

## النشرة الوبائية السعودية تصدرها وزارة الصحة

الوكالة المساعدة للطب الوقائي وبرنامج الوبائيات الحقلية

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### Knowledge, Attitude and Practices of Physicians Regarding Smoking in Makkah Region.

Health professionals are in a unique position where they can participate in tobacco control activities by acting as a role model, while advising and counseling smokers. Saudi Arabia has a large and effective health care setup, with a total of 31,502 physicians; in 2070 health facilities (physician/population ratio of 17.1/1,000).<sup>1</sup> If appropriately utilized, this large pool of health manpower can be an active force for the control of smoking in the Kingdom. However, very little is known about the current knowledge, attitude and smoking behavior of physicians in Saudi Arabia. The objectives of this study were to assess the knowledge, attitude and practices of physicians in Makkah region regarding smoking and its ill effects on health, to quantify the relationship between knowledge and practice, and to provide a quantifiable basis for strengthening of different components of Tobacco Control Program.

This was a cross sectional survey, covering the Makkah Governorate / administrative region, which includes 3 health regions; Makkah, Jeddah and Taif. The study population included all physicians working in this region, whether in Government or Private sectors. A stratified random cluster sampling technique was used to identify subjects (physicians) to be recruited into the study. A structured self-administered data collection instrument was designed. It included information about demographic variables such as gender, date of birth, nationality and place of work; current and past tobacco use; knowledge of effect of active and passive smoking on health; knowledge and attitude about role of physicians in control of smoking; and current practices regarding control of smoking. A pre-test was conducted to test the logistics of the methodology and the quality of the questionnaire, then necessary adjustments were made. Data was entered using Epi-Info then analyzed using SPSS. To take care of bias created by varying response rates from different strata of health facilities, a weight variable was created based on the original sampling proportion of each strata and its proportion among the received questionnaires. Throughout the analysis the weighted statistic are presented based on this weight variable.

A total of 1290 physicians participated in the study; 93.6% medical and 6.4% dental. Among the respondents 27.7% were General Physicians, 68.1% Special-

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# Knowledge, Attitude and Practices of Physicians regarding Smoking in Makkah region, cont ....

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ists, 3.4% Consultants, and 0.8% did not specify. 28.6% were from Makkah Health Region, 42.8% from Jeddah and 28.6% from Taif. 46.6% were working in MOH Hospitals, 8.0% in MOH Primary Health Care Centers, 7.7% in non-MOH government Hospitals, 23.6% in Private Hospitals and 14.1% in Private Health Centers. There were 79.5% males and 20.5% females. Their average age was 42.5 years (SD  $\pm 8.1$ ).

The majority of the physicians were from Egypt (39.9%), Saudi Arabia (14.3%), India (12.7%), Pakistan (9.3%), Sudan (7.6%), Syria (6.5%), Bangladesh (1.7%), and 3.9% were from other Arab countries. 2.7% were from developed countries, 0.9% from the Far East, and 0.7% from other African countries.

Out of 1256 physicians who responded to the question on cigarette smoking practices, 74.4% claimed they had never smoked, 10.8% had quit smoking, 7.9% smoked occasionally and 7.0% smoked regularly. The prevalence of "current cigarette smoking" was 14.9% and "ever cigarette smoker" was 25.6%. Current smoking was significantly lower in females (4.7%) than males (17.5%), ( $P < 0.001$ ). There was practically no difference between dental surgeons (14.1%) and medical doctors (14.9%) in current cigarette smoking practices, and no difference between those working in Rural (17.0%) or Urban (14.4%) health facilities ( $P = 0.380$ ).

Bangladeshi physicians had the highest prevalence of current cigarette smokers (21.7%), followed by 21.4% among Syrians, 18.6% among Other Arabs, 17.1% among Saudis, 16.2% among Egyptians, 11.1% among Sudanese, 9.6% among Pakistanis, and 6.5% among developed countries. There were no smokers among the small group from other African and Far Eastern nations.

Among physicians who were current smokers at the time of the study, the mean age of starting smoking was 23.2 years (SD  $\pm 5.8$ ), 1.4% had started smoking at 10 years of age and 15.9% were smoking by age 18.

