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Community Health & Disease Surveillance Newsletter

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Community Based Projects (CBP) Competition

Since 1990 Ministry of Health (MoH) implemented immense developmental efforts and decentralization was a symbol for this development. This was started with the decentralization of the regional and Wilayat authorities. The MoH developed a planning culture in the system; the managerial process for national health planning was introduced in the eighties to develop the national five years plan. The Wilayat problem solving approach was also adopted in the early nineties to develop yearly plans at Wilayat and regional levels between the five years.

With the establishment of WHC in 1999 it was considered as a focal point of the program because its members include government intersectoral representatives, civil societies, and the community. What adds to its importance is that it is headed by the Wali of the province, and the committee is assigned by the director or supervisor of health services in the province.

Health Committee: Responsibilities

1. Participating in the planning, establishing strategies, and assessing five-year health plans for the ministry on the level of the province
2. Propagating the importance of health and raising health awareness with the objective of mobilizing community capacities and attracting active participation of the community in all stages and on all levels
3. Facilitating and coordinating cooperation between the Ministry of Health and other health related sectors, as well as civil societies and volunteer groups.

The Wilayat Health Committees (WHC) approach was accompanied by the introduction of the community based projects competition which is one of the major achievement planned and implemented by WHC. And these projects were based on the WTPS approach. The MOH took successive steps in the sustainability of these projects through a yearly award for the best community-based project. All the Wilayat in the sultanate (61) participated in these projects in the year 2007/08 competition and 16 of them reached to the finals.

Methodology

- Formation of the evaluation team which consist of MOH personnel, and technical officers from UNICEF and UNFPA.
- Development of evaluation tool (quantitative and qualitative)
- Filed visits and data collection
- Data analysis
- Result dissemination

The projects reached to the finals were divided as follows:

- Five healthy lifestyle related projects (physical activity and quitting smoking)
- Six other health related and health education projects (PEM, diabetes, hypertension, hepatitis A)
- Four environmental health projects
- One basic developmental needs project (BDN).

"The FIRST prize was awarded to Wilayat Khaboura for the project titled 'Combating against obesity in the Wilayat' (Phase 1)."

An award ceremony was held in collaboration with UNICEF on 30 April 2009 to merit the best running projects. This ceremony was held under the auspices of the HE the Under-secretary of Ministry of Interior with the presence of several Government officials, Walis and community members. The awarded projects were as follows:

①First place winner

Wilayat Al Khaboura

The project: Combating against obesity in the Wilayat (Phase 1)

②Second place winner

Wilayat Qurayat

The project: Social development of Wissal village

③Third place winner - 2 projects

Wilayat Al Mudhaibi

The project: The nutrition information center in Talool village

Wilayat Taqah

The project: early detection and prevention of high cholesterol, hypertension & obesity.

♦ Award for the best project in resource utilization

Wilayat Liwa

The project: The campaign against hepatitis A in Harmool village

♦ Award for the best sustainable project

Wilayat Jallan Bani Bu Ali

The project: Healthy environment project in Wadi Al Laabedaa

Fig.2: The First Place Winner

♦ Award for the best community information centre

Wilayat Al Awabi

The project: Reduction of PEM in children below 5 years of age

Other significant findings

Reduction of PEM in children below 5 years of age in the sultanate (five projects)

- Providing the basic developmental needs in some villages in the sultanate
- Increase community participation and collaboration
- Awareness campaign against several diseases and ways of prevention.
- Increase community awareness of the importance of physical activity and epically for the females
- Provide training holes and equipment for physical activity.

Fig.2: Dignitaries at the Award Ceremony

Community Nutrition Education Centre in *Talool*

Talool village is one of the villages in Wilayat *Al Mudhaibi* (North Sharqiyah Region) which is characterized by scattered small rural population settlements. A high level of protein energy malnutrition (PEM) was found existing among children below 5 years of age. The total registered children under 5 years in the village were 53, 23 (44.2%) of them were diagnosed with PEM and of them 3 cases were with severe PEM.

Realizing the magnitude of PEM, Wilayat *Al Mudhaibi* included this health issue in its plan of action and developed several activities and interventions with the participation of the community, government sectors and civil organization. One of these activities was the development of the Nutrition Education Centre in 2006. Furthermore the Wilayat Health Committee approved this activity as a community participation to address such issue.

Aims of the Centre

- Provide a community focal point to liaison with mothers of affected children.
- Train the community support groups in the village on communication plan in nutrition to mothers, supervision (including health education and skills in preparation of complementary feeding).
- Initiate "Triple A" approach to follow-up growth rate of children under 3 years.
- Address and correct misconceptions and wrong beliefs among the community.

Intervention plan

- Community survey: All children under the age of 5 years were assessed and PEM cases were identified and further assessed for possible causes for PEM Cases were referred to the health centre for medical review.
- Formation and training of community support group and involve them in the plan of action
- Regular follow-up of affected children and their monthly weight monitoring
- Training on complementary feeding, healthy diet and healthy cooking.

