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PATH is an international nonprofit organization that transforms global health through innovation. Its mission is to improve the health of people around the world by advancing technologies, strengthening systems, and encouraging healthy behaviors.

Q: Please tell about your activities in India?

Dr Ghosh: PATH began its work in India the late 1990s, bringing governments, communities, private-sector companies, and experienced public health practitioners together to address some of the country's most crucial health problems. One of our first large projects was the USAID funded Program for Advancements of Commercial Technology-Child and Reproductive Health (PACT-CRH). In early 2000, the scope of our India program expanded with a major immunization initiative for Andhra Pradesh state. Today, with offices in Bhopal, Lucknow, Mumbai, New Delhi, Patna, and Hyderabad, PATH's India projects focus on immunization, HIV/AIDS, injection safety, and microbicides.
In Indian context, the organization is also involved in strengthening routine immunization services and introducing new vaccines (including hepatitis B vaccine) into India's Universal Immunization Programme. We are also the secretariat of the India Injection Safety Coalition, for which we were a founding member.

We have also been in the business of clinical development of vaccines over a long period of time. In 2012, the institute of one world health which was another product development department merged with PATH. We work closely with the department of biotechnology (DBT), Clinical Development Services Agency (CDSA), and Translational Health Science and Technology Institute (THSTI). With CDSA, we have been involved in developing the clinical development capacity of clinical researchers in India over the past three years.

Q: Please tell about the Japanese Encephalitis vaccine and its implementation in the Indian national immunization programme?

First cases of JE were reported in India in 1960 but not much could be done at that time. Later when there was a major outbreak in 1970, the government of India decided to take action against these cases. And the vaccine they were using was this three dose vaccine manufacturing at Central Research Institute (CRI), Kasauli. Then in 2005, when there was massive outbreak in Gorakhpur, we played a positive role in pressing the government to be more proactive. Hence, finally the government decided to include the vaccine in the national program.

First of all, the supply was very small. The production of vaccines too was an issue. So, the Indian govt started work with PATH as we were handling the JE project. The vaccine SA 240 manufactured at Chengdu Institute of Biological vaccine, China was introduced by the GOI in India. The logic was that it was already used in Nepal, South Korea and China with a good feedback and evidence. Hence, government sent teams and it was decided that over the period of five years, in 15 states, 112 districts would be vaccinated. Early awareness was followed by the integration in the NIP.

We are in a better position than in 2000. Now, we have 83.7 million children vaccinated till date. While the PATH worked with the government for technical support, JE disease burden load has come down. too with the active GATES Foundation has with us. WHO also provided the technical assistance. Now we are taking these lessons to the other countries that require attention. We are now focusing on the alternative inactivated vaccines including the Intercell vaccine.

Q: How have your experiences regarding developing versus developed nations? What about India and other countries in the region?

The developed nations always hold an edge. They have a system to retain the crucial disease afflicted population data required for devising the programmes aimed to tackle the same. Whereas that is a big problem in case of developing nations. The patent data/surveillance data available from the countries such as Thailand, China. Lao, Cambodia is not available. So then we have to rely on other factors such as findings from government sources supported by us . The availability of resources is a constraint. Moreover, we too have to act under limited conditions some times. The GAVI eligible vaccine nations are the only ones who get the prequalified vaccine as a part of funding and JE till now is not in the list. But the good news is that soon WHO is expanding the horizons to include few nations.

Now, when there are no resources, India has pulled its own resources to introduce and support the vaccine. Our vaccine manufacturing industry is growing and we are donating the vaccine for global projects in other developing or poor nations. In countries like Cambodia, Vietnam, Bhutan and Phillipines, they have a local vaccine market which is cheaper yet may be low on quality. China has its own system for impact assessment procedure. Thailand has its own robust capturing system. Every two years, we have this regional conference in South East Asia.

Q: How is the monitoring programme in India?

In India, the monitoring has been difficult. The imely reporting and data capture doesn't include the actual lab based tests. NIV has confirmed that but the natural vaccine can be different. Uttar Pradesh and Bihar is asking 30% and 40%. But why coverage evaluation survey done by UNICEF but a continuous process of capturing date. Institutionalization of monitoring process has to be done. There is a silent area that we need to identify. We are all moving in the right direction but probably it will take some time. When we started in 2006, we had an India where there was no experience in surveillance. It can be limited to malarial programme.

As an example, the Visceral Lieishmaniasis is one of the neglected diseases in India. In 2001, we reviewed the situation and realized that in South East Asia, the problem is huge. In India, Bihar was among the worst affected. Funded by the Bill and Melinda Gates Foundation, tropical disease wing of WHO, the initiative on studying socio-economics of visceral leishmaniasis by eminent medical professor, Dr C P Thakur and Dr Shyam Sudar of ICMR came as a great help. WHO pharmacovigilance and one world health supported phase IV three districts. The former union minister revolutionized the concept of treatment of Kala Azar. In 2006, Drug Controller Genral ogf DCGI Manufacturer identified and least costly drug worth US $ 20 for 21 injections came as a breakthrough. Now the focus on the early detection is a key as after seven days of infection, there is a reflection.

By 2014, we will hopefully get the single dose Amphotericin B ready. We are part of a bigger plan for elimination of Kala Azar by 2020. Once it becomes a national programme, the government will surely be a part of it. We must have the very well. While the under developed Nepal has focused intervention in this area, India continues to remain in hot spot. Funding is an important issue but the monitoring is an aspect that cannot be ignored.