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In the present study, 12% of health care workers have not complied with completion of three doses of vaccine. Six (10.5%) of the successfully vaccinated health care workers who were low or non-responders (<10 mIU/mL) were advised to receive additional dose of vaccine since some may mount an anti-HBs response when given a dose of vaccine years later. All the defaulters were advised to have their anti-HBs levels checked at least once in two years for the sustainability of minimal protective levels of antibody.

It is essential that long-term follow-up studies should continue to monitor groups of immunized individuals to determine if clinically significant breakthrough episodes of hepatitis B occur or whether the carrier state develops. The outcome will help in future decisions on booster policies.

### References


*TV Rao, IJ Suseela, KA Sathiavathy

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### Table: Estimated levels of anti-HBs in health care workers

<table>
<thead>
<tr>
<th>No. of vaccine recipients (n = 65)</th>
<th>Quantization of anti-HBs titers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;10 mIU/mL</td>
</tr>
<tr>
<td>Three doses (n = 57)</td>
<td>6 (10.5%)</td>
</tr>
<tr>
<td>Two doses (n = 6)</td>
<td>0</td>
</tr>
<tr>
<td>One dose (n = 2)</td>
<td>0</td>
</tr>
</tbody>
</table>
90.32% in the 41-45-year age group, excepting a slight drop (2.63%) in 31-35-year age group. A similar trend was observed in both urban and rural females when arranged according to age groups (Table). The percentage of new cases, i.e., incidence rate, in a specific group was calculated by deducting the total percentage of rubella IgG positives in that group from the percentage of the preceding age group; there was a significant increase (31.14%) in the incidence of infection in the 6-10-year age group ($P < 0.001$).

The gradual increase in the prevalence of rubella infection with age indicates a continuous exposure of the population to rubella virus. Similar findings were reported in previous studies from India\cite{1} as well as in most of the industrialized countries before the introduction of rubella vaccination programme.\cite{2,3} The highest incidence of infection occurred in 6-10-year age group, and children become protected from further rubella infection. Although it was thought that population density, area of residence and socioeconomic factors of a given community influence rubella infection, the prevalence of rubella antibody was more or less similar in urban and rural areas. It indicates that the women of both areas are at similar risk of infection to rubella virus in Bangladesh.

In this study, it was seen that 65.20% female children acquired immunity to rubella by the age of 12 years. Thereafter, 25.12% of women in the child-bearing age (i.e., 13-45 years) acquired new infection; if they contracted rubella infection during their early pregnancy, there is a high probability of developing CRS.

World over, 124 countries reported a national policy of rubella vaccination in 2002. Although studies indicate that rubella immunization is a cost-effective means of reducing the impacts of CRS, Bangladesh and other South Asian countries, except Sri Lanka and Maldives, have not yet included this vaccine in their national vaccination system.\cite{4} In the present study, we found that more than 50% of pre-pubertal girls were immunized by natural infection. As reduction of infant mortality was one of the priority objectives of the Millennium Development Goal, introduction of rubella vaccine in the pre-pubertal age may be beneficial in further reducing infant mortality rate and CRS.

References


A Nessa, MN Islam, S Tabassum, *SU Munshi, MAhmed, R Karim

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Table: Distribution of prevalence of rubella-specific IgG in the study population

<table>
<thead>
<tr>
<th>Age group (n)</th>
<th>Rubella serology</th>
<th>Rubella prevalence@</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive* (%)</td>
<td>Negative (%)</td>
</tr>
<tr>
<td>1-5 years (61)</td>
<td>13 (21.31)</td>
<td>48 (78.69)</td>
</tr>
<tr>
<td>6-10 years (61)</td>
<td>32 (52.45)</td>
<td>29 (47.55)</td>
</tr>
<tr>
<td>11-15 years (63)*</td>
<td>42 (66.66)</td>
<td>21 (33.34)</td>
</tr>
<tr>
<td>16-20 years (62)</td>
<td>48 (77.41)</td>
<td>14 (22.59)</td>
</tr>
<tr>
<td>21-25 years (83)</td>
<td>68 (81.92)</td>
<td>15 (18.08)</td>
</tr>
<tr>
<td>26-30 years (67)</td>
<td>56 (83.58)</td>
<td>11 (16.42)</td>
</tr>
<tr>
<td>31-35 years (63)</td>
<td>51 (80.95)</td>
<td>12 (19.05)</td>
</tr>
<tr>
<td>36-40 years (60)</td>
<td>53 (88.33)</td>
<td>7 (11.67)</td>
</tr>
<tr>
<td>41-45 years (62)</td>
<td>56 (90.32)</td>
<td>6 (9.68)</td>
</tr>
<tr>
<td>Total (582)</td>
<td>419 (71.99)</td>
<td>163 (28.01)</td>
</tr>
</tbody>
</table>

*11-15-year age group has been broken into 11-12 years and 13-15 years, and prevalence in 12 years was 65.20; @According to area of residence, Z-tests done, $P > 0.05$; *Percentage of prevalence, number of positives (number tested in this section); *Antibody titer $\geq 10$ IU/mL was considered positive, <5 IU/mL negative, and $\geq 5$ to <10 IU/mL indeterminate