

Evaluation of knowledge and practice regarding oral health care among diabetic patients in PHCCs in Al Ahsa, 2006.

Periodontal disease is one of the common complications of Diabetes Mellitus. Adults with diabetes have both a higher prevalence of periodontal disease and more severe forms of the disease. This study was conducted to study knowledge and practices of diabetic patients regarding oral health and their perception of the management by dentists. A cross-sectional study was conducted among diabetic patients attending general clinics of nine randomly selected Primary Health Care Centers (PHCCs) in Al-Ahsa area of Eastern region, Saudi Arabia. A pair of one male and one female health worker was trained at each health center to interview patients using a structured questionnaire, and extracting relevant data from their records.

Among 530 diabetic patients, mean age was 53.6 years (SD±13), 50.4% were female, and over half were uneducated (57.9%). Among the diabetic patients interviewed, 20.5% were smokers (current smokers 7.5% and ex-smokers 13.0%); while 57.9% had other concurrent chronic diseases. Mean duration of diabetes was 9.6 years (SD±7). Most of the patients (73.8%) brushed their teeth and 25.1% used miswak. Only 18.9% pointed out oral and gum problems as complications of diabetes. Among the total, 109 (20.6%) had routine check up for some oral problem and overall 30.7% were referred to dentists. Over half had some oral problem (47.5%), including spontaneous toothache (35.1%), bleeding gums (10.8%) and bad breath (10.2%). 65.3% claimed to have received health education about oral health; sources included television (28.9%), dentists (24.2%) and doctors (20.8%).

Regular follow up of diabetic patients in dental clinic was thought to be important by 419 patients (79.1%). Four hundred thirty patients (81.1%) had had oral surgery, 427 (80.6%) undergone tooth extraction. Only 43 (8.1%) used dentures.

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One hundred fifty patients (28.3%) reported that they had fear of going to the dentist. Among all the diabetic patients, 156 (29.4%) were not satisfied with the dental care in the health facility.

Oral health problems were more common among females ($P<0.001$), uneducated ($P=0.012$), unemployed ($P<0.001$), patients with longer duration of diabetes ($P=0.10$), with other coexisting chronic diseases ($P=0.004$).

It was concluded that a large proportion of diabetic patients had oral health problems, while the majority had reasonably satisfactory oral hygienic practices. Referral of diabetic patients for routine check-up was not satisfactory; and when patients are referred for dental care, at times their diabetic status was not fully taken into consideration. Fixed features like lower educational status, unemployment, chronic diseases, and longer duration of diabetes show a positive relationship with existence of oral problems; while changeable behavioral factors like smoking, brushing teeth, using miswak, visiting dental clinics, acquiring and possessing health knowledge showed an inverse relationship with existence of oral problems.

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Editorial notes: One of the major complications of diabetes is periodontal disease,¹ which has been associated with development of glucose intolerance and poor glycemic control among adults with diabetes.^{2,3}

The treatment of diabetes has always centered on the control of blood sugar through medication and appropriate nutritional intake. Preventing oral infection, as an adjunct in controlling blood sugar, has been given little attention.

Regular dental visits provide opportunities for prevention, early detection, and treatment of periodontal disease among dentate adults; moreover, regular dental cleaning improves glycemic control in patients with poorly

controlled diabetic conditions.^{4,5}

Physicians and dentists should cooperate to improve the current diabetes dental care by taking the appropriate steps to improve the delivery of dental services to diabetic patients. These steps should include formulation of guidelines, update current curriculums of dental schools on diabetes, and improve participation of dentists and nurses in oral health education.

In this study, almost half of the diabetic patients had some oral health problem, and among them quite a few had toothache, dental extractions and bleeding gums. However, it appears

that diabetic patient do not clearly appreciate that their dental problems are related to their diabetes, since only one fifth mentioned it as complication of diabetes. Oral self-care plays a role in maintaining and promoting periodontal health and the prevalence of periodontal disease varies according to individual health behavior.⁶ The study showed some good habits that can help in reducing oral problems, over two thirds brushed their teeth and actually 41.2% brushed their teeth twice daily. Almost a quarter also used Miswak and a few used dental floss. These healthy

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Table 1: Relationship of selected factors with having oral problem

