

schedule. The OPV is retained mainly for two reasons, first, its propensity to induce superior intestinal mucosal immunity to decrease the spread of WPV, and secondly, to avoid confusion regarding OPV at community level that would have resulted had we gone for complete cessation of OPV use since the vaccine is exclusively employed in ongoing SIAs and RI in India. Though it's true that 'effective' mucosal immunity is not visible at ground level, especially in the two endemic hotspots, yet there is no trial that demonstrates superior or even comparable intestinal immunity of IPV in India. The ongoing trials may have some answers and may ultimately settle the issue.

There is limited experience of using IPV in routine immunization schedules in developing countries. Where IPV has or is being used (for example, in Egypt, states in the Gulf Cooperation Council, Malaysia, South Africa, and Yogyakarta Province, Indonesia), it is usually administered in a sequential schedule with OPV. This schedule is also in accordance to WHO policy which states that "IPV alone may be considered an alternative to sequential schedule only in countries that have the lowest risk of both WPV importation and WPV transmission [1].

The last two doses of polio vaccines i.e. IPV at 15-18 months and OPV at 5 years are retained primarily to accord long-lasting protection to individual vaccinee. We may be erring on 'over-immunizing' an individual, but in the absence of any indigenous trial and experience, this was the safest path to choose.

The main reason why industrialized countries have switched over to 'all IPV' schedule and deprived their children the 'critical benefit of gut immunity' is safety concerns of OPV. As stated earlier, we are providing the best of both the vaccines till the 'services' of OPV are still available while minimizing the damage inflicted by it.

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Shakespeare's Honourable Men and Conflicts of Interest

Thank you for all the work put into the consensus recommendation on Immunization and IAP Immunization Timetable 2012 published by the IAPCOI [1]. However, I humbly request the consideration of the following while utilizing the information provided.

This consensus states that it is primarily for pediatricians in office practice. The reality is, that the term "office practice", actually means "private practice", where we need to generate profit to sustain our lifestyles, which is not unethical itself, but is dependent upon patients who can pay. Methods utilized to market vaccinations are sometimes controversial with aggressive practices to market vaccines of questionable public health significance, the huge margins of profits and ethics of physician-industry relationships [2]. However, the article states that "Competing Interests" of authors were stated as "None" though, as physicians, we have much to gain especially from vaccine prescriptions with excellent margins of profit [3]. Our Journal states that competing

interest for a manuscript exists when authors have ties that could inappropriately influence his or her judgment, whether or not judgment is in fact affected. It is a matter of professionalism and integrity for legitimate conflicts of interest to be recognized and for the aware reader to consider the implications of information derived from such sources [4,5]. In addition, it is difficult to be convinced that members of the IAPCOI (and many others not on the committee) have never received any support, tokens of appreciation and grants of any sort from the vaccine Industry. It appears that they remain convinced that accepting support has no role to play in their decision making process though they are human. I'm sure that even the Industry will disagree with them. Since this is a consensus and data is scarce, it is necessary to reveal Conflicts of Interests. Surprisingly, there were special invitees 9 out of 10 of which are from the Vaccine Industries present at sessions which is certainly a gross conflict of interest or have I got everything wrong?

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REPLY

Thanks for providing an opportunity to discuss in detail the issues related to conflict of interests.

No, you have not got everything wrong, but partially yes! I would not outrightly accuse you of possessing a prejudiced mindset considering the recent state of affairs where industry goes all out to pressurize academic bodies to get favorable recommendations. But probably you have not thoroughly gone through the recommendations which have many subtle and many not so subtle indications pointing toward impending change in its thinking and process of issuing recommendations. Conflict of interests issue is indeed a very serious matter, especially for the realm of vaccines and vaccination where controversies are brewed every now and then. This committee has two very specific topmost objectives, first, to settle the issue of conflict of interests for committee's members and second, to initiate a new process of issuing evidence-based recommendations.. We have devised a new 'code of conduct' for every member, advisor, and office-bearer of the committee which will be mandatory for everyone to sign and follow before joining this committee. Each member and even invitee will have to declare their conflicts of interests before participating in any meeting of the committee. A three-member committee appointed by the executive board of the academy will decide whether a member has got 'significant' conflicts and whether he/she should be allowed to remain a part of the committee or of the decision making body. All these forms will be brought in to public domain very soon. So, we are not only for disclosing all the conflicts but also for resolving them by taking appropriate measures to ensure they do not affect the ultimate process of decision making. The 'evidence based process' and 'conflicts of interest' issues are interlinked and the former cannot be practiced without addressing the latter. As stated in the consensus

recommendations [1], the main focus is on scientific evidence and transparency so that the system can be reproducible and can also be reviewed by other experts. The author probably has not visited IAPCOI website (www.iapcoi.com) which is recently also acknowledged by WHO as reliable source of obtaining information about vaccines and included in its list of websites that adhere to the credibility and content criteria of good information practices [2]. Hence, maintaining transparency is another agenda of current committee. Detailed proceedings of each meeting including agenda, detailed minutes, participants, presentations, etc are regularly posted to our website.

If we go by the author's 'yardstick' of measuring competing interests, no practicing academician would be eligible for the membership of any decision making body. We need to be specific and should have some specific guidelines, codes, etc for dealing with specific issues.

Regarding the issue of industry's participation in the meeting, the author should know that the vaccine industry forms an important ingredient of practice of vaccine science today. They have become integral part of the system that affects every aspect related to vaccines, be it developing an antigen, planning and conducting a vaccine clinical trial, approval by a national regulatory authority, collaboration with experts, agencies, governments, philanthropic societies, NGOs, academic bodies, etc. The onus is on us how to best utilize this 'unavoidable' association without being influenced. The industry people are also invited regularly by CDC/WHO in their meetings whenever they need some brand-specific data on certain specific aspects. We also invited them with certain objectives. First, we wanted to gather information on post-marketing surveillance (PMS) on newer vaccines. Once a new vaccine is licensed in the country by the NRA (i.e. DCGI in India), the vaccine companies usually start a marketing blitzkrieg targeting different quarters but usually fail to apprise them of the post-marketing performance of these vaccines. Even NRA forgets to take notice about what is happening at the community level, i.e. the AEFI, the efficacy and effectiveness, the impact on disease epidemiology, etc. The committee invited the industry people and requested them to share their data on PMS of some newer vaccines. They were also requested to initiate PMS of the vaccines where it did not exist. Secondly, we sought their help in developing a passive VPD surveillance system in the country so that some useful data can be gathered by the year end. IDSurv and the surveillance subcommittee of IAP are the steps in this direction. Another objective was to request them to cut the margins offered to practitioners (i.e. to reduce the MRP) on the sales of newer vaccines so