A wide range in the number of ciga-

rettes smoked per day was reported (1-60), but the average number was 10.6 (SD  $\pm 9.67$ ). Twenty-three different brands of cigarettes were being smoked. 79.4% of the current smokers had attempted to stop smoking sometime during their life, but then re-started. When asked about their current intentions to quit smoking, 40.4% of 152 respondents stated they were ready to quit immediately, 30.4% were thinking to quit within the next 6 months, and 29.2% had no intention of quitting in the next 6 months.

Among physicians who had quit smoking, 67.3% had been regular smokers and 32.7% occasional smokers. The mean age for starting smoking in this group was 22.3 years (SD  $\pm 4.3$ ) and mean age of quitting was 35.6 years (SD  $\pm 7.4$ ), with an average smoking duration of 13.3 years (SD  $\pm 7.8$ ).

A smaller number of physicians reported using tobacco products other than cigarettes, either daily or occasionally, such as Shisha (6.2%), cigar (5.4%), and pipe (1.7%). 0.9% reported eating tobacco with betel quid, 0.7% chewed it alone, 0.5% smoked Bidi, 0.4% used oral snuff and 0.1% used nasal snuff. Shisha smoking was restricted to Arabs (94.4%) and a few Indian subcontinent doctors (5.6%). Among shisha smokers 37.8% were Egyptians, 36.4% were Saudis, 9.6% were Syrians, 6.7% were other Arabs and 3.9% were Sudanese.

Overall tobacco use in any form was 23.0%, and overall tobacco smoking was 22.4%. There was a strong correlation between current cigarette smoking and other tobacco use. Among cigarette smokers 36.9% reported smoking shisha, compared to 8.0% among non-cigarette smokers, and this difference was statistically significant ( $P < 0.001$ ). Similar significant relationships were observed between cigarette smoking and other tobacco use including Cigar ( $P < 0.001$ ), Pipe ( $P < 0.001$ ), Bidi ( $P < 0.001$ ) and oral snuff ( $P = 0.006$ ).

The physicians' responses varied on different aspects of knowledge and attitude towards smoking, as demonstrated in Table 1.

To assess the overall knowledge of

each physician and study its relationship with the practices, it was considered appropriate to develop a composite score based on the 22 questions and use it for further analysis. As all the statements asked were positive in nature, each 'strongly agree' response was scored as 5, 'agree' as 4, 'unsure' as 3, 'disagree' as 2 and 'strongly disagree' as 1. Non-response to any of the questions excluded the physician from scoring, thus restricting the data set to 1071 individuals who responded to all the 22 questions. In this manner, the possible score range was 22 to 110. The mean score was 98.29 (SD 8.66) and a median of 99, with a statistically non-significant negative skewness of -0.872. In the absence of any standard criteria of scoring for such knowledge and attitude questions for the given environment, median score of 99 was used as a cut off line to split the physicians into two categories according to knowledge-attitude (K-A): high knowledge group (score 99-110), which included 526 (49.1%) physicians; and a low knowledge group (score 55-98), which included 545 (50.9%). It was observed that there was a gradual, non-significant, decrease in the K-A score of older compared to younger physicians ( $P = 0.82$ ). There was no difference in K-A scores among males and females with 49.2% of males and 48.6% of females in the high score group ( $P = 0.99$ ). Physicians in hospitals had a higher proportion of high knowledge compared to those in PHCCs ( $P = 0.866$ ). The proportion of high score group was highest among physicians from far eastern countries (62.7%), followed by Indians (52.8%), Saudis (51.1%), Egyptians (48.8%) and Pakistanis (48.3%). Physicians who had a high K-A score were more likely to be current smokers (21.8%) compared to those with low score (9.7%) ( $P < 0.001$ ).

It was found that 46.2% worked in places without a smoke-free policy, 7.3% had smoking rooms available, and 46.5% worked in facilities where smoking was not allowed. Among those who responded that smoking was not allowed at their work place or smoking rooms were available, 37.0%

responded that the policy was enforced at all times, 35.2% responded that it was enforced sometimes, while others responded as not enforced or did not know. 12.9% of physicians working in places with no smoke-free policy were current cigarette smokers, compared to 15.0% of those working in places where smoking was not allowed and 35.0% of those who had smoking rooms at their workplace ( $P < 0.001$ ).

