Evaluation of surveillance system of diarrheal diseases during 1998-2009 in Albania

PhD Elida MATAJ[1], MSc Genci DERVISHI[1], Samira MATAJ[2],
Pranvera KASAJ[1]

[1]*Institute of Public Health*
[2]*Primary Health Centre No.7, Tirana, Albania*

ABSTRACT: *Reporting of infectious diseases in Albania is based on monthly reporting of cases through 14/Sh form. The data flow is carried out from local level (districts) to central level (IPH). In 1998, the surveillance system were carried out changes which are needed to improve the information available to health care providers.***Objective:** *Assessment of the surveillance system to identify strengths and its limitations and to make appropriate recommendations on improvements.***Methods:** *The study were descriptive one. In the study were included reported data by monthly form during the period 1998-2009 and notified individual form during the period 2007-2009, it to see the authenticity of the reported data and to know the situation regarding the level of health risks.The study was conducted in 12 major districs.***Results:***Obtained results showed the discordance between the individual information generated by the hospitals and laboratories and monthly information generated by reporting units.*

This surveillance system is represented by the low quality data which is expressed through incomplete, inaccurate and slow data. **Conclusion:** *Need for standardization of the system with the standard required by ECDC.*

KEY WORDS: *surveillance system, infection diseases, diarrhea diseases, data reporting*

I. INTRODUCTION

The Surveillance data are required for planning disease control activities and evaluating the impact. Disease surveillance data are also required to identify high-risk areas and high-risk groups for providing special attention[1]. However, like in most developing countries, health information system in most parts of Albania lacks the capacity to provide timely information on health events requiring prompt action[2].The National Program of Surveillance of Communicable Diseases (14/Sh) began functioning at 50' years; the burden of infectious diseases continues to be high compared with the European countries. We have evaluated the Diarrheal Diseases Surveillance System in Albania with the objective of describing and identifying of the weak points and constraints; and based upon the findings we have suggested appropriate measure to sustain strengths and overcome constraints[3].

II. MATERIAL AND METHODS

The evaluation of surveillance system of diarrheal diseases was shared such as (1) objective of surveillance evaluation (2) methodology to be adopted for the surveillance evaluation (3) disease to be evaluated (4) data collection methods (5) data analysis (6) dissemination of results[4].
The study were descriptive one. In this study were included 12 major districts.

Identified diseases as an epidemic potential were listed as: (1) Typhoid Fever (2) Salmonellosis (non-typhoid) (3) Shigellosis (bacillary dysentery) (4) Poising and (5) Amoebiasis. The objectives of the surveillance system for these diseases were included identifying core diseases like acute diarrheal diseases, estimating the disease burden, suggesting the trends of the disease, and analysis[5]. Reporting forms containing identifying variables such as age, sex, geographic area, date of onset, laboratory results etc…(*see annex 1)*[6].We assessed the simplicity through a review and analysis of data flow to see the possibility of obtaining the same results from both forms of reporting (individual and monthly). We assessed data quality by examining the percentage of "unknown" or "blank" responses to items on the surveillance forms. We reviewed diarrheal surveillance records to estimate the timeline for reporting. We qualitatively evaluated the surveillance system's ability to add new components and the ability to be operational when needed (flexibility) [7].

III. RESULTS

Table 1 shows the discordance between the data (monthly reporting and individual) expressing a major gap in the system of surveillance of infectious diseases in Albania.

Table.1 Number of cases of diarrhealdiseases in Albania [reportedbymonthly and individual form ( )]

Disease	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Typhoid fever	41	13	15	21	30	29	13	19	22	29 (16)	8 (4)	11 (7)
Salmonellosis (non-typhoid)	757	395	380	407	401	242	270	294	352	584 (133)	257 (69)	241 (61)
Shigellosis (bacillary dysentery)	848	817	728	885	694	795	764	607	614	652 (170)	390 (87)	300 (60)
Poising	1176	1186	1826	1987	2601	2665	2536	2200	2415	3067 (58)	2764 (57)	3370 (70)
Amoebiasis	45	49	20	4	24	4	5	7	6	0 (4)	6 (6)	0