	Variable	(N=530)	Have oral problem	X ² value	P-value
Age groups:	< 25 years	19	10(52.6%)	2.51	0.643
	25-39 years	44	20(45.5%)		
	40-54 years	210	93(44.3%)		
	55-69 years	206	105(51.0%)		
	≥ 70 years	51	22(43.1%)		
Gender:	Male	263	90(34.2%)	35.1	<0.001
	Female	267	160(59.9%)		
Education:	Non-educated	307	159(51.8%)	6.25	0.012
	Educated	223	91(40.8%)		
Employment status:	Non-employed	339	188(55.5%)	25.9	<0.001
	Employed	191	62(32.5%)		
Brushed teeth:	Yes	391	195(49.9%)	4.37	<0.037
	No	139	55(39.6%)		
No. of times teeth brushed daily:	None	139	55(39.6%)	9.92	<0.019
	Once	178	100(56.2%)		
	Twice	161	70(43.5%)		
	3+ times	52	25(48.1%)		
Used Miswak:	Yes	133	67(50.4%)	0.73	0.392
	No	397	183(46.1%)		
Smoking:	Current	40	13(32.5%)	3.86	0.145
	Ex smoker	69	32(46.4%)		
	Never	421	205(48.7%)		
Duration of diabetes:	Short	270	118(43.7%)	2.65	0.103
	Long	260	132(50.8%)		
Other Chronic disease:	Yes	307	161(52.4%)	8.14	0.004
	No	223	89(39.9%)		
Health education:	Yes	346	171(49.4%)	2.03	0.154
	No	184	79(42.9%)		
Knowledge:	Low	290	133(45.9%)	0.44	0.507
	High	240	117(48.8%)		
Regular check-up:	Yes	109	70(64.2%)	16.0	<0.001
	No	421	180(42.8%)		
Regular follow-up in dental clinic for dental problems:	Yes	176	86(48.9%)	0.3	0.582
	No	354	164(46.3%)		
Attendance of diabetic clinic:	Regular	486	225(46.3%)	1.79	0.181
	Irregular	44	25(56.8%)		
Diabetic medication:	Regular	478	221(46.2%)	1.71	0.191
	Irregular	52	29(55.8%)		

Measles outbreak, Jazan, KSA, April - December, 2006.

On 2/12/2006, the General Health Directorate of Jazan region reported an unusual increase in measles cases. The Field Epidemiology Training Program (FETP) was assigned to investigate this outbreak and recommend control measures.

A descriptive study followed by a case-control study was carried out. The descriptive study covered all the cases of measles that occurred from April 1 to December 31, 2006 in Jazan region. The case-control study covered Al Ardha and Baish areas in Jazan where most of the measles cases had occurred.

A measles case was defined according to clinical surveillance case definition of suspicious and confirmed cases. A questionnaire was prepared and filled by direct interview and by reviewing all related records. All cases that met the case definition and had positive serologic test for IgM were enrolled in the descriptive study; 110 of these cases from Alardha and baish sectors were enrolled in the case-control study. One control from the same family or neighborhood was selected for each case, during the study period.

During that time period, 347 cases of clinically diagnosed measles were reported in Jazan region, out of which 265 cases were confirmed serologically.

Among the confirmed cases 158 were from Al Ardha sector and 41 from Baish sector. Figure 1 demonstrates the monthly trend of this measles outbreak, as compared to the previous 2 years.

Females constituted 58.6% and 83% from rural areas. Only 4.9% of cases were below 6 months of age, 12.9% were 6-8 months of age, 19.6% cases were 9-11 months of age and another 9.1% were at age 12 months i.e. put together 46.6% of cases were in the age group where they are not likely to be immunized under the current immunization schedule for Measles. Another 14.8% cases were in the 1-5 year age group i.e. age not yet entitled for 2nd dose of MMR at school entry; 11.0% of cases were in the 6 to 15 year age group, which are expected to have received two doses of measles vaccine; 27.7% were older than 15 years. Among the 99 cases up to 12 months of age only 1 was vaccinated and among 21 cases of 12 months age only 3 (12.5%) were vaccinated. Among children 1-5 years of age 86.2% were vaccinated, among those 6-15 years of age 37.5% were vaccinated, and among cases over 15 years only 5.5% were vaccinated

Regarding the case-control study, among cases, 26.4% had been previously immunized, as compared to 36.4% of

controls (OR 0.637, 95% CI 0.353-1.114). Among children 1-4 years of age 94.7% were vaccinated compared to 95.8% of controls. Among those 15-24 years of age 13.3% were vaccinated compared to 14.3% of controls. Among the measles cases 91.1% gave history of visiting hospital/PHC since April 2006 compared to 60% controls (OR 6.833; 95% CI 2.951-15.822).

Among the measles cases 99 (92.5%) gave history of visiting hospital/PHC within the 3 weeks before onset of the disease compared to 54 (60%) controls with OR of 8.250 (95% CI 3.580 – 19.010) which exhibited a statistically significant relationship.

Among the measles cases 52.6% gave history of contact with a measles case since April 2006 as compared to 63.6% controls (OR 0.633, 95% CI 0.340-1.179).