Fig.1: Community Nutrition Education Session in Progress

Fig.2: The Nutrition Education Centre in Talool Village

Project achievements

- Reduction in PEM in children under 5 years from current 44% to 0%
- Availability of gathering place for education of mothers of affected children
- Cooperation and interaction between health workers and community
- Correction of misconception and wrong practices of feeding among community
- Availability of a centre which will be used in future for different community learning activities.
- Contribution of the community to resolve health problems based on local resources

– Involvement of community members in building the centre

– Provide transport for the

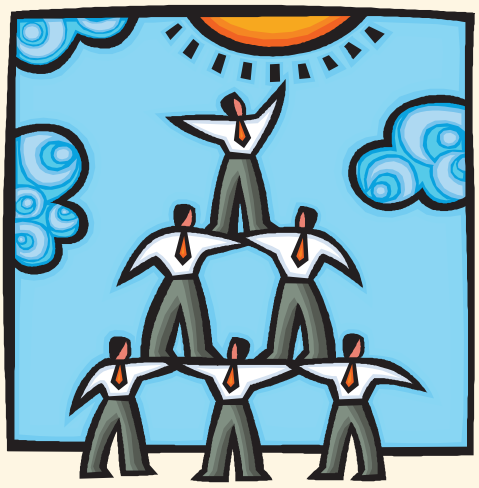
(Continued on page 5)

"Realizing the magnitude of PEM, Wilayat *Al Mudhaibi* included PEM in its plan-of-action & developed several activities & interventions with the participation of the community."

Partnership

"Partnership is an important method for bringing together a diversity of skills & resources for more effective health promotion outcomes."

The term partnership can be used to describe relationships that vary in complexity from simple information sharing (cooperation) to formal joint governance of arrangements between organisations (collaboration).



A network may be formed when particular service providers (for example counsellors or family violence workers) establish regular informal communication to share information about the kinds of issues and service difficulties they share in common. A partnership may be formed when organisations agree to work together cooperating voluntarily for a common purpose but remain as independent organisations. A federation occurs when they agree to merge some aspect of operations.

Partnership is an important method for bringing together a diversity of skills and resources for more effective health promotion outcomes. It can increase the efficiency of the health and community service system by making the best use of different but complementary resources. Collaborations, joint advocacy and action can also potentially make a bigger impact on policy-makers and government. If partnership is to be successful, however, they must have a clear purpose, add value to the work of the partners and to be carefully planned and monitored.

A distinction can be made between the purposes and nature of partnerships. Partnerships in health promotion may usefully be seen to range on a continuum from networking through to collaboration.

- Networking involves the exchange of information for mutual benefit. This requires little time and trust between partners. For example, youth services within a local government area may meet monthly to provide an update on their work and discuss issues that affect young people
- Coordinating involves exchanging information altering activities for a common purpose. For example, the youth service may meet and plan a coordinated campaign to lobby the council for more youth -specific services.
- Cooperating involves exchanging information, altering activities and sharing resources. It requires a significant amount of time, high level of trust between partners and sharing the turf between agencies. For example, a group of secondary schools may pool some resources with a youth welfare agency to run a 'Diversity Week' as a way of combating against violence and discrimination.
- Collaborating. In addition to the other activities described, collaboration includes enhancing the capacity of the other partner for mutual benefit and a common purpose. Collaborating requires the partner to give up a part of their turf to another agency to create a better or more seamless service system. For example, a group of schools may fund a youth agency to establish a full-time position to coordinate a Diversity Week, provide professional development for teachers and train student peer mediators in conflict resolution.

In the health sector, the need to link the organisations that provide diverse services has been recognised as a key to meet the health needs of populations. The principles of collaboration in the public and private sectors are very similar; the context in which they occur is different.

In the public sector, partnerships are normally viewed as strategies to achieve system integration and better outcomes for system users. The benefits sought in public sector partnerships include:

– more relevant and effective services to individuals and the community;
– services focused on community need rather than organisational structures;
– gathering the resources to find solutions to complex problems;
– services tailored for local regions and communities;
– cost savings through sharing resources and reducing duplication;
– new ways of designing services using new technologies

Structural arrangements for partnership work in the public sector can and do take many forms. In the United Kingdom the Audit Commission defined the minimum requirements for a partnership. These were that the member organisations:

– are otherwise independent bodies;
– agree to cooperate to achieve a common goals;
– create a new organisational structure or process to achieve this goal;
– plan and implement a joint program; and
– share relevant information, risks and rewards

Working collaboratively is not always easy. The challenges and tensions created by working collaboratively as well as the importance of deciding when partnership is not an appropriate or effective strategy for achieving success.

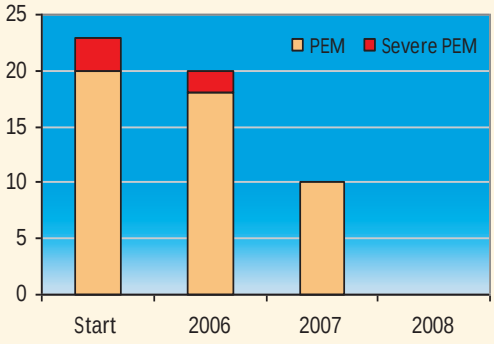
Walker also describes the critical factors for successful collaboration including the need for partners to establish a process ensuring that organizations develop a shared vision and objectives.

Ongoing monitoring and shared reflection on how the partnership is working is critical to strength and sustain relationships between organizations and achieve effective outcomes. In particular collaborative partnerships require the support and involvement of senior agency personnel, since project workers may be relatively junior or on short-term contracts. This can affect their capacity to mobilise the agency resources required for collaboration.