( ) =includedindividual cases

Fig.. 1 The incidence rate (cases/100,000 inhabitants) of diarrheal diseases over the study period (1998-2009)
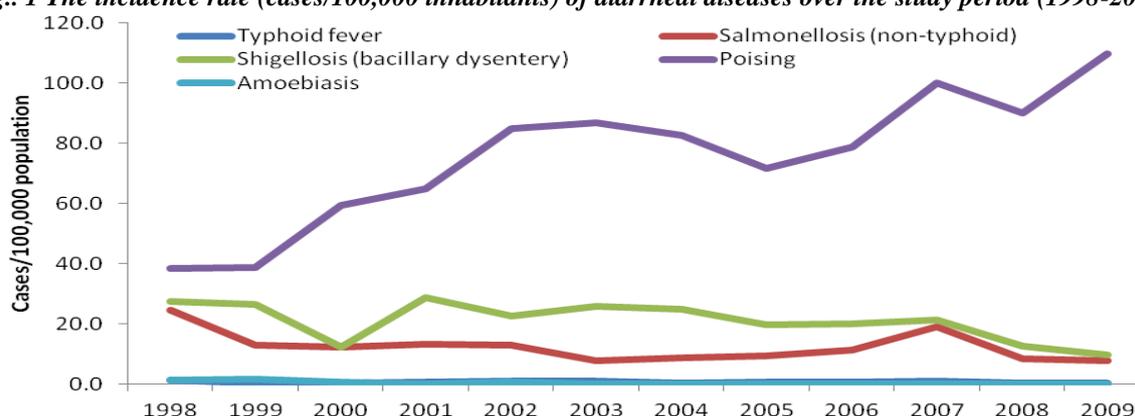
The annual incidence rate of diarrheal diseases during the period 1998 - 2009, shows the decreased trend for each disease presented in figure.1 except the incidence rate of poising which is higher than the other diarrheal diseases and is increased from 40.0 to 120.0 cases/100.000 population.

Table. 2 Number of diarrheal diseases case reported by monthly and individual form ( ) by regions during the years 2007-2009

Districs	Typhoid fever	Salmonellosis (non-typhoid)	Shigellosis (bacillary dysentery	Poisoning	Amoebiasis
Berat	1 (2)	54 (39)	157 (107)	1514	1 (4)
Diber	2	5 (4)	5 (5)	1003	0
Durres	3 (5)	3 (1)	48 (3)	84	0
Elbasan	9 (9)	107 (2)	100 (5)	84 (80)	0 (6)
Fier	1	6 (5)	16 (2)	138 (4)	0
Gjirokaster	0	0	4 (3)	10 (7)	0
Korce	2	13 (7)	90 (78)	144	6 (0)
Lezhe	1	68 (58)	28 (30)	0	0
Tirane	23 (11)	231 (132)	170 (42)	105 (87)	0
Shkoder	0	523	618	0	0
Kukes	4	60	76	6111	0
Vlore	2	10	30	8	5
Total	**48 (27)**	**1080 (248)**	**1342 (275)**	**9201 (178)**	**12 (10)**

( ) =includedindividual cases

The ***table 2*** presents number of diarrheal diseases cases by regions reported by monthly and individual form over the period 2007-2009. It's evident a discordance between the number of notified cases with the total case number reported by monthly form.

50 % of districts have reported only the number of cases by monthly reporting form (14/Sh); 33% of them have presented monthly and individual data. As shown in the table above, some of districts represent more data by individual notification form than monthly data such as: Berat and Durres for typhoid fever; Lezhe for shigellosis; and Berat and Elbasan for amoebiasis.

Distribution of diarrhealdiseasesovertheperiod 1998 – 2009 by districts Country Mean Incidence (cases/100,000 population) and range

Typhoid fever	*Salmonellosis (non-typhoid)*
0.6 (0.1 – 1.4)	*13.6 (1.3 – 42.0)*
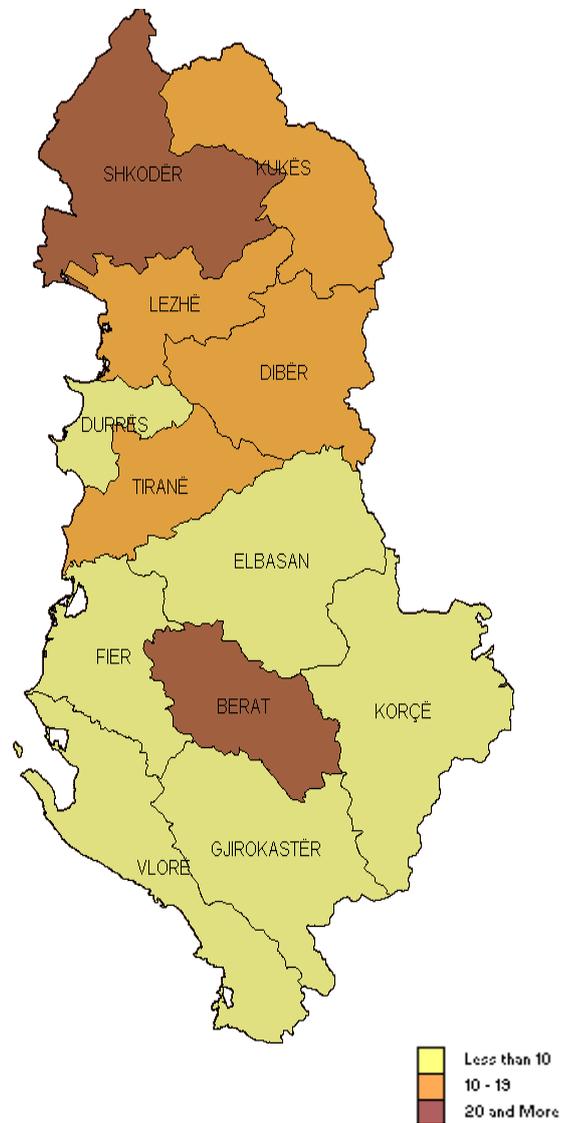