Among the total respondents only 3.0% had received any formal training in smoking cessation approaches. Trained people were homogeneously distributed across different health sectors, genders and nationalities.

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**Editors notes:** Active cigarette smoking and involuntary exposure to tobacco are major preventable causes of morbidity and mortality.<sup>2</sup> Health care providers have a great potential to reach a majority of smokers because of their high contact rate with the general public. Although such data is not available for Saudi Arabia,

in developed countries it has been estimated that 70-80% of smokers visit their family doctor at least once a year.<sup>3</sup> Multiple studies conducted in the UK, Australia and USA have shown that the advice of general physicians significantly decreased the prevalence of smoking among their patients.<sup>4,5</sup>

In a study conducted in the early 1990's in Riyadh, it was found that among 689 physicians, 48% were ever smokers and 34% were smoking at the time of the study, with male smokers (38%) significantly higher than females (16%). More than 60% agreed that smoking is a major contributing factor in the causation of coronary artery dis-

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**Table 1: Knowledge and attitude of physicians regarding smoking – Makkah, 2002**

Factor studied	No.	strongly agree (%)	agree (%)	unsure (%)	disagree (%)	strongly disagree (%)
<b>Effect of smoking</b>						
Smoking harmful to health	1184	91.1	7.4	0.8	0.0	0.7
Neonatal death with passive smoking	1154	37.9	35.7	22.5	3.2	0.7
Smoking in pregnancy increase SIDS	1157	48.1	35.2	15.0	1.5	0.2
Passive smoking increase lung disease	1163	53.7	40.8	4.7	0.6	0.2
Passive smoking increase heart disease	1160	46.3	39.2	12.6	1.8	0.1
Parental smoking increase Lower resp. tract infection in children	1156	47.3	39.1	12.2	1.3	0.2
<b>Role of Health Professionals</b>						
Act as Role model	1176	63.8	30.0	3.7	1.9	0.6
Should set good example	1182	75.5	20.8	2.0	1.3	0.3
Chances of patient's quitting on advice	1174	37.2	40.9	17.3	4.3	0.3
Should routinely ask patients about smoking habits	1176	59.0	36.5	2.8	1.1	0.6
Should routinely advise smoking patients to quit	1175	63.6	30.2	3.0	2.7	0.5
Smoker professional less likely to advise people	1172	39.6	37.1	11.5	9.7	2.1
Should get specific training on cessation techniques	1163	45.1	41.2	9.8	3.4	0.4
Should speak to lay groups	1160	40.4	46.8	10.2	2.3	0.5
Should routinely advise smoking patients to avoid smoking around children	1163	79.3	19.1	1.2	0.3	0.2
<b>Smoking Control Measures</b>						
Prohibited in enclosed public places	1172	86.5	10.6	1.3	1.0	0.6
Health warnings in big print on cigarette packages	1173	70.1	21.4	4.4	2.4	1.7
Sales banned to adolescents and children	1172	86.8	10.3	1.5	0.8	0.7
Sport sponsorship by tobacco industry should be banned	1170	71.6	21.8	4.2	1.7	0.8
Complete ban on advertising of tobacco products	1165	73.4	19.3	5.0	1.1	1.2
Hospital and health care centers should be smoke-free	1165	84.2	9.2	1.0	2.0	3.5
Price of tobacco products should be increased sharply	1157	53.4	24.2	10.6	8.8	3.0

# Pattern of Chemical Poisoning, Riyadh 1999-2001

Acute chemical poisoning is the third most common cause of deaths in the home.<sup>1</sup> The medical costs of poisoning treatment can be substantial, exerting considerable burden on the national health care service in both developed and developing countries. Due to the absence of regional poisoning control centers and standardized reporting methods, data on the epidemiology of poisoning in Saudi Arabia are not available and few studies have been conducted to explore this problem locally. This study aims to describe the pattern of chemical poisoning in Riyadh region during a three year period (January 1999 – December 2001), and to highlight some demographic associates.