(Continued from page 3)

members and mothers
– Provide raw food material for the healthy cooking sessions
– Participation of CSG in Health education and raising awareness of community in health related issues

Fig-3: PEM cases in *Taloo*l village



The Future plans

- To continue using the Centre for health education activities
- To continue children follow up to maintain the absence of PEM in the village
- Follow up of pregnant women in the village diagnosed with anemia
- Training diabetic patients on self blood glucose testing
- Establishing first aid training program in the village
- Work in collaboration with Ministry of Municipality and Ministry of Education to initiate activities to improve village environment

"Ongoing monitoring & shared reflection on how the partnership is working is critical to strengthen & sustain relationships between organizations and achieve effective outcomes."

Nizwa Healthy Lifestyle Project (NHLP) Evaluation

"The Department of Community Based Initiative (CBI) worked in collaboration with the WHO office to develop a methodology for this evaluation."

The native population of the Sultanate of Oman has undergone a major lifestyle changes in the past forty years after renaissance that resulted in the increased incidences of morbidity and mortality related to non-communicable diseases (NCDs) such as hypertension, diabetes, heart diseases and cancer. The Ministry of Health acknowledged the increasing need to equally focus on prevention of non-communicable diseases along with communicable diseases.

The Healthy Lifestyle Project in Nizwa Wilayat in Dakhliyah region started in 1999 as a Community-Based initiative for primary prevention of NCDs and their risk factors. The Ministry of Health in collaboration with WHO declared the whole of Nizwa town "A Healthy City" adopting Community-Based Initiative (CBI) principles and approaches in further promoting the healthy lifestyle. The objectives of the Nizwa Healthy lifestyle programme are to map the emerging epidemics of NCDs and to analyse the social, economic, behavioural and political determinants of the disease; to reduce the exposure of individuals and populations to the major determinants of NCDs, to prevent the emergence of preventable common risk factors; and to strengthen health care for people with NCDs by supporting effective interventions. It has been over 5 years since the launching the project intervention in March 2004.

Project goal

The ultimate project goal is to improve the health of people in Nizwa by the implementation of a Community-based project for primary prevention of non-communicable diseases by promoting healthy lifestyle.

Objectives

- To map the emerging epidemics of NCDs and to analyze the social, economic, behavioral and political determinants of the disease.
- To reduce the exposure of individuals and populations to the major determinants of NCDs and to prevent the emergence of preventable common risk factors.
- To strengthen health care for people with NCDS by supporting effective interventions.

To achieve the project objectives the interventions were focused on five main aspects: promoting physical activity, healthy diet, tobacco control, healthy environment and preventing road traffic accidents and domestic injuries.

During the period of 5 years many activities and interventions have been conducted to achieve the objectives of the project. At this time evaluation of the project is crucial to assess the progress made on the implementation of the five-year strategic plan of action and to measure the effectiveness of the project activities in changing peoples' behaviour and to identify opportunities for improvement. The overall objective is to evaluate the NHLP and assess the inputs, outputs, process, and short and midterm impacts in the local programme area.

Evaluation Objectives

- To measure the effectiveness of the project activities in changing behavior and adapting healthy life style.
- Determine the extent of the implementation of project activities.
- Assess different project components.
- Identify lessons learned and major constraints.
- To establish a standard framework for CBI evaluation.
- Recommend actions for improvement.

Steps in NHLP Evaluation

The Department of CBI worked in collaboration with the WHO office to develop a methodology for this evaluation. The evaluation was divided into stages, each with a specific task and time frame. These are:

- The preparatory stage
- The quantitative and qualitative stage
- The survey stage and data collection
- The data analysis and result dissemination stage.

So far the preparatory stage is in progress and several tasks were accomplished. This stage included the preparatory workshop held in collaboration with the WHO office

National training for Wilayat Health Committees

Wilayat Health Committee (WHC) is recognized as a tool for community participation. The Ministry of Health introduced this mechanism to engage individuals in the community to participate in planning and implementing health projects and health related campaigns.

Fig.1: The Wilayat Health Committee Workshop

The Wilayat Health Committee (WHC) is headed by the Wali (Governor) of the Wilayat. Therefore his role is recognized as a primary support for the health services in the Wilayat i.e. to promote and implement different health programs. The committee includes in its membership representatives from different related government sectors and representatives from the community which helps to facilitate decision making as well as the implementation of the project.

Under the auspices of HE Dr Ahmed bin Mohammed Al Saidi, Under secretary of health affairs, Ministry of Health the CBI department in collaboration with UNICEF conducted a workshop on 24-26 May 2009 to establish an operational tool for Wilayat Health Committees (WHC). Total 33 participants attended the workshop from various health directorates, supervisors of WHC and members of the community.

Objectives

- To define the significance of the WHC and the role of different sectors and individuals in promoting health. In addition, it aimed to highlight the roles of central level in supporting Health Committee activities.
- To highlight the concepts of the voluntary work and it is importance to the trainees.
- To define the technical team and health administrative team and to recognize the relationships between these groups with WHC.
- To develop a standard operational mechanism for WHC.
- To emphasize the importance of participating in the WHC projects, competition and to review the evaluation forms.

Expected Outcome

- Develop operational guidelines on WHC
- Capacity building and training of master trainer on different aspect of WHC.
- Develop a plan of action for each region
- To conduct a model workshop to train WHC members

on 29-31 March 2009 in the presence of two regional consultants. Also a central advisory team and a local committee and subcommittee were formed each with a specific terms of reference and tasks. In addition to that several documents were prepared during this period including the desk review of the project intervention, the evaluation protocol which contains the methodology of the evaluation steps and the survey questionnaire which was adopted using several sources. The quantitative tool will be used for stepwise survey.

