IMMUNIZATION COVERAGE AT A MILITARY STATION

Dear Editor,

This is in reference to the article “Immunization coverage at a military station” [1]. Certain points need clarification and are redefined.

The basic principle behind universal immunization programme is that it is the birth right of every child. Further the practice of immunization involves a great amount of counselling and education of parents. This is adopted on the basis of epidemiological profile of the population, option exercised by parents & welfare programmes in the station. Lastly, the delivery of this programme is to be very scientific and based on rigid and accepted protocol.

In Armed Forces, the delivery of this programme is mostly through Station Health Organization and usually prescribed by general duty medical officer. In a minority of cases (mostly in bigger hospitals) immunization clinic is conducted by paediatrician. However, it has been noticed that with increasing awareness among clientele the demand for better immunization facility has been steadily increasing. Failure to meet these demands is leading parents to buy vaccines from chemists. This is fraught with danger including the most important aspect of the programme i.e. ‘cold chain’.

The practice of paediatrician conducting the vaccination programme in a station has definitely brought about tremendous

change in terms of quality & quantity. Time has come probably for Armed Forces to adopt this as a policy. Lack of paediatrician should not be a negative factor, because any medical officer could be trained on this programme and regular updating of knowledge & practices can be incorporated in the policy.

Author’s observation that paediatrician must include immunization history in outpatient cases is out of place. Every student of paediatrics is trained to focus attention on breast feeding, weaning practices, growth & development and immunization of every child.

Lastly, two comments on the methodology adopted in the study. In any study if exclusion criteria are going to affect the result and inference drawn then those criteria are not valid. A study which is inferring on immunization coverage in a given population, a segment of population (officers) cannot be excluded. Secondly, as per UIP schedule every child will get minimum five doses of OPV including zero dose with BCG at birth. This has not been reflected in the study (Table 1).

References

1. Joshi RM, Bala S. Immunization coverage at a military station. MJAFI 2003;59:223-5.

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REPLY

We thank the reader for his kind interest and valuable suggestions and comment about the article “Immunization coverage in the military station” [1].

Immunization is primarily a domain of Family Welfare Centres, however over a period of time, thanks to changing pattern of medical care, it has now come under the domain of paediatrician/PSM specialist, and delivery of the services is generally through Station Health Organizations (SHO). A large number of SHOs are now conducting Well Baby Clinics in which immunization services are provided once a week. There is no doubt that with increasing awareness clientele is asking for newer vaccines, especially not supplied by Govt. At the Well Baby Clinic in the study station as well as in the present unit of author, vaccines like MMR, Hepatitis B, Typhoid etc are purchased directly from the supplier and provided to the consumers to ensure a proper cold chain. There is a need to adopt a uniform policy in this regard by the Armed Forces and concern of the reader is well appreciated.

In the study, it was recommended that paediatrician must include immunization history in all the OPD cases, to detect missed opportunities of immunization. It will be agreed that now a days most of the paediatricians conduct OPD daily without referrals. Aswar et al [2], found that in 49% cases the missed opportunities for immunization were due to paediatricians or health personnel. They found that in 35% cases immunization status was not assessed at all and in 14% cases, there were wrong ideas about the contraindications. Thus, the recommendation is very much relevant and not out of place as commented by the

reader. In fact immunization is not a sole responsibility of paediatrician or PSM specialist only. Immunization history should be assessed in all the contacts with children/parents by the medical, nursing staff and parents advised accordingly.

In the study officer’s children were excluded, since the sample size was very small to draw any valid conclusion. Inclusion and exclusion criteria in any study is the privilege of the investigators, who depending upon the local conditions design a study. The limitations of such a study applies to this study as well. The results of this study cannot be generalized to the officers.

The observation of reader that zero dose should have been mentioned in Table number 1 is agreed to. However, it is brought out that though zero dose is included in the immunization schedule, the UIP still aims for 85% coverage with three doses of OPV during the first year of age [3,4]. Thus inclusion of zero dose though desirable, is not mandatory while evaluating vaccine coverage in a station. Similarly, immunization received during pulse polio immunizations is not included in the UIP and this study as well.