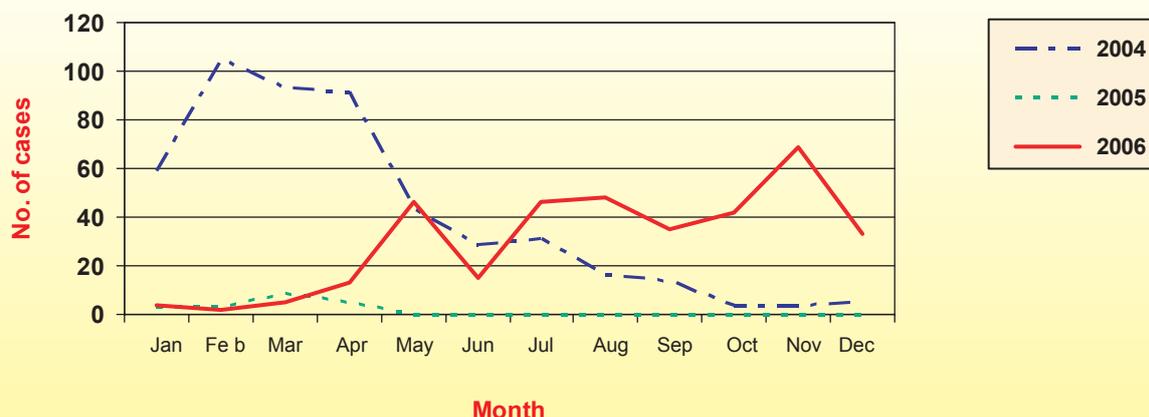
Regarding nutritional status 89.7% among the measles cases were normal as compared to 90.9% of controls (OR 0.871; 9 CI .277-2.744).

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Table 1: Impact of bronchial asthma on lifestyles of asthmatic children and their mothers: (N = 200)

Figure 1: Monthly trend of Measles cases in Jazan region 2004 - 2006G



Measles outbreak, Jazan, KSA, April - December, 2006, cont...

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Editorial notes: In this outbreak, a total of 347 confirmed cases of Measles were reported until December 31, 2006. Based on the review of the data since 1995, the pattern shows that the number of confirmed cases reported is clearly in excess of normal occurrence of Measles cases in the region and should be considered of epidemic nature.

In year 2002, EPI vaccination schedule of one dose of Measles vaccine at age of 6 months followed by a dose of MMR vaccine at age of 15 months was replaced with first dose of MMR at age of 1 year followed by a second dose at school entry. Since the change in schedule, this is the second outbreak in the region in the last 3 years. However as compared to the February to April peak in 2004, this year the disease is apparently having the same level of presence since its beginning in May.

Kamel et al 1 reported that 68.1% of the reported cases of measles in Saudi Arabia were among the age group of 5 years to less than 15 years. Another study conducted in Alexandria, Egypt 2 reported that 69.1% of measles cases were seen in the 5 to under 15 years age group.

The shift in age distribution of measles cases towards older children is one of the major effects of immunization programs on measles epidemiology due to the lowering of exposure rate in the community.³ Young adults aged 15 to 24 in this outbreak (13.6%) might have been susceptible because of their lower vaccination coverage at the start of the immunization program, when they could have been too old for immunization or they might have received a vaccine of low potency and less heat stability, or they might have escaped measles infection during childhood due to a general decline in incidence rate in the community.^{4,5}

It is recognized that a substantial number of individuals are now entering their adult life without having encountered the measles virus either in its wild or vaccine forms.⁶ We found that 29 (26.4%) cases of measles occurred in immunized individuals, which is lower than in a study conducted in Alexandria, Egypt reporting that the majority of

measles cases have histories of measles vaccination (79.4%).²

The large number of cases of measles occurring in immunized individuals is related to the level of coverage achieved. It is known that as immunization coverage increases, a higher proportion of cases will occur among immunized children.¹

It was recommended to immunize children between 6-12 months of age to control this outbreak, in addition to strengthening routine vaccination at 1 year of age. Health education messages should be directed to mothers to promote vaccine-seeking behavior. In addition to the MMR measles containing vaccine given at 12 months and at school entry (4-6 years), the adult population should be considered for measles vaccination as they become at risk to develop the disease. Follow up studies should be conducted to update the epidemiological and immunological situation of measles, particularly in response to higher vaccination coverage.

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Measles outbreak, Jazan, KSA, April - December, 2006, cont...

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oral health practices are expected to prevent oral diseases, as observed in a study conducted in USA for assessment of periodontal disease in type I diabetes, which showed an association between periodontal disease and tooth brushing less than once per day.⁶

It is recommended that referral for routine dental examination should be emphasized to physicians managing diabetes in PHCCs. Dental surgeons should ensure control of diabetes in their diabetic patients before surgery in accordance with the standard guidelines, while keeping the visits of the patients to minimal to improve patient satisfaction. Patients should be provided with health education regarding the role of diabetes in oral health, requesting physicians for routine dental check-up, improving their diabetes control, and the importance of testing and control of diabetes prior to dental surgery.

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Assessment of Knowledge, Attitudes, and Practices of Physicians working at private dispensaries and hospitals in Riyadh city towards the Surveillance System.

