that they end up serving as pawns at the hands of giant multinationals. As custodians of our children, we must ensure that the vaccine use is based on the intent, content and science, and raise voice against the pricing mischief. All the stakeholders should advocate, support and promote a 'fair pricing' policy for the vaccines for the well being of all our future citizens.

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Remodel ICDS Centers as Early Child Care and Education Centers

The recent correspondence on 'Utilization of Anganwadi services in Rural Population of Kerala' is an eye opener to the currently prevailing situation [1]. With mushrooming of private kindergartens,which cater to young children before formal schooling, society tends to turn away from the Anganwadi centers. There is an alarming competition in this field, resulting in soliciting of available children, by offering transport, uniform and other privileges. There are other reports of sub-optimum utilization of Integrated Child Development Scheme (ICDS) centers [2]. Qualitative studies should be undertaken to find out the reasons for under utilization and the societal expectations about these centers [1]. However, the solutions seem remote. Hence, it is proposed that the ICDS centers may