This cross-sectional study was performed by analysis of data extracted from registers of all recorded cases of chemical poisoning (drugs and chemicals) reported to Directorate of Health Affairs, Riyadh, Ministry of Health, from all Riyadh hospitals during the study period. Cases of food and animal poisoning were excluded. Cases of Chemical poisoning were defined as all cases that had resulted from ingestion of (or contact with) substances that can produce toxic effects; including exposure to drugs, chemicals, or any environmental substance. Environmental substances include: household items, cleaning substances, insecticides, pesticides, rodenticides, solvents, cosmetics, fuels, and carbon monoxide and other toxic gases.

A data collection form containing demographic characteristics e.g. age, gender, nationality, occupation, type and name of poisonous substance, time, route and circumstances of exposure, management and outcome, was completed. Data were checked for completeness and consistency by matching a random sample of the reprints in the Directorate of Health with that of affiliated hospitals. Most cases of chemical poisoning occurred in children under five years of age (Table 1), followed by the 5-11 year age group. Males (56%) predominated females (44%) (ratio 1.3:1.0). Children under five constituted 74.8% of males and 56.3% of females. The majority of studied cases

were Saudis (93%). Cause of poisoning was accidental in 83.7%, intentional in 12.4%, and unknown in 4%. A high percentage of intentional poisoning (70%) occurred in individuals under 30 years of age, most of who were females (743%).

A single substance was implicated in 94% of cases and 6% had been exposed to two substances or more. The most common mode of toxin ingestion was orally (91.6%), and most occurred due to pharmaceutical products (67.2%), followed by antiseptics (11.3%). Paracetamol was the most common cause of poisoning (9.8%) followed by antihistamines (9.1%). 35% of poisoning cases reported symptoms; 30.4% within one hour of exposure. 50% of symptomatic cases presented with vomiting, 26% were drowsy, 18% had difficulty in breathing, and 2.5% had convulsions. Most cases (62.5%) sought treatment within one hour of the poisoning episode. Most cases were reported on the same day (81.8%), or on the second day in 12.8%. Most (94.6%) arrived to hospital in a stable condition, 5% deteriorated, and 0.4% arrived dead. Regard-

ing management, 56.8% received treatment and were discharged from the ER, 37.2% were admitted into hospital and 6.1% were discharged against medical advice. Most cases recovered completely (92.7%). The mortality was 1%.

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**Editorial note:** Chemical poisoning remains hugely underestimated in some developing countries,<sup>2</sup> where poisoning by pesticides and household products, as well as overdose with pharmaceuticals are extremely frequent especially among children.<sup>2,3</sup>

A study of cases of accidental poisoning among children admitted to all Riyadh Governmental Hospitals, Saudi Arabia, during a five year period (1983–1987) showed that household products were the most common poisoning agent, accounting for 59% of all cases. Fatality rate was 0.1%.<sup>4</sup>

The findings of the present study are

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**Table 1: Characteristics of chemical poisoning cases, Riyadh 1999-2001**

Characteristics	Number	Percent
<b>Age group:</b>		
<5	755	66.6
5-11	121	10.6
12-20	87	7.6
21-30	108	9.5
31-40	52	4.5
>40	10	0.8
<b>Nationality:</b>		
Saudi	1053	93.0
Non-Saudi	80	7.0
<b>Route of poisoning:</b>		
Oral	1038	91.6
Respiratory	68	6.0
Unknown	12	1.1
Dermal	10	0.9
Parenteral	5	0.4
<b>Type of substance:</b>		
Pharmaceutical products	761	67.2
Antiseptic	128	11.3
Insecticides	69	6.1
Hydrocarbons	69	6.1
Rodenticides	3	0.3
Herbicides	3	0.3
Other	70	6.2

## Pattern of Chemical Poisoning, Riyadh, cont....

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in agreement with findings worldwide.<sup>1,2</sup> Pharmaceutical products contributed to most cases of poisoning, which may be due to dispensing of drugs in envelopes instead of child-resistant containers, free medical treatment and easy access to drugs.

Unlike other developing countries where household products represent the most frequent cause of poisoning,<sup>5</sup> in Riyadh, Pharmaceutical products constituted a greater problem. In a previous study, Pharmaceutical products accounted for 53% of cases of accidental home poisoning and household products for 46%.<sup>6</sup>

Health education for parents and caregivers of young children is recommended. Child resistant containers should be used for packing drugs instead of envelopes to avoid drug-related poisonings. Regional poisoning control centers should be initiated and enforced. Their role in prevention is also imperative through planning, research, and education.