References

1. Joshi RM, Bala S Immunization coverage at a military station. MJAFI 2003;59:223-5.
2. Aswar NR, Deotale PG, Kale KM, Bhawalkar JS, Dhage VR. Socioeconomic correlates of missed opportunities for immunization. Indian J of Pub Health 1999;43:148-51.
3. Park K. Health Programmes in India. In: Park’s Text Book of

Preventive and Social Medicine. 15th ed. 1997;302-9.

4. Kar M, Reddaiah, Kant S. Primary Immunization status of children in slum areas of South Delhi - The challenge for reaching

urban poor. Indian J Comm Med 2001;26:151-4.

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OUR STRESS-PROOF JAWAN

Dear Editor,

This is with reference to the Original Article titled 'Evolving Medical Strategies for Low Intensity Conflict' (MJAFI 2003;59:96-99). The authors are to be complimented for highlighting a pertinent issue which has not been in the radar screen of our policy makers. The essence and flavour of Low Intensity Conflict have been projected in graphical detail. However, a few points need clarification.

1. The authors have not mentioned the number and details of the cases studied by them under the heading 'Material and Methods' based on which the Original Article has been written.
2. The total number of deaths among American battle casualties in Vietnam War was 55000. The authors have given the figure of 110000 suicides in Vietnam War due to Post Trauma Stress Disorder which appears to be a gross exaggeration.
3. The authors have recommended posting a psychiatrist and a psychologist at the Brigade level in theatres of Low Intensity

Conflict in J&K and North East. If this recommendation is implemented there will be several times more psychiatrists than surgeons in these sectors. This is perplexing because the data given by the authors themselves shows that the incidence of psychological casualties and Post Trauma Stress Disorder in Low Intensity Conflict in J&K is only a fraction of the incidence in conventional wars in Korea and World War II (Table 3 of the article).

4. Classical PTSD cases are a rarity in the psychiatric wards of hospitals in CI Ops locations. Admissions due to combat stress are more common but even these admissions amount to less than 60 per year in a Zonal Hospital. This low incidence of combat stress is a tribute to the hardy soldier who bears adversity with remarkable equanimity and commendable fortitude unlike his Western counterpart.

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EVOLVING MEDICAL STRATEGIES FOR LOW INTENSITY CONFLICTS - A NECESSITY

(a) The details mentioned in the Tables has been taken from Reference -3 under the heading 'References' of the article.

(b) The deaths that were experienced in Vietnam due to Agent Orange and other jungle diseases have become well known by the general public. However, it is suicide that has resulted in the deaths of over 150,000 Vietnam soldiers during and after the war. An enormous amount of suicides resulted from what most people call "protecting our country". References: "Harris Erik: Suicide of Vietnam Veterans, Archived Term paper, VFW magazine and the Public Information Office, HQ CP Forward Observer - 1" Recon, Apr 12 1997".

There are sites that have popped up over the Internet dealing with the men and women who served in the Vietnam War. The site, "Suicide Wall", "...is an attempt to determine how many Vietnam veterans have actually taken their own lives..." (Suicide Wall, 11-10-2000). An on going study on why and how these suicides take place is continuing everyday. A big controversy is actually how many people did take their lives due to the war. The United States have their statistics, but Australia went in-depth to see an actual amount. The U.S. claims about 58,000 suicides have taken place due

to the war. This count is about 20% of all deaths in the Vietnam War, which would be placed in the category of suicide. But Australia believes through the same and other statistics that about 150,000 people committed suicide.

The Vietnam and other wars have mentally and sometimes physically dismembered veterans. Another factor that plays a role in a war-related suicide is the addition of many on-site diseases such as defoliants, Agent Orange in particular. Made up of equal parts N-Butyl Ester 2,4,-D and N-Butyl Ester 2,4,5,-T. Agent Orange made many Vietnam soldiers go insane (Vietnam Veterans, 11-10-2000). This atrocious chemical led and still today, leads to death, deformation, and diabetes.

(c) The recommendations of an 'Emotional support team' at the Brigade level in theatres of Low Intensity Conflicts in J&K and North East is an ideal solution, nevertheless 'Mobile Emotional support team', suggested as an opinion has made its ground and has been implemented.

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