Effective surveillance is the key to effective disease control. Once an infectious disease has been detected (or suspected) it should be notified to the local health authority, whose responsibility is to put into operation control and preventive measures. In addition to the government health system, the private health care system constitutes an essential part of surveillance mechanism. However, the knowledge of reporting requirements and responsibilities among physicians working in private health care has not been adequately examined as a cause of under-reporting. This study was designed to assess the knowledge, attitudes, and practices of physicians in Riyadh private hospitals and dispensaries about disease surveillance.

The study was conducted as a cross sectional study using self administered questionnaires. Private health care in Riyadh city is provided through a widespread network of around 237 private dispensaries and 17 private hospitals. A multistage stratified random cluster sampling technique was used to identify the physicians to be recruited into the study. A total of 45 dispensaries and 6 hospitals were selected. All physicians working in these selected private dispensaries and hospitals who encounter patients with communicable diseases (General Practitioners, Physicians in Medicine, Pediatrics, ENT, Dermatologists, Emergency, and Laboratory doctors) were included in this study.

A total of 255 physicians were included in this study, 76.5% of them were male, 46.7% were in the 36–45 years age group, and almost all were non Saudis. Of all participating physicians, 76.9% were working in private dispensaries; 14.9% of them had one year experience in the health field in Saudi Arabia; and 45.5% were working as medical or pediatric physicians.

About 43.5% of physicians had good knowledge of the definition and components of surveillance system and scored more than 70% of the total score, and only 9.4% had good knowledge about the time of notification for the 36 notifiable diseases in Saudi Arabia, and scored more than 70% of the total score (i.e. ≥ 26 of 36), the remaining 90.6% scored under 70% (i.e. ≤ 25 of 36).

In the assessment of physicians attitudes toward different components of the surveillance system, 76.1% agreed that the case definition is clear, 63.5% agreed that the operating surveillance system is good, 67.4% agreed that the notifiable diseases are sufficient, 56.1% didn't agree that some diseases should be added, 56.4% didn't agree that some diseases should be removed, 95.7% agreed that the Ministry of Health (MOH) should arrange training courses in surveillance, and 87.1% agreed that they would like to attend such courses.

About 41% of participating physicians had a clear manual about the surveillance system, and 92% of them claimed that they were following the MOH strategy. Only 6% had attended training courses in surveillance system. About 80% of all participants read about surveillance system, ranging from always 3.9% to rarely 22.4%. Journals were reported as the main source of reading about surveillance among 46.7% of the physicians.

In case of detecting any notifiable disease or outbreak, 78% of participating physicians notified this disease or outbreak to the MOH. Among those who did notification for communicable disease, 27.6% never faced any difficulties during notification, and 72.4% faced difficulties ranging from always 4.5% to rarely 19.6%. Some of these difficulties were related to patients' such as lack of cooperation in giving the information (43.7%) and patient not knowing his address (18.1%). Other difficulties were related to the health facility, which included that there wasn't enough time for recording the information due to too many patients (21.6%), no health inspector (28.6%), or the health inspector is there but not always present (22.1%). The difficulties related to the surveillance system included that the notification system is not clear (36.7%), and that there was too much information to record (21.6%).

Of all participating physicians, 71.4% took control measures in case of detecting any notifiable disease or any outbreak, 20.3% of those conducting control measures did not have any difficulties in conducting

the control measures, 35.2% faced difficulties due to uncooperative patient's contacts, 26.9% due to unclear control measures for some diseases, and 18.7% due to unknown patient's address.

Out of all physicians, 46.7% never received any feedback, 4.5% always received feedback, 8.6% received it mostly, 24.1% received it sometimes, and 16.1% rarely received feedback. Regarding feedback types, letters were received by 34.2%, Journals/Bulletin by 23.1%, Report by 16.1%, Symposium by 3%, and periodic meetings 1%. The feedback was received via mail (27%), fax (25%), or hand carried (21.6%).

There was no statistically significant difference in the knowledge of physicians according to their characteristics. The only statistically significant difference was found between physicians due to difference in their place of work, those working in hospitals had a proportion of good knowledge about surveillance definition ($P=0.013$) and notification time ($P= <0.0001$) higher than those working in dispensaries.

It was concluded that knowledge about disease notification among doctors working in Riyadh private hospitals and dispensaries was poor, which can affect disease surveillance. Most participating physicians had not received any training courses about surveillance system, and most of them claimed not to have received any feedback on infectious disease surveillance. The training and retraining of physicians responsible for data generation, collection and forwarding in health facilities on disease notification, regular feedback on diseases reported and provision of forms were recommended in order to improve the disease surveillance system.

– Reported by: Dr. Ibraheem M. Al-Zahrani, Dr. Abdullah M. Al-Rabeah, Dr. Randa M. Nooh (Field Epidemiology Training Program).

Editorial notes: Surveillance is an important source of epidemiological information. In this study, it was observed that although under half of the participant physicians had a good knowledge of disease notification

ملخص باللغة العربية

مدى معرفة وإدراك وتطبيق أطباء مراكز ومستشفيات القطاع الخاص بمدينة الرياض للتبليغ عن الأمراض السارية، ٢٠٠٦ م.