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## Biological Warfare: A New Challenge?

There has been increasing concerns on Biological Weapons (BW) in the past few years. Most countries are not well prepared to deal with them.

Early attempts at biological warfare have included the crude use of filth, and cadavers to contaminate wells and water sources. Ships carrying plague-infected refugees sailing through Mediterranean ports are thought to have contributed to the second plague pandemic in 1348. In the 18<sup>th</sup> century, smallpox was used as a biological weapon against Native - Americans.<sup>1</sup>

During World War II, both Axis and Allied Nations devoted efforts to BW research. In Japan, prisoners were infected with anthrax, cholera, typhoid, plague, and Typhus. In Germany, prisoners were forcibly infected with *Rickettsia prowazekii*, Hepatitis A, and Plasmodium species, and treated with investigational drugs. In England, bomb experiments of weaponized spores of *Bacillus anthracis* were conducted on Gruinard Island near the Coast of Scotland resulting in heavy contamination.<sup>1,2</sup> During the Korean war, China and Korea accused the USA leadership of using BW.<sup>3</sup> By the late 1960s, the US military had developed a BW arsenal that included numerous bacteria, toxins, and fungal plant pathogens.<sup>4</sup>

In 1972, the "Biological Weapons and Toxin Convention" (BWC) was signed by several nations, prohibiting the development of BW. In spite of that, several signatory have participated in activities outlawed by the treaty.<sup>5</sup> The true nature of the 1979 anthrax outbreak in Sverdlovsk, former Soviet Union, has been exposed as an accident at a military BW facility.<sup>6</sup> Recently, appropriate legally binding protocols to strengthen the BWC have been considered.<sup>5</sup>

There are four general types of BW agents: bacteria, rickettsia, viruses and toxins. Each type causes a different complex of symptoms. Only a few organisms found in nature have the combination of pathogenicity, stability and ease of production needed to make effective BW, such as anthrax, botulinum toxin, Variola virus, *Yersinia pestis*, *Francisella tularensis*, and *Brucella*.<sup>7</sup>

The threat of biological warfare with a specific agent is proportional to susceptibility of the population to that

agent. Currently, there are insufficient supplies of medicines and trained personnel to cope with a massive bioterrorist event.<sup>8</sup>

Prevention of BW proliferation requires education, specific protective measures, and environmental modification. Prevention of BW also rests on creating a strong global attitude that rejects their development and use. The medical and scientific communities play an important role in raising global awareness during international conferences, and in continuing research and development of improved diagnostic tools, therapeutic agents, and effective response plans.<sup>5</sup>

- Reported by: Mona Mohammed Bassora (FETP, MOH).

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## ملخص باللغة العربية

### المعلومات و المواقف و الممارسات الصحية بالنسبة للتدخين بين أطباء منطقة مكة المكرمة

تم اجراء هذه الدراسة لتقييم مستوى المعلومات و المواقف و الممارسات الصحية للأطباء بالنسبة للتدخين في منطقة مكة المكرمة، كي يتسنى انشاء برنامج مكافحة التدخين لهذه الفئة التي من الممكن الاستفادة منها في برامج مكافحة التدخين عامة في المملكة.

تم اجراء دراسة مقطعية باستخدام استبيان خاص تم توزيعه على الأطباء، و يشمل استفسارات عن معلوماتهم العامة، و مواقفهم و ممارساتهم الصحية تجاه التدخين، اضافة الى المعلومات الشخصية. تم تقسيم العينة الكلية للبحث على أساس القطاع الصحي و نوعية الوحدة الصحية، و من ثم اختيرت عينة الأطباء المشاركين في البحث على أساس عينات تجميعية مقسمة.

اشترك في البحث ١٢٩٠ طبيب، ٧٩,٥% كانوا من الذكور و ٢٠,٥% من الاناث. كان ٣٩,٩% من العينة مصريين، ١٤,٣% كانوا سعوديين، ١٢,٧% هنود، ٩,٣% باكستانيين، ٧,٦% سودانيين، ٦,٥% سوريين، ١,٧% بنجلاديشيين، ٣,٩% من دول عربية أخرى، ٢,٧% من دول غربية، ٠,٩% من دول افريقية أخرى.

