Charms” in Childrearing”

Traditional or cultural practices are time honored rituals and beliefs which are prevalent in the community and they may pertain to a wide range of activities. A charm is defined as something worn about the person to ward off evil or ensure good fortune. Commonest purpose for use of charm is for general wellbeing, and is found to be higher among people living in rural areas in joint family with poor socioeconomic status, or with advanced age of parents and poor literacy status of parents.

The traditional practices are so ingrained in the society that it is difficult to change them even when they are identified to be useless or harmful [1]. Though harmless, their presence can be a source of infection due to frequent contamination [2]. Moreover, they often result in delay in health-seeking with resultant deterioration of the child [3].

This study was done between October 2011 and September 2012 in the Department of Pediatrics JJM Medical College, Davangere. We studied 1000 children (500 cases with charms and 500 controls without charms) attending the hospital for the presence of “charms”, and factors related to their usage; using a structured form, followed by interview with a single researcher (ANR). The case and control groups were comparable in terms of age and gender composition and religion. More than two-third cases (77.2%) and controls (71.2%) were under 5 year old. There were no differences between cases and controls with respected to sex distribution (62.2% and 64.4% males) and religion (91% and 87.6%) Hindus, respectively. The various types of charms in the study were: Tayatha 41.2%, Ele (thread) and Anthra 26.1%, Drishtimani (string of beads) 10.6% and Cheeti 10.6% . Other types constituted around 12%. 64% and 36% were from rural and urban areas. Similar observations have been reported by other studies [4,5]. Most of the charms used are harmless. Each charm is usually related to particular symptoms or a disease, but most are non-specific. It can be suggested that culture and health beliefs should be taken into account when training programs are prepared to change traditional child care practices and to promote health behavior. A pediatrician should understand the local tradition and charms, which can guide in the clinical practice. Nursing education curriculums should also train nurses to assess traditional practices, to reinforce positive cultural practices, and to discourage potentially harmful ones.

Almost all the charms in the study were harmless. The results of this study can help health professionals to recognize the role of traditions in child health.

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Autoimmunity in Immunodeficiency

A 1-year-oldboy presented with recurrent attacks of severe life threatening infections since 5 months of age along with persistent diarrhea for last 3 months. He was visibly malnourished And had generalised erythroderma with scaling. Immunophenotyping from peripheral blood showed very low CD4+ and CD8+ count (9/μL and 94/μL, respectively); CD4/CD8 ratio was 0.09. Immunoglobulin (IgM: 6 mg/100 mL; IgA: 6 mg/100 mL, IgG:110 mg/100 mL: IgE :5.7I.U/mL) levels were below normal suggesting a diagnosis of severe combined immunodeficiency (SCID). This patient developed high fever, hepatosplenomegaly and pancytopenia (total leukocyte count 0.3 ×10⁹/μL, neutrophil 12 %, platelet count 78 ×10⁹/μL, hemoglobin 6.8 g/dL. Fasting triglycerides (342 mg/dL) and serum ferritin (9240 ng/mL) were raised, and bone marrow showed hemophagocytosis. Intravenous
immunoglobulins were started along with antibiotics. General condition of the patient deteriorated and the patient expired in next few days.

Although it sounds paradoxical, an autoimmune phenomenon can complicate a pre-existing primary immunodeficiency disorder, thereby creating a diagnostic and therapeutic challenge to the caring physician. Cases like Autoimmune thrombocytopenia and Autoimmune hemolytic anemia in Common variable immunodeficiency [1], and Omen syndrome and Autoimmune thrombocytopenia in SCID [2] have been reported. Impairment of both central and peripheral tolerance is responsible for autoimmunity observed in SCID [3]. Treatment with immunosuppressive agents such as corticosteroids can exacerbate the infections associated with immunodeficiency disorders. So non-immunosuppressive agents such as Intravenous immunoglobulins and targeted monoclonal antibodies are likely to be preferable [4].

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Pentavalent vaccines and operational difficulties

The Puducherry Government provides vaccines for BCG, OPV, DPT, Hepatitis B, Measles and MMR vaccines to all government hospitals, medical colleges and primary health centres. The Government of Puducherry launched the pentavalent vaccine programme in January 2013 [1]. The pentavalent vaccines are given in three doses at 6, 10 and 14 weeks along with oral polio vaccine (OPV). IAPCOI timetable 2013 recommends HB vaccine at 6, 10, 14 weeks and a booster dose between 15-18 months [2]. Some want to follow the older regimen instead of pentavalent vaccines as they feel the safety of vaccines is more important than the number of injections. With the non-availability of HB vaccine, parents are advised to buy it vaccine from outside.

When the Government of India and Indian academy of Paediatrics is sure of implementation of pentavalent vaccine program, why it is not incorporated in the National immunization programme and IAPCOI Recommendations 2013. Is it not wiser to expand the National immunization programme first-and-more importantly make it uniform throughout the country-and-then go for the combined vaccines? Is it not wiser to expand the spectrum of vaccine preventable diseases rather than focus on combination vaccines? No doubt the combined vaccines are there to stay, but the policy makers cannot ignore the pitfalls. The most important objective is effective and safe vaccines, and to achieve the goal of 100% immunization coverage in the country.

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REPLY
Apropos of the query regarding Hib vaccination schedule, this is to clarify herewith that IAP ACVIP recommendations are mainly for individual protection of a particular child in an office practice setting. They are the most appropriate way of using available licensed vaccines to provide best possible protection to an individual child. It may not always be feasible to apply these guidelines in-toto while designing a mass, national level vaccination program. The logistics, cost and other...