يعرف نظام المراقبة الوبائية على أنه العملية المنتظمة والمستمرة لجمع وتحليل وترجمة المعلومات الإحصائية الصحية اللازمة لتخطيط وتنفيذ وتقييم نشاطات الصحة العامة، مع التغذية الراجعة للجهات ذات العلاقة واستخدام المعلومات في اتخاذ إجراءات الوقاية والمكافحة. وقد نالت المراقبة الوبائية الاهتمام في المملكة، كما أجريت عليها العديد من التطويرات. هدفت هذه الدراسة المقطعية إلى تقييم معرفة الأطباء العاملين في المنشآت الصحية الخاصة وكيفية مزاوله هذا النظام في مدينة الرياض. تم اختيار عينة عشوائية عنقودية بسيطة، حيث تم اختيار ٤٥ مستوصفاً خاصاً و ٦ مستشفيات من جميع القطاعات الخمس التابعة لمدينة الرياض، ومن ثم اختيار الأطباء العاملين في هذه المستشفيات والمستوصفات.

كان عدد الأطباء المشاركين في هذه الدراسة ٢٥٥ طبيبياً، ٧٦,٥٪ منهم من الذكور، ٤٦,٧٪ منهم في المجموعة العمرية ٣٦ - ٤٥ سنة، وكان غالبيتهم من غير السعوديين. عند تقييم معرفة الأطباء عن نظام المراقبة الوبائية في المملكة من حيث التعريف والمكونات كانت نسبة من حصلوا على تقييم جيد وأجابوا إجابة صحيحة أكثر من ٧٠٪ من مجموع الإجابات الصحيحة البالغة حوالي ٤٤٪ من المجموع، حوالي ٩٪ من الذين حصلوا على تقييم جيد من حيث معرفتهم بالوقت الواجب للتبليغ.

بلغت نسبة الموافقين على ان تعريف الحالة المرضية في نظام التبليغ واضح حوالي ٧٦٪، ووافق حوالي ٦٤٪ على ان النظام المعمول به حالياً في المملكة جيد، ووافق حوالي ٦٧٪ على ان الامراض الواجب التبليغ عنها كافية.

نسبة الأطباء الذين تلقوا دورات مسبقة عن نظام التبليغ لم تتعد ٦٪. أجاب حوالي ٧٨٪ بأنهم يقومون بالتبليغ عند اكتشاف اي حالة مرضية معيبة، منهم حوالي ٧٢٪ يواجهون صعوبات عند التبليغ، منها عدم تعاون المرضى (٤٤٪)، عدم وضوح نظام التبليغ (٣٦,٧٪)، كثرة البيانات المطلوب تعبئتها في النموذج (٢١,٦٪)، عدم وجود مراقب صحي (٢٨,٦٪)، إضافة إلى ضيق الوقت (٢١,٦٪). أجاب ٧١٪ بأنهم يقومون باتخاذ الإجراءات المناسبة للسيطرة على الأمراض المعدية في حال اكتشافها، منهم حوالي ٨٠٪ أجابوا بأنهم يواجهون الكثير من الصعوبات عند القيام بهذه الإجراءات، منها عدم تعاون المخالطين (٣٥٪)، عدم وضوح الإجراءات اللازم اتخاذها (٢٧٪)، وعدم معرفة عنوان المريض (١٩٪).

ذكر حوالي ٤٧٪ بأنه ليس هناك أي نوع من أنواع التغذية الراجعة.

أوضحت الدراسة أن غالبية الأطباء المشمولين بالدراسة لا توجد لديهم معرفة بمفهوم ومكونات المراقبة الوبائية والغالبية العظمى منهم لا يوجد لديهم معرفة عن وقت التبليغ. كما بينت القصور في الدورات التدريبية للأطباء، وفي التغذية الراجعة.

تمت التوصية على تقوية نظام المراقبة الوبائية، من خلال إيجاد نماذج تبليغ سهلة التعبئة، إعادة النظر في الأمراض التي تتطلب التبليغ من حيث الإضافة أو الحذف منها بصورة مستمرة، و القيام

بالتغذية الراجعة. كما تمت التوصية على العمل على تقوية معرفة الأطباء في المراكز الصحية والمستشفيات الخاصة عن نظام التبليغ من خلال الدورات التدريبية، بالإضافة إلى استمرار التقييم لهذا النظام من حيث الكفاءة ومن حيث مزاوله الأطباء للتبليغ.

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تقرير حول فاشية مرض الحصبة في جازان ٢٧هـ (٢٠٠٦م).

لاحظ المسؤولون في مديرية الشؤون الصحية بجازان زيادة في عدد حالات الاشتباه بالحصبة خلال شهر ذي القعدة ١٤٢٧هـ. تم الإبلاغ عن أكثر من ٢٠٠ حالة حصبة خلال عام ٢٠٠٦م في المنطقة. وحتى ٣١ ديسمبر ٢٠٠٦م كان العدد الكلي للحالات المؤكدة ٣٤٧، مقارنة بـ ٢٠ حالة سجلت في المنطقة عام ٢٠٠٥م. واستناداً إلى مراجعة عدد الحالات منذ عام ١٩٩٥م، تبين بوضوح وجود معدلات أعلى من العادي السابق، الأمر الذي يمكن اعتباره حالة فاشية.

