

The Authors' Reply

Dear Editor

We thank the reader for raising some important issues related to the paper titled 'Mass Measles Vaccination Campaign in Aila Cyclone-Affected Areas of West Bengal, India: An In-depth Analysis and Experiences' published in Iranian Journal of Medical Sciences, Vol 36(4), December 2011. We would like to share our views regarding the points raised.

Comment 1: Vaccination at the age of 6 months may be not effective enough, Therefore, this would lead to the loss of public health funds, which is important for any countries.

It is true that measles vaccination at the age of 6 months may not be effective enough. It was already decided by policy makers to schedule MCV1 administration at the age of 9-12 months in the Universal Immunization Program in India. The upper age limit was fixed as 5 years for those who missed it. However, natural calamity may warrant measles vaccination in a comparatively wider age bracket to save the most vulnerable subjects.

The WHO-CDC guideline states that 'mass measles immunization together with vitamin A supplementation is immediate health priorities following natural disasters in areas with inadequate coverage levels. Where the baseline coverage rates among those aged <15 years are below 90%, mass measles immunization should be implemented as soon as possible. The priority age groups are 6 months to 5 years, and up to 15 years if resources allow.¹

The standard guidelines may require mass vaccination to cover <10-year-old children. Previously in India in Koshi flood affected areas, children from 6 months to 14 years old were vaccinated in the initial phase after the disaster.² In our setting, the plan deviated from the norm in consultation with the State Health Authorities considering the vaccine-logistics and other support availability and feasibility to implement the programme in a short time frame.

Comment 2: The coverage of vaccination in routine EPI vaccination may be low, but for mass vaccination program a strategy should be in place to resolve any problem that prevents the increase of vaccination coverage to more than 95%.

It would have been definitely better if a higher number of children were vaccinated during the campaign. The campaign aimed at covering all children in the stipulated age range in the short time period, and estimated number of beneficiaries was calculated based on records available at block/district level. However, not all beneficiaries were present during the campaign, as many of them had left for a safer and unaffected area. Hence, actual number of denominator may have been less than the estimated number of beneficiaries. Moreover, the report exclusively documented achievement of the campaign, and did not incorporate routine immunization activity that followed the campaign once the situation had been stabilized.

Comment 3: Any disaster may destroy public health infrastructures, but the right decision for prevention is important. For example in Iran after an outbreak of measles, Ministry of Health decided to vaccinate 5-25 year-old individuals. The reason of mass vaccination in report of Mallik S et al is not clear. In any disaster unnecessary works may increase complications of the disaster that authorities of public health should have in mind.

Decision for mass vaccination campaign was jointly taken up by the State Government and other stakeholders like Unicef and WHO-NPSP. It was a post-disaster response when a large pool of susceptible children was in the affected areas, and many of them were staying in overcrowded camps and increasing potential of transmission. Also, the living conditions, large scale migration, sanitation situation, nutritional status of children in those areas were considered. During the vaccination for Koshi flood affected area, the coverage was about 75%.

Regarding cost-effectiveness, we believed that we were dealing with a high-risk situation, in which the objective was to increase the immunity status to mitigate the outbreak potential and consequent mortality/morbidity, the intervention was a justified decision. In retrospect, the coverage may appear to be deficient, but that does not disqualify the rationality of the intervention.

Comment 4: After mass vaccination, a pilot study could certainly help to distinguish immunity for measles. Such a pilot study was not done, but in Iran immunity assay after mass vaccination identified that more than 98% was immune to measles.

The suggestion of post vaccination evaluation is appreciated. However at present in our setting it is quite difficult to arrange a survey to assess immunity following vaccination at community level.

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- 2 Varkey S, Krishna G, Pradhan N, Gupta SK, Caravotta J, Hombergh HV, et al. Measles vaccination response during Kosi floods, Bihar, India 2008. *Indian Pediatr.* 2009;46:997-1002. PubMed PMID: 19955583.