The evaluation will be conducted in October 2009, till then the work in different stages of the methodology is in progress.

Expected Outcome of Evaluation

- Develop national plans
- Strengthen partnership
- Identify strengths, weakness and opportunities to improve
- Provide recommendation to enhance programs

"The CBI department in collaboration with UNICEF conducted a workshop on 24-26 May 2009 to establish an operational tool for Wilayat Health Committees (WHC)."

Assessment of Wilayat Health Committees

The establishment of the Wilayat Health Committees (WHC) in 1999 in cooperation with health system is indicative of the importance of involving the community and the Government sector in order to create the concept that people are responsible toward maintaining and improving their own health. Since the establishment of the WHC they worked in improving individual and community health and that was through providing health related programmes and raising the awareness of community participation concept in order to foster the development of health. It also contributes effectively in planning, implementing and follow-up to solve community health problems. Through these years there was no tool for the evaluation of the performance of the WHC. Hence and because of the significance of evaluation in the process of development and in terms of studying the effectiveness of the Wilayat Health Committees, the Central Committee decided in 2008 to setup a team work which was consisting of administrators from the Ministry of Health and UNICEF to evaluate the current situation and to study the achievements and to identify challenges.

Objectives

The general goal is to expand the role of health committees emphasizing their role and importance within the health system

- To study the current situation and functioning of the Health Committees (achievements and constraints)
- To recommend organized and unified tools for assessing the functioning of the Health Committee

Method

A team was established consisting of 7

"The Wilayat Health Committee (WHC) decided in 2009 to adopt *Seeq* (Wilayat *Al Kamil Al Wafi*; *North Sharqiyah* Region) for the 'Healthy Village' initiative."

Seeq: Healthy Village Initiative

Seeq is one of the villages of the Wilayat of Al Kamil and Al Wafi in North Sharqiyah region. The village is inhabited by 620 individuals. The Wilayat Health Committee (WHC) decided in 2009 to adopt *Seeq* for the 'Healthy Village' initiative. The rationale for choosing *Seeq* as healthy village in addition to fulfilling the criteria developed by the World Health Organization viz. access to facility, availability of all service, availability of supportive environment are as follows.

- The existence of significant health and social problems in the village
- The willingness of the local community members to participate and their support for the voluntary work
- The availability of previous health related studies such as Protein Energy Malnutrition in children under five years of age.

As a result, those key factors have been presented to the WHC headed by the Wali.. The WHC accepted the idea of launching the initiative based on scientific methodology.

The WHC conducted a meeting to introduce and explain the concept of the initiative and the idea was welcomed by the community. An introductory seminar was conducted under the auspices of the Wali and in coordination with the Department of Community Based Initiative (CBI) to explain the concept. This seminar was also attended by the representatives of the *Majalis Al Shoura* council, community leaders in the Wilayat, local members of the community and community supports group members. The total attendance was 150. Further work is planned in 2010 that includes organizational structure, developing plan of action, training of community members and household survey etc.

members (4 Ministry of Health, 2 UNFPA and 1 UNICEF). After three meetings the team selected two methodologies to facilitate their evaluation which were quantitative and qualitative.

Sample size

In the sultanate there are 61 WHC and in this study 18 WHC were selected. All committee members in the selected sample were included in the study with a total of 101 directors and members.

Quantitative: A survey was conducted. It was designed and reviewed by the team. The survey questionnaire was distributed to the target groups such as members from Government sector, community members and health workers.

Qualitative: Focus group discussions (FGD) were chosen as a tool in this study. During the discussions the health committee's situation was assessed from different perspective and dimensions such as methodology, training, tools, performance and incentives. The assessment was subdivided in two levels—first level consisted of Wali (the head of the health committee). The second level was General Directors/sectors managers in the region and numbers of health workers who worked in cooperation with the health committees.

Results

Overall the results of the study indicated a positive feedback from all interviewed about the importance of the WHC and its motivational role in improving health of the individual and the community.

Table1: Constraints and Challenges

Constraints and Challenges	%
No allocated budget for activities	25
Low attendance in meetings	18
Lack of qualified workers	18
No identified correspondent	17
Inactive community members	14
Lack of follow-up at all levels	9
No response to recommendations	7

The focus group discussion emphasized that there is absence of organized structure for the WHC. It is crucial to have an identified correspondent who works only at the central and regional level in order to follow up tasks and recommendations of the committees. Also there is insufficient training for the members and committee correspondent.

Another important result in this study was that more than 82.8% of target group in the study recommended that it is necessary to have directors as representatives of the Government sector in WHC. The study shows that government sector is prominently participating in all WHC in the Sultanate.

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Fig.1: Distribution of Government Members

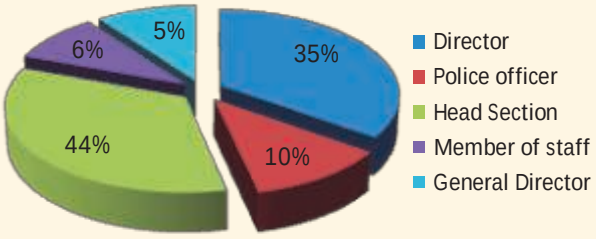


Fig.2: Private Sector Participation

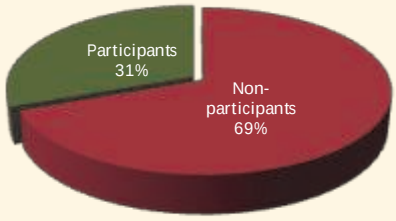
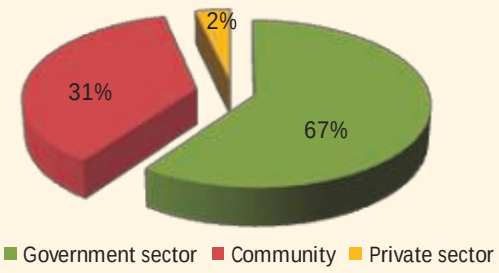


Fig.3: Distribution of Health Committee Members



"Overall the results of the study indicated a positive feedback from all interviewed about the importance of WHC and its motivational role in improving health of the individual and the community."