و للمعلومية، فإنه في عام ٢٠٠٢م تم التحول من تحصين الأطفال في سن ٦ أشهر بجرعة للحصبة لتتلوها جرعة MMR في سن ١٥ شهراً، إلى التحصين بجرعة MMR واحدة في نهاية السنة الأولى من العمر لتتلوها الجرعة الثانية في سن الإلتحاق بالمدرسة، والملاحظ أن هذه هي الفاشية الثانية في منطقة جازان منذ تغيير جدول التحصين خلال الثلاث سنوات الأخيرة.

من العدد الإجمالي للحالات المشمولة بالدراسة وهي ٢٦٥ من أصل ٣٤٧، هناك ١٥٨ (٥٩,٦٪) في قطاع العارضة و ٤١ (١٥,٥٪) في قطاع بيثش. غالبية الحالات من السعوديين باستثناء ٧ حالات (٢,٦٪) من الجنسية اليمنية وحالة واحدة (٠,٤٪) من الجنسية الصومالية. بلغت نسبة الإناث ٥٨,٦٪. كان ٤٦,٦٪ من الحالات أقل من السنة أي دون السن المحددة للتطعيم ضد الحصبة بموجب الجدول المعمول به حالياً. بالإضافة فإن ١٤,٨٪ من الحالات كانوا في الفئة العمرية من ٥-١٥ سنوات وهي الفئة التي لا تزال غير مؤهلة لتلقي الجرعة الثانية من التحصين والذي يستوجب عند دخول المدرسة.

بين ٩٩ حالة أعمارهم حتى سن ١٢ شهر كانت هناك حالة واحدة فقط قد تلقت التطعيم ضد الحصبة، وبين ٢١ حالة في سن ١٢ شهر ٣ (١٢,٥٪) فقط تم تطعيمها. بين الأطفال في الفئة من ١-٥ سنوات ٨٦,٢٪ كانوا مطعمين، في فئة ٦-٩ سنوات ٣٧,٥٪ منهم مطعمين وبين الفئة العمرية ١٥ سنة فما فوق ٥,٥٪ كانوا مطعمين.

استجابة لفاشية الحصبة فقد قامت الشؤون الصحية بتحصين أفراد العائلات التي بينها مصابون بالحصبة بجرعة من MMR والذين أعمارهم فوق السنة الواحدة. وقد تم استخدام الاميونولوجيون في بعض الحالات نتيجة لعدم توافر MMR وقد تم القيام بحملة تطعيم لسكان المناطق الجبلية القاطنين ضمن الحدود السعودية اليمنية لتشمل كل السكان في تلك المناطق فيما بين سنة واحدة إلى عشرين سنة من العمر.

تم إجراء دراسة ضابطة أخذت فيها ١١٠ من حالات الحصبة المؤكدة مخبرياً في كل من العارضة

وبيثش. عمر الحالات كان بين ٣ أشهر إلى ٤٧ عاماً، وكان الأطفال الأقل من سنة الأكثر إصابة ٥٤ (٤٩٪). بلغت نسبة الإناث ٤٦,٥٪، والسعوديين ٩٨,٢٪. كان ٦٦,٤٪ في سن ما قبل الدراسة.

وفقاً للحالة المناعية ٢٩ (٢٦,٤٪) من الحالات و ٤٠ (٣٦,٤٪) من الضابطة كانوا قد تلقوا التطعيم ضد الحصبة. لم يبين وجود علاقة بين التطعيم والإصابة بالحصبة إحصائياً (معامل الشذوذ ٠,٦٢٧ ونسبة التاكيد ٩٥٪ من ٠,٣٥٣ إلى ١,١١٤). وحسب التوزيع العمري فإن ٥٤ حالة كانوا أقل من سنة وبالتالي كانوا لم يتلقوا أي تطعيم ضد الحصبة بعد. في الفئة العمرية من ١-٤ سنوات تبين أن ١٨ (٩٤,٧٪) من ١٩ قد تلقوا التطعيم ضد الحصبة مقارنة بـ ٢٣ (٩٥,٨٪) ضابطة من أصل ٢٤.

ضمن حالات الحصبة ٩٩ (٩٢,٥٪) أفادوا بزيارتهم لمستشفى أو مركز رعاية صحية خلال الثلاث أسابيع قبل أصابهم بالمرض مقارنة بـ ٥٤ (٦٠٪) من الحالات الضابطة. ومن التحليل الإحصائي تبين وجود علاقة قوية بين زيارة المرفق الصحي والإصابة بالحصبة خلال تلك الفترة (معامل الشذوذ ٨,٢٥ ونسبة التاكيد ٩٥٪ من ٣,٥٨ إلى ١٩,٠١).