ذكر ٧٤,٤% من الأطباء المشاركون في البحث انهم لم يدخنوا أبداً، و ذكر ١٠,٨% انهم أقلعوا عن التدخين، و ٧,٠% كانوا مدخنون دائمون، و ٧,٩% كانوا يدخنون في بعض الأحيان. عدد المدخنين الذكور كان أعلى من الاناث، لكن لم يكن هناك تأثيراً للعمر، أو لنوعية أو مكان القطاع الحي. بلغ الاستخدام الكلي للتبغ في العينة ٢٣%، و التدخين ٢٢,٤%. المدخنين بين الأطباء العرب كانوا أكثر منهم بين غير العرب. ذكر ٦,٢% انهم يستخدمون الشيشة، ٥,٤% يدخنون السيجار، ١,٧% كانوا يدخنون الغليون، ٠,٩% كانوا يمضغون التبغ و التمباك، ٠,٧% يمضغون التمباك فقط،

٠,٥% يستعملون البيدي، ٠,٤% يمضغون التبغ، و ٠,١% يستخدمون النشوق. تدخين الشيشة كان محصوراً على الأطباء السعوديين و المصريين فقط.

كانت المعلومات العامة و المواقف و الممارسات الصحية للأطباء في العينة و دورهم في نشر الوعي الصحي ضد التدخين اجمالاً جيدة، لكن كان هناك بعض الضعف في المعلومات عن التدخين السلبي. كما لوحظ ان الوعي الصحي عن التدخين كان أعلى بين المدخنين عن غير المدخنين. وجد ان ٤٦,٢% من الأطباء في العينة يعملون في أماكن لا تطبق سياسة بمنع التدخين، بينما ٧,٣% يعملون بأماكن بها غرف مخصصة للتدخين، و ٤٦,٥% كانوا يعملون بجهات تمنع التدخين. ذكر ٣,٠% فقط من العينة انهم تلقوا تدريباً في طرق منع التدخين.

وجدت الدراسة انه هناك حاجة ماسة الى تطبيق برنامج مكثف ضد التدخين بين الأطباء، مع التركيز على مشاكل التدخين السلبي و التدخين أثناء الحمل.

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### حالات التسمم الكيميائي في الرياض ١٩٩٩ - ٢٠٠١

حددت المشكلة العالمية للتسمم الكيميائي بشكل واسع بواسطة تقديرات فردية متنوعة. أوضح فريق عمل منظمة الصحة العالمية انه من الممكن أن يكون هناك مليون حالة تسمم كيميائي خطيرة وغير متعمدة كل سنة، إضافة الى مليوني شخص تتم معالجتهم بعد محاولتهم الانتحار باستعمال المبيدات التي هي أحد أنواع السموم الكيميائية.

التسمم الكيميائي الحاد هو رابع الأسباب الأكثر شيوعاً لحالات الموت الغير متعمد في الولايات المتحدة الأمريكية، كما يعتبر السبب الثالث الأكثر

شيوعاً للموت في المنزل. تهدف هذه الدراسة لوصف حالات التسمم الكيميائي في منطقة الرياض و ابراز بعض الإحصائية المساعدة.

تم الحصول على المعلومات لهذه الدراسة المقطعية عن طريق مراجعة كافة السجلات المدونة لحالات التسمم الكيميائي المبلغه للمديرية العامة للشئون الصحية بمنطقة الرياض، المملكة العربية السعودية، خلال فترة ثلاث سنوات من ١٩٩٩ إلى ٢٠٠١ م. عرفت حالات التسمم الكيميائي ككل الحالات الناتجة عن تناول أو ملامسة مواد من الممكن أن تعطي تأثيرات سامة. تم تعبئة نموذج يحتوي على معلومات عن مواصفات المرضى، اسم المادة السامة، نوعها، استعمالها الرئيسي، ووقت وطريقة وظروف التعرض لها.