Seeq 'Healthy Village' Initiative: Meeting in Progress

necessary to have directors as a representatives of the Government sector in WHC.

However only 28% of the WHC have representatives from the private sector. In 72% of WHC, private sector is not represented as illustrated in figure 2.

The study also showed that 51% of the participants pointed out that there is no allocated budget for the WHC activities that affected the functioning of the WHC. Over 38% of the members admitted that there were no responses from the national level.

Conclusions and Recommendations

The study concluded with the most important recommendations as follows:

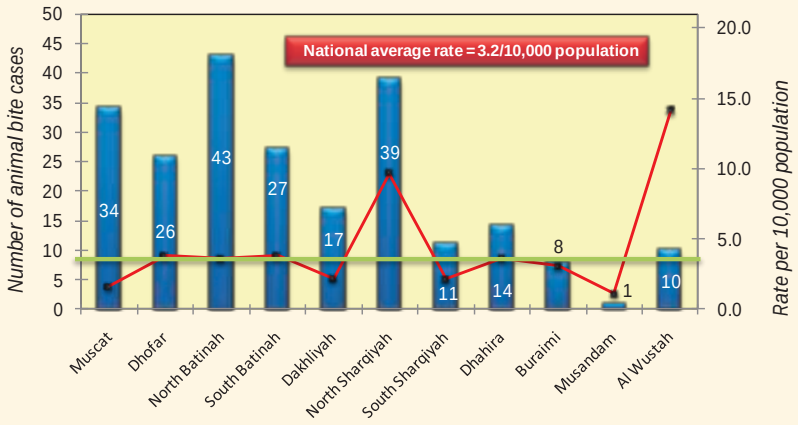
- Report should be sent to all Government sector members of WHC to motivate and increase level of their participation.
- Review the Ministerial Qarar (# 23/1999) which addressed WHC structure from the perspective of adding members in some Government sectors which are not mentioned in the Qarar. Also review the roles of WHC and examine whether it is appropriate to achieve its goals.
- Endorse and implement all WHC recommendations at all levels.
- The Ministry of Health should provide some financial resources (budget) to WHC which will contribute in motivating the committee members to search for other sources of finance for their activities.
- It is essential to develop standard operational guidelines (SOPs) that will help in organizing the work of WHC and to clarify roles and tasks of each member.
- Set up training and workshops for the directors and the members once a year to present the outcome of the most important health related programs and to clarify the aims of structuring committees and developing plan of action. Also to address the meaning of the team work and emphases the concept of the volunteer work

"It is essential to develop standard operational guidelines (SOPs) that will help in organizing the work of WHC and to clarify roles and tasks of each member."

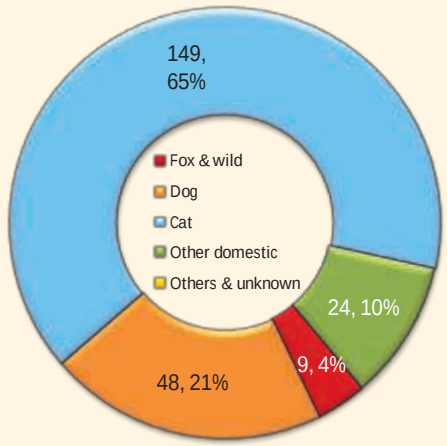
Animal Bite Surveillance Data

Third quarter: July-September 2009

Notified animal bites by Regions (# & annualized rate/10,000 population)



Notified animal bites by type of animal (# / %)



Brief Summary & Observations on

Communicable Disease Surveillance Data: Third quarter; July-September 2009

Group A Diseases & Syndromes

- AFP: Four AFP cases were reported from Musanah (South Batinah), Mudaibi (North Sharqiyah), Mutrah and Bawsher (Muscat) which were later classified as non-polio AFP with final diagnosis of Guillian Barre Syndrome in Musanah case and myositis in other three cases.
- Fever & Rash illness: Of the 320 cases reported in Q2, blood sample was not collected in 5 cases hence classified as clinical measles (1- S.Sharqiyah, 1- N.Batinah, 3-Muscat). Of the 3 seropositive cases 2 were imported (Asia) and none were due for vaccination (i.e. <1 yr). 3 rubella cases were seropositive (N.Batinah, S.Sharqiyah & Dakhliyah).
- Meningococcal infections: No case of meningococcal disease was reported.
- Hib Meningitis: In Q2, one case was reported from Dima Wa Al Tayeen (N.Sharqiyah). The case was vaccinated.
- Pulmonary Tuberculosis: Of the reported cases, 33 were sputum positive and 11 were sputum negative.
- Food poisoning: 24 minor episodes accounting for 150 cases were reported in Q2.
- Other priority diseases (unlisted): One imported (Thailand) case of travel associated Dengue fever (Type-4) was reported from Bowsher Wilayat (Muscat). Travel history within past 2 weeks was elicited.

