'killers', except polio, are obviously prevalent. India does not practice public health surveillance and no reliable data exist on burdens or spectrum of IDs. This is like closing eyes to miss the obvious.

Why does India's health system neglect to prevent IDs? Lack of intervention tools cannot be blamed. Is lack of systematic intervention by national policy(5)? If lack of public demand is an excuse not to spend funds on public health, Indian Academy of Pediatrics ought to make that explicit demand. Whatever the reasons, the Government is not justified in passively promoting morbidity, mortality and family-level poverty by not controlling IDs.

The manifesto of Indian National Congress (INC) for 2009 parliamentary elections promised 'health security for all'(6). After winning the elections INC remains silent on it. The Party President and Prime Minister are accountable to people on the promise. Health security subsumes ID-control, for which responsibility with accountability should be assigned to the Minister and Secretary, Department of Health and to Directors of Health Services and National Centre for Disease Prevention and Control.

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Declaration. I declare no conflict of interests. The opinions are personal and do not necessarily reflect those of any organization/committee of which I am a member.

NTAGI Recommendations Overlooked Crucial ICMR Data

We thank the NTAGI for publishing its recommendation on Hib vaccine in Indian Pediatrics(1) as this journal allows 'extended peer review' in its correspondence columns. We are concerned that the technical advisory body has overlooked crucial evidence gathered in studies done by the ICMR while making its recommendations.

In 2002, one of the members of this subcommittee, Professor Thomas Cherian wrote in this journal quite categorically, that based on the data available Hib vaccine could not be recommended for routine use in the EPI in India(2). He recommended more studies be done to establish the need for vaccination. Press reports in 2005(3) suggest that one such study was indeed undertaken by the ICMR in Anaicut block, Vellore. We did not find the results of the study published in an indexed journal in spite of an extensive search of the literature. We presume the data must have been made available to the NTAGI.

The first part of the ICMR study was supposed to look at the incidence of pneumonia (regardless of

etiology) and deaths from pneumonia. The WHO suggests that 19% of the under five mortality (U5MR) in India is due to pneumonia(4). Given the fact that the U5MR is 71.9/1000 this implies that 14/1000 children under 5 years of age die of pneumonia.

The NTAGI report of 2008(1) says 'there is (now) sufficient evidence of relatively high Hib disease burden in India to warrant early introduction of Hib vaccine into the UIP'. Professor Cherian Thomas represented WHO on this NTAGI sub-committee. We expected new research done after 2002, which had made the author change his mind and which allowed the expert group to make this recommendation, would be quoted in the report. However in looking through the data reviewed during the subcommittee process (Appendix 2), we find no reference to any population based study from India done after 2002 under the heading 'Hib disease burden and Epidemiology'. The studies quoted on pneumonia and respiratory infections were all published between 1984 and 1999.

We believe that the data from the ICMR study in Anaicut on the incidence of pneumonia and deaths from pneumonia are crucial for advising policy. We wonder why it was not made available to the NTAGI. If it were available, we are curious as to why it has not been referred to in the report. We urge that this be done urgently and published as a reply to this communication, so it can advise policy. Selective use of data is not compatible with the principles of evidence based medicine.

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