كانت معظم حالات التسمم الكيميائي في الأطفال دون الخمس سنوات من العمر (٦٦,٦%)، شكل الذكور ٦٣٢ حالة (٥٦%) و الإناث ٥٠١ حالة (٤٤%) (نسبة الذكور الى الاناث ١,٣:١). أغلبية الحالات كانت لسعوديين (٩٣%). المنتجات الصيدلانية كانت الأكثر شيوعاً (٦٧,٧%). حوالي الثلث فقط من المتعرضين للسموم أبغوا عن أعراض عضوية، حيث كان القيء العارض الأكثر شيوعاً. في هذه الدراسة كان التسمم عن طريق الخطأ هو الأبرز (٨٣,٧%). أكثر حالات التسمم حصلت في المنزل (٩٤,٧%). تناول السم عن طريق الفم كان الأكثر شيوعاً (٩١,٦%). معظم حالات التسمم قد بلغ عنها في نفس اليوم (٨١,٨%). كانت نسبة الوفيات (١%).

تم التوصية على أهمية التنقيف الصحي للأهل والمربين. استعمال العبوات المقاومة لوصول يد الأطفال إليها بدلاً من المظاريف لحفظ الأدوية. أهمية انشاء المراكز الإقليمية لمكافحة التسمم لسرعة تحديد ومعالجة حوادث التسمم التي من الممكن تجنبها بالتخطيط والبحث والتنقيف.

اعداد: د. عبدالله عزيري (برنامج الوبائيات الحقلية)، د. عشري جاد محمد (كلية الطب، جامعة الملك سعود).

## Knowledge, Attitude and Practices of Physicians, cont ....

(Continued from page 27)

ease, lung cancer and chronic bronchitis; less than 20% said the same for bladder cancer and neonatal death. Setting a good example for children was the most important reason stated for not smoking.<sup>6</sup>

In this study, it is encouraging to note that 11% had quit smoking, 79% of current smokers had tried to quit, and 40% were willing to try to quit in the next 6 months. These indicate existing motivation among physicians but also highlight their need of external support. However, there were certain lacunae in their knowledge and attitudes of the effects of smoking and the role of health professionals in prevention, which need to be addressed in basic medical training, smoking cessation training programs and general health education programs.

It was also interesting to note that smokers in general had higher knowledge than non-smokers, which may suggest that smokers may be more motivated in gaining knowledge on the hazards of smoking. In about half the facilities there was no explicit smoke-free policy which exhibits a weakness in implementation of governmental regulations, which clearly prohibit smoking in health centers.

It was recommended to hold extensive Anti-smoking and health education training programs for physicians, targeting more physicians of Arab nationalities, explicitly warning them about shisha and cigars in addition to cigarettes. The smoke-free policy should be enforced in all health care facilities, big or small, governmental or private.

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### Mark your calendar . . .

#### Inside the Kingdom

##### May 4-7, 2003: 4th Family Medicine Essentials Workshop.

Location: Towaiq Palace, Diplomatic Quarter, Riyadh.

Contact: Department of Family and Community Medicine, King Saud University. Tel.: 55-413-536-719 / 55-413-427-175

Fax: 55-413-536-719 / 55-413-427-175, E-Mail: idealiza@idealiza.com.br

#### Outside the Kingdom

##### February 23-28, 2003: 27th International Congress on Occupational Health.

Location: Iguassu Falls, Brazil.

Contact: ICOH 2003 - Idealiza, Av. Sete de Setembro, 5388 cj. 1301, CEP 80240-000 - Curitiba - PR - Brasil. Tel.: 55-413-536-719 / 55-413-427-175

Fax: 55-413-536-719 / 55-413-427-175, E-Mail: idealiza@idealiza.com.br

##### June 25-27, 2003: Hepatitis C - Past, Present, Future

Location: Dublin, Ireland.

Contact: Catherine White, Tel.: 0044(2)897-561993, Fax: 0044(2)897-565073

E-Mail: catherine@project-planning.com

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Bulletin Editor.