Group B Diseases

- Meningitis: 16 cases of bacterial meningitis other than Nm and Hib were reported.
- Viral Hepatitis: Total 259 cases were reported of which only 11 were confirmed as type 'A'. A large number of samples (248) were not tested (unspecified) due to shortage of diagnostic kits at the Central Public Health Laboratory.
- Pertussis: 30 clinical cases were reported of which two were confirmed by IgM ELISA. Of these one child was aged less than 1 year hence the IgM positivity could be vaccine related. A paired sample is required for confirmation.
- Brucellosis: 35 cases were reported from the endemic Dhofar Governorate except one from Muscat.
- Leishmaniasis: 3 sporadic cases of cutaneous Leishmaniasis were reported from Muscat, N. Batinah and Buraimi.
- HIV [AIDS]: 11 new HIV infections were diagnosed and 8 AIDS cases were reported among the HIV positive chronic carriers.

Group C Diseases

- Varicella: In the Q2 a total of 22,226 cases of chickenpox (annualized incidence rate = 32.4/1,000 population) were reported from all over the country.
- Mumps: 189 cases of clinical mumps were reported through the passive surveillance system while from sentinel sites 84 cases were reported that were subjected to laboratory confirmation. Of these 27 were IgM positive.

Communicable Disease Surveillance Data: *By Month*

Third quarter: July-September 2009

Priority Communicable Diseases	2009				2008		2009	
	July	Aug	Sep	Total	Q3 Jul-Sep	Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun
Group A Diseases								
Cholera	-	-	-	0	-	-	-	-
Plague	Never reported							
Yellow Fever	Never reported							
Meningococcal Infection	-	-	-	0	1	1	-	-
H. influenzae type b, meningitis *(Hib)*	-	-	-	0	1	-	1	-
Rabies	-	-	-	0	-	-	-	-
Malaria (*Imported Cases*)	85	113	81	279	335	347	92	288
Pulmonary Tuberculosis (*sputum positive*)	8	7	6	21	30	18	27	27
Group A Syndromes								
Acute Flaccid Paralysis [Polio]	4	-	-	4	2	9	8	4
Fever & Rash-Illness	50	43	27	120	209	148	158	231
Clinical Cases	1	2	3	6	4	2	3	1
Measles (*IgM positive*)	-	-	-	0	1	-	1	2
Rubella (*IgM positive*)	-	-	1	1	1	-	1	-
Congenital Rubella Syndrome (*CRS*)	-	-	-	0	-	-	-	-
Severe Acute Respiratory Syndrome *(SARS)*	Never reported							
Acute Haemorrhagic Fever Syndrome	-	-	-	0	-	-	-	-
Food Poisoning (*Infectious origin*)	22	43	32	97	170	60	36	77
Group B Diseases								
Bacterial Meningitis *(other than Hib & Nm)*	1	1	-	2	8	11	6	2
Viral Meningitis	-	-	-	0	-	-	1	-
Other Meningitis (*unspecified*)	1	1	1	3	7	13	6	8
Acute Viral Hepatitis (*Total*)	30	21	11	62	189	186	222	292
Acute Viral Hepatitis A	20	10	7	37	4	133	175	199
Acute Viral Hepatitis B	3	3	1	7	-	7	2	7
Acute Viral Hepatitis C	1	-	1	2	-	2	2	9
Acute Viral Hepatitis D (*amongst B positive*)	-	-	-	0	-	-	-	-
Acute Viral Hepatitis E	1	2	-	3	-	3	-	7
Acute Viral Hepatitis (*unspecified*)	5	6	2	13	185	41	43	70
Typhoid & Paratyphoid Fever	5	5	3	13	18	14	16	22
Clinical Pertussis [IgM positive]	5	-	1	6	17 [3]	6	10	14
Trachoma (*active*)	2	-	3	5	19	16	13	12
Brucellosis *(human)*	7	7	11	25	22	19	18	19
Leishmaniasis Cutaneous (CL)	1	1	-	2	2	1	-	2
Leishmaniasis Visceral (VL)	-	-	-	0	-	-	-	1
Schistosomiasis (*intestinal*)	-	-	-	0	-	-	-	1
Pulmonary Tuberculosis (*sputum negative*)	2	2	3	7	-	1	4	1
Extra-pulmonary Tuberculosis	11	7	6	24	22	29	28	29
Leprosy	1	-	-	1	-	1	-	1
HIV [AIDS]	6 [4]	3 [0]	7 [0]	16 [4]	13 [7]	19 [3]	14 [7]	18 [5]
Group C Diseases and Syndromes								
Influenza Like Illnesses (*ILI*)	28386	48006	51677	128069	7041	13152	153137	124384
aLRTI & Pneumonia *(childhood)*	115	184	134	433	2914	4896	773	637
Acute 'Watery' Diarrhoea *(childhood)*	3504	4253	4192	11949	5266	7045	30588	17310
Chickenpox	2094	1610	758	4462	7378	4747	8607	10068
Clinical Mumps [Sentinel sites-IgM positive]	50 [1]	35 [2]	41 [1]	132 [4]	120 [11]	418 [3]	195 [5]	161 [2]