بالنسبة للمخالطة بأشخاص مصابين بالحصبة ٤١ (٥٢,٦٪) من الحالات كانوا قد خالطوا مصابين مقارنة بـ ٥٦ (٦٣,٦٪) من الحالات الضابطة ولكن لم تبين وجود علاقة إحصائية قوية بين المخالطة والإصابة (معامل الشذوذ ٠,٦٣٣ ونسبة التاكيد ٩٥٪ من ٠,٣٤٠ إلى ١,١٧٩).

أوضحت الدراسة ان معظم الحالات تتركز بين الذين لم يشملهم التحصين الحالي (الأطفال دون السنة من العمر) أو الذين شملهم البرنامج القديم للتطعيم أي الذين تزيد أعمارهم عن ١٥ عاماً، ووجود خليط من المقيمين اليميين الذين تم تطعيمهم بصورة جزئية مما يجعلهم مستودعا دائماً للمرض.

تمت التوصية على تطعيم الأطفال من سن ٦-١٢ شهراً بجرعة إضافية واحدة من طعم الحصبة على أن تتلوا جرعة من MMR في سن ١٢ شهراً مع المراجعة التامة لفواصل زمني بعد أنى ٤ أسابيع بين الجرعتين. وفي حالة عدم توافر طعم الحصبة يمكن استخدام MMR بدلاً منه لهذه الفئة العمرية. ينبغي التشديد على التحصين الروتيني في سن السنة الأولى وتنفيذه خلال أسبوع من وقته المحدد وذلك بالمشاركة النشطة للمستهدفين بالتطعيم وبالتعاون مع نشاطات مستمرة بالتوعية للمواطنين، وتطعيم كل المخالطين ما فوق سن ٦ أشهر الذين يعيشون في نفس منزل الحالة المؤكدة وخلال ٧٢ ساعة من بدء الإصابة. وإذا لم يتوفر طعم الحصبة فيمكن استخدام MMR مع استثناء المتزوجات واللاتي هن في سن الانجاب (ينبغي إعطاؤهن IG حسب الإجراءات الطبية المتبعة). بالنسبة للإجراءات على المدى الطويل، تمت التوصية على تقوية التحصين في سن الواحدة والذي يجب إعطاه خلال أسبوع واحد من وقته المحدد وذلك من خلال تتبع فعال ونشط للأفراد المستهدفين والتوعية المستمرة. كما ينبغي التأكيد على تحصين غير السعوديين من المقيمين مع حفظ سجلاتهم بصورة منفصلة.

اعداد: د. عبده دحلان، د. سالم الكثيري، د. عبدالجamil شودي، د. ناصر الحمدان (برنامج الوبائيات الحقلية).

Assessment of Knowledge, Attitudes, and Practices of Physicians in private dispensaries and hospitals in Riyadh city towards the Surveillance System, cont...

(Continued from page 13)

about 78% were reporting notifiable diseases to the MOH. However, under the circumstances we have no idea about the completeness, presence, or accuracy of personal and disease data, and whether they are reporting on time. A study conducted in Jeddah to assess the reporting system of communicable diseases found that the reporting rate was 74%, but its usefulness was diminished because of the incomplete, absent or incorrect personal and disease data.¹

Worldwide, notifiable disease surveillance often suffers from incomplete reporting; many difficulties can be faced by physicians during reporting which can lead to underreporting, some of these difficulties may be related to physicians themselves, some related to patients, and some related to the surveillance system.² In this study, the most frequent difficulties faced by physicians during reporting were due to uncooperative patients in giving the correct information about the disease, unclear notification system, the time for recording the information is not enough, and the patient didn't know his address; these difficulties were similar to that found in many other studies done worldwide. In one study two primary barriers to reporting were not knowing what diseases were reportable, and the perception that the reporting process required too much time and effort.³ In another study the major barriers to reporting most frequently identified included time required for notification, lack of knowledge regarding which diseases are reportable, and a belief that many notifiable diseases are too common or unimportant to merit the effort of reporting.⁴

Poor attitude has been attributed to physician assumption that someone else will report, concerns regarding the effort required for reporting, insufficient compensation for doing so, and a view that no useful action is taken on notifications.⁵ Feedback to doctors, showing them that preventive action is taken as a result of notification, may be an effective way to improve notification practices. However, this study showed that few doctors received any feedback.⁶ Only 6% of physicians working in private hospitals and dispensaries had attended training

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Inside the Kingdom

June 4-6, 2007: 7th Scientific Meeting of the Saudi Society of Family and Community Medicine

Venue: King Faisal Hall Conference, Riyadh, Saudi Arabia.