## Selected notifiable diseases by region, Oct—Dec 2002

	Riyadh	Makkah	Jeddah	Taif	Madinah	Qassim	Eastern	Hasa	Hafr AlBatin	Asir	Bisha	Tabuk	Hail	Al Shamal	Jizan	Najran	Baha	Al Jourf	Gorlat	Gonfuda	Total	
Measles	16	1	1	0	0	0	3	0	0	0	0	0	0	0	0	1	0	0	0	0	0	22
Mumps	38	21	150	8	19	19	8	20	8	9	4	4	2	3	6	4	3	0	1	1	1	328
Rubella	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Varicella	2300	969	5122	242	543	2365	592	394	448	1149	195	632	222	105	207	197	177	104	53	102	16118	
Brucellosis	83	41	50	41	51	140	51	5	35	265	51	5	72	2	24	34	14	14	3	5	986	
Meningitis mening	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Meningitis other	50	23	82	7	5	5	4	26	3	6	0	5	2	0	8	0	0	0	0	0	0	226
Hepatitis A	82	28	140	3	28	64	31	23	29	66	21	11	57	12	4	44	2	5	6	1	657	
Hepatitis B	351	171	1255	32	62	41	151	1	0	65	13	20	1	17	12	2	29	3	3	2	2231	
Hepatitis C	239	120	1308	9	27	22	66	4	0	9	10	7	1	11	5	4	8	1	0	1	1852	
Hepatitis unspecified	51	10	102	0	2	0	0	2	0	30	0	12	1	0	75	0	0	0	0	0	285	
Typhoid & paratyphoid	8	11	1	0	8	3	9	1	0	24	11	0	3	5	1	1	2	0	0	0	88	
Amoebic dysentery	10	3	1946	25	2	57	19	4	1	108	41	0	19	0	31	21	0	0	1	1	2289	
Shigellosis	21	8	42	0	13	8	12	4	0	0	3	7	0	3	1	22	11	0	0	0	155	
Salmonellosis	153	57	221	13	1	2	198	35	5	6	10	19	2	0	1	26	5	0	0	0	754	
Syphilis	6	0	67	0	0	0	8	7	0	3	1	0	0	0	0	0	2	0	0	0	94	
VD, other	9	3	86	0	0	0	22	18	1	1	1	0	0	0	6	0	1	0	0	0	148	

## Comparisons of selected notifiable diseases, Oct - Dec 2001-2002

DISEASE	Oct-Dec	Oct-Dec	Change	Jan-Dec	Jan-Dec	DISEASE	Oct-Dec	Oct-Dec	Change	Jan-Dec	Jan-Dec
	2002	2001		%	2002		2001	2002		2001	%
Diphtheria	0	0	0	0	0	Meningitis other	226	180	26	753	604
Pertussis	11	3	267	42	35	Hepatitis A	657	520	26	2926	3069
Tetanus neonat	10	7	43	28	27	Hepatitis B	2231	933	139	5638	3864
Tetanus other	11	6	83	21	8	Hepatitis C	1852	669	177	4283	2608
Poliomyelitis	0	0	0	0	0	Hepatitis unspecified	285	285	0	1227	1414
Measles	22	40	-45	277	155	Typhoid &	88	94	-6	390	367
Mumps	328	259	27	976	941	Amoebic dysentery	2289	570	302	4584	2772
Rubella	2	3	-33	12	16	Shigellosis	155	120	29	472	589
Varicella	16118	8036	101	53204	32642	Salmonellosis	754	527	43	2539	1927
Brucellosis	986	897	10	4687	4865	Syphilis	94	31	203	187	136
Meningitis mening	3	40	-93	55	316	VD, other	148	84	76	386	395

## Diseases of low frequency, Oct – Dec 2002

Yellow fever, Plague, Diphtheria, Poliomyelitis, Transverse myelitis: No cases

Rabies: one case (Qassim)

Pertussis: 11 cases (Jeddah 5, Eastern 5, Makkah 1)

Tetanus neonatorum: 10 cases (Jeddah 5, Makkah 4, Jazan 1)

Echinococcosis: 3 cases (Riyadh 2, Hafr Al-Batin 1)

Guillain-Barre syndrome: 24 cases (Riyadh 7, Jeddah 3, Madinah 1, Qassim 1, Hasa 2, Makkah 1, Asir 2, Najran 1, Jazan 2, Tabuk 1, Baha 1, Qunfudha 1)