Communicable Disease Surveillance Data: *By Regions*

Third quarter: July-September 2009

Priority Communicable Diseases	Total	Muscat	Dhofar	North Batinah	South Batinah	Dakhli-yah	North Sharqi-yah	South Sharqi-yah	Dhahira	Buraimi	Musan-dam	Al Wustah
Group A Diseases												
Cholera	0	-	-	-	-	-	-	-	-	-	-	-
Plague	Never reported											
Yellow Fever	Never reported											
Meningococcal Infection	0	-	-	-	-	-	-	-	-	-	-	-
H. influenzae type b, meningitis *(Hib)*	0	-	-	-	-	-	-	-	-	-	-	-
Rabies	0	-	-	-	-	-	-	-	-	-	-	-
Malaria (*Imported Cases*)	279	102	26	45	26	18	20	9	6	15	3	9
Pulmonary Tuberculosis (*sputum positive*)	21	7	3	4	2	-	-	2	-	3	-	-
Group A Syndromes												
Acute Flaccid Paralysis [Polio]	4	1	1	-	-	-	2	-	-	-	-	-
Fever & Rash-Illness	120	7	16	10	28	25	6	19	5	2	-	2
Clinical Cases	6	-	4	-	2	-	-	-	-	-	-	-
Measles (*IgM positive*)	0	-	-	-	-	-	-	-	-	-	-	-
Rubella (*IgM positive*)	1	-	-	-	1	-	-	-	-	-	-	-
Congenital Rubella Syndrome (*CRS*)	0	-	-	-	-	-	-	-	-	-	-	-
Severe Acute Respiratory Syndrome *(SARS)*	Never reported											
Acute Haemorrhagic Fever Syndrome	0	-	-	-	-	-	-	-	-	-	-	-
Food Poisoning (*Infectious origin*)	97	5	-	21	1	34	31	5	-	-	-	-
Group B Diseases												
Bacterial Meningitis *(other than Hib & Nm)*	2	-	1	-	1	-	-	-	-	-	-	-
Viral Meningitis	0	-	-	-	-	-	-	-	-	-	-	-
Other Meningitis (*unspecified*)	3	-	-	3	-	-	-	-	-	-	-	-
Acute Viral Hepatitis (*Total*)	62	8	10	4	4	3	11	14	1	1	1	5
Acute Viral Hepatitis A	37	5	8	2	1	-	8	10	-	1	1	1
Acute Viral Hepatitis B	7	1	-	-	1	1	-	2	1	-	-	1
Acute Viral Hepatitis C	2	-	1	-	1	-	-	-	-	-	-	-
Acute Viral Hepatitis D (*amongst B positive*)	0	-	-	-	-	-	-	-	-	-	-	-
Acute Viral Hepatitis E	3	1	-	-	-	-	1	-	-	-	-	1
Acute Viral Hepatitis (*unspecified*)	13	1	1	2	1	2	2	2	-	-	-	2
Typhoid & Paratyphoid Fever	13	4	3	3	-	2	-	-	-	1	-	-
Clinical Pertussis [IgM positive]	6	-	2	2	-	1	1	-	-	-	-	-
Trachoma (*active*)	5	-	-	-	-	3	2	-	-	-	-	-
Brucellosis *(human)*	25	-	23	1	-	-	1	-	-	-	-	-
Leishmaniasis Cutaneous (CL)	2	1	-	1	-	-	-	-	-	-	-	-
Leishmaniasis Visceral (VL)	0	-	-	-	-	-	-	-	-	-	-	-
Schistosomiasis (*intestinal*)	0	-	-	-	-	-	-	-	-	-	-	-
Pulmonary Tuberculosis (*sputum negative*)	7	1	1	1	3	1	-	-	-	-	-	-
Extra-pulmonary Tuberculosis	24	7	3	5	2	4	-	2	1	-	-	-
Leprosy	1	-	-	-	-	-	-	-	1	-	-	-
HIV [AIDS]	16 [4]	2 [1]	1 [1]	9 [2]	2 [0]	1 [0]	-	-	1 [0]	-	-	-
Group C Diseases and Syndromes												
Influenza Like Illnesses (*ILI*)	128069	30616	11964	23733	10665	20304	6522	6525	7907	4678	3925	1230
aLRTI & Pneumonia *(childhood)*	433	65	145	19	70	36	30	54	6	6	1	1
Acute 'Watery' Diarrhoea *(childhood)*	11949	1328	1536	1749	1344	2736	745	972	809	212	214	304
Chickenpox	4462	540	217	374	620	1269	242	279	652	170	29	70
Clinical Mumps [IgM positive]	132 [4]	23 [1]	10 [1]	21	22 [1]	23	3	8	19 [1]	2	-	1