Contact: Saudi Society of Family & Community Medicine Prince

Hamud Street, Prince Faisal Bin Fahd bin Abdulaziz PO Box 40161, Al-Khobar 31952, Saudi Arabia. Fax. +966-3-8824241

E-mail: ssfcmhq@yahoo.com

Outside the Kingdom

June 19-21, 2007: 6th Jordanian Public Health Association Conference & 3rd TEPHINET Regional Scientific Conference

Contact: Jordan FETP program director: Dr. Sami Sheikh Ali

(email: saadshali@hotmail.com) or Dr. Bassam Hijawi at Directorate of Disease Control, Abdel Hamed Sharaf Street, Amman – Jordan.

E-mail: dcd@wanadoo.jo

http://jordan.tephinet.org/cgi-files/abs_db.cgi?action=abstype

courses in surveillance, which indicates lack of coordination with MOH, and needs to be taken care of if the surveillance system is to be improved.

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Consultant Epidemiologist.

Selected notifiable diseases by region, Apr — Jun 2007

	Riyadh	Makkah	Jeddah	Madinah	Taif	Qassim	Eastern	Hassa	Hafr Al-batin	Asir	Bisha	Tabuk	Hail	Al-Shamal	Jizan	Najran	Baha	Al-Jouf	Goriat	Gonfuda	TOTAL	
Measles	291	155	132	2	65	27	116	30	134	329	0	72	275	120	58	108	54	65	85	12	2130	
Mumps	10	1	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	13
Rubella	21	0	0	0	0	0	0	0	0	3	0	0	0	3	0	0	4	0	0	0	0	31
Varicella	2141	653	2351	498	358	1596	2171	2037	486	1569	161	1433	414	248	378	454	86	232	45	77	17388	
Meningitis mening.	1	0	1	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Meningitis other	19	5	13	3	10	10	3	3	4	3	1	3	0	0	0	0	0	2	0	1	80	
Hepatitis B	300	2	273	88	24	96	189	6	4	58	21	78	2	2	26	24	0	44	0	14	1251	
Hepatitis C	203	6	245	27	2	43	142	5	0	36	16	22	0	1	0	6	0	16	0	13	783	
Hepatitis unspecified	9	0	0	0	2	0	0	2	0	8	0	0	0	0	44	0	0	0	0	0	65	
Hepatitis A	58	45	52	9	1	46	8	3	6	26	0	14	13	16	55	28	5	8	3	8	404	
Typhoid & paratyphoid	4	6	19	7	0	1	9	8	4	2	0	1	3	1	3	0	0	0	0	5	73	
Amoebic dysentery	28	0	495	6	9	3	89	66	6	30	14	0	5	5	18	0	0	0	0	4	778	
Shigellosis	2	0	3	3	0	0	7	0	1	0	0	2	0	0	0	5	0	0	0	0	23	
Salmonellosis	189	2	19	3	0	7	178	39	11	1	53	28	0	0	0	27	0	22	0	0	579	
Brucellosis	182	29	6	49	72	307	114	9	61	150	90	35	123	65	48	44	2	24	3	6	1419	

Comparisons of selected notifiable diseases, Apr - Jun 2006-2007

DISEASE	Apr-Jun 2007	Apr-Jun 2006	Change %	Jan-Jun 2007	Jan-Dec 2006	DISEASE	Apr-Jun 2007	Apr-Jun 2006	Change %	Jan-Jun 2007	Jan-Jun 2006
Cholera	2	4	-50	2	10	Meningitis mening	4	3	33	11	22
Diphtheria	0	0	0	0	2	Meningitis other	80	129	-38	177	395
Pertussis	24	10	140	31	34	Hepatitis B	1251	1177	6	2468	4264
Tetanus,neonat	0	5	-100	9	18	Hepatitis C	783	821	-5	1564	2964
Tetanus,other	1	2	-50	4	8	Hepatitis unspecified	65	272	-76	133	691
Poliomyelitis	0	0	0	0	0	Hepatitis A	404	732	-45	758	2631
Guilain Barre Syndrome	19	34	-44	51	105	Typhoid & paratyphoid	73	94	-22	151	293
Measles	2130	226	842	4230	807	Amoebic dysentery	778	681	14	1793	2907
Mumps	13	27	-52	19	79	Shigellosis	23	33	-30	61	149
Rubella	31	10	210	31	23	Salmonellosis	579	447	30	877	1572
Varicella	17388	16008	9	28372	43070	Brucellosis	1419	1294	10	2373	3997

Diseases of low frequency, Apr—Jun 2007

Yellow fever, Plaque, Poliomyelitis, Rabies, Haemolytic Uraemic Syndrome, Diphtheria, Neonatal tetanus: No Cases

Pertussis: 24 Cases (Eastern 13, Qassim 5, Hassa 4, Asir 1, Riyadh 1)

Ecchinococcosis : 2 Cases (Riyadh 2)

Guillian Barre Syndrome: 19 Cases (Jeddah 5, Riyadh 4, Qassim 2, Hafr Al-Batin 2, Madinah 1, Makka 1, Tabuk 1, Hassa 1, Najran 1, Hail 1)