Communicable Disease Surveillance Data: *By Wilayat*

Third quarter: July-September 2009

Region / Governorate	Wilayat	AFP	Measles	Rubella	Meningococcal infection	Viral Hepatitis A	Viral Hepatitis B	Malaria	Pertussis [IgM +ve]	TB Total	TB Sputum positive
Muscat	Muscat							3		2	1
	Mutrah	1				2		31		4	3
	Bawsher							33		2	1
	Seeb					3	1	30		3	1
	Al Amerat							4		3	1
	Qurayat							1		1	
Dhofar	Salalah					1		16	2	7	3
	Taqah										
	Mirbat										
	Thumrait							10			
	Sadha										
	Rakhyut										
	Dhalkut	1									
	Shaleem										
	Muqshan										
	Mazyoona					7					
North Batinah	Sohar							23		1	
	Suwaiq							3		2	1
	Saham					1		6		4	1
	Shinas							1	1	1	1
	Liwa					1		11			
	Khaburah							1	1	2	1
South Batinah	Rustaq			1				6		1	
	Barka					1	1	14		3	1
	Musanah							4		2	1
	Nakhl									1	
	Wadi Maawil										
	Al Awabi							2			
Dakhliyah	Nizwa						1	7			
	Samail							2			
	Bahla							4	1	3	
	Izki							1		1	
	Adam							4			
	Al Hamra									1	
	Manah										
	Bidbid										
North Sharqiyah	Ibra	1						2	1		
	Mudaibi							7			
	Bidiyah					3		4			
	AL Qabil					5		3			
	Dima Wa Al Tayeen	1						4			
	Wadi Bani Khalid										
South Sharqiyah	Sur					1		2		2	
	Jalan Bani Bu Ali					7	1	2		1	1
	Jalan Bani Bu Hassan					1				1	1
	Al Kamil Wa Al Wafi					1	1	5			
	Masirah										
Dhahira	Ibri							6		1	
	Yankul						1				
	Dhank										
Buraimi	Buraimi					1		13		3	3
	Mahda						1	1			
	Sunaina							1			
Musandam	Khasab							3			
	Daba Al Biya										
	Bukha										
	Madha										
Al Wustah	Haima					1	1	6			
	Duqum							2			
	Mahoot							1			
	Al Jazer										
Total		4	0	1	0	37	7	279	6	52	21

Communicable Disease Surveillance Data: *Age Distribution*

Third quarter: July-September 2009

Priority Communicable Diseases	Total	Age groups in years								
		< 1	1-4	5-9	10-14	15-19	20-24	25-34	35-45	45+
Group A Diseases										
Cholera	0	-	-	-	-	-	-	-	-	-
Plague	Never reported									
Yellow Fever	Never reported									
Meningococcal Infection	0	-	-	-	-	-	-	-	-	-
H. influenzae type b, meningitis *(Hib)*	0	-	-	-	-	-	-	-	-	-
Rabies	0	-	-	-	-	-	-	-	-	-
Pulmonary Tuberculosis (sputum positive)	21	-	-	-	1	2	1	4	4	9
Group A Syndromes										
Acute Flaccid Paralysis [Polio]	4	-	4	-	-					
Fever & Rash-Illness	120	54	47	10	2	2	2	3	-	-
Clinical Cases	6	4	1	1	-	-	-	-	-	-
Measles (*IgM positive*)	-	-	-	-	-	-	-	-	-	-
Rubella (*IgM positive*)	1	-	1	-	-	-	-	-	-	-
Congenital Rubella Syndrome (*CRS*)	-	-	-	-	-	-	-	-	-	-
Severe Acute Respiratory Syndrome *(SARS)*	Never reported									
Acute Haemorrhagic Fever Syndrome	0	-	-	-	-	-	-	-	-	-
Food Poisoning (*Infectious origin*)	97	2	23	26	17	8	3	7	4	7
Group B Diseases										
Bacterial Meningitis *(other than Hib & Nm)*	2	1	-	-	-	-	1	-	-	-
Viral Meningitis	0	-	-	-	-	-	-	-	-	-
Other Meningitis (*unspecified*)	3	-	1	-	1	-	-	-	-	1
Acute Viral Hepatitis (*Total*)	62	-	13	22	6	4	2	7	4	4
Acute Viral Hepatitis A	37	-	13	19	2	1	-	1	1	-
Acute Viral Hepatitis B	7	-	-	-	-	-	-	5	2	-
Acute Viral Hepatitis C	2	-	-	-	-	1	1	-	-	-
Acute Viral Hepatitis D (*amongst B positive*)	0	-	-	-	-	-	-	-	-	-
Acute Viral Hepatitis E	3	-	-	-	-	2	-	1	-	-
Acute Viral Hepatitis (*unspecified*)	13	-	-	3	4	-	1	-	1	4
Typhoid & Paratyphoid Fever	13	2	2	1	2	2	1	1	1	1
Clinical Pertussis [IgM positive]	6	3	1	2	-	-	-	-	-	-
Trachoma (*active*)	5	-	1	2	-	-	-	-	2	-
Brucellosis *(human)*	25	-	7	6	3	3	-	4	-	2
Leishmaniasis Cutaneous (CL)	2	-	-	-	-	1	-	-	1	-
Leishmaniasis Visceral (VL)	0	-	-	-	-	-	-	-	-	-
Schistosomiasis (*intestinal*)	0	-	-	-	-	-	-	-	-	-
Pulmonary Tuberculosis (*sputum negative*)	7	-	-	1	-	-	1	1	1	3
Extra-pulmonary Tuberculosis	24	-	-	2	4	2	2	7	5	2
Leprosy	1	-	-	-	-	-	-	1	-	-
HIV [AIDS]	16 [4]	-	1 [0]	-	-	-	2 [0]	3 [0]	10 [2]	0 [2]

Note:

- *The quarterly data are **'provisional'** & should be scrutinized & verified by the focal point of communicable diseases (Epidemiologist) at the provincial level. The data would be finalized. after receiving feedback.*
- *From year 2009, Group C data are compiled from computerized database by certain grouping of ICD-10 codes (Source: Nabd Al Shifa, DGIT, MoH)*
- *Tuberculosis, Leprosy & HIV [AIDS] data are for nationals only.*
- *All notified cases of Malaria are imported cases.*
- *(i) = imported case.*

"The wisest mind has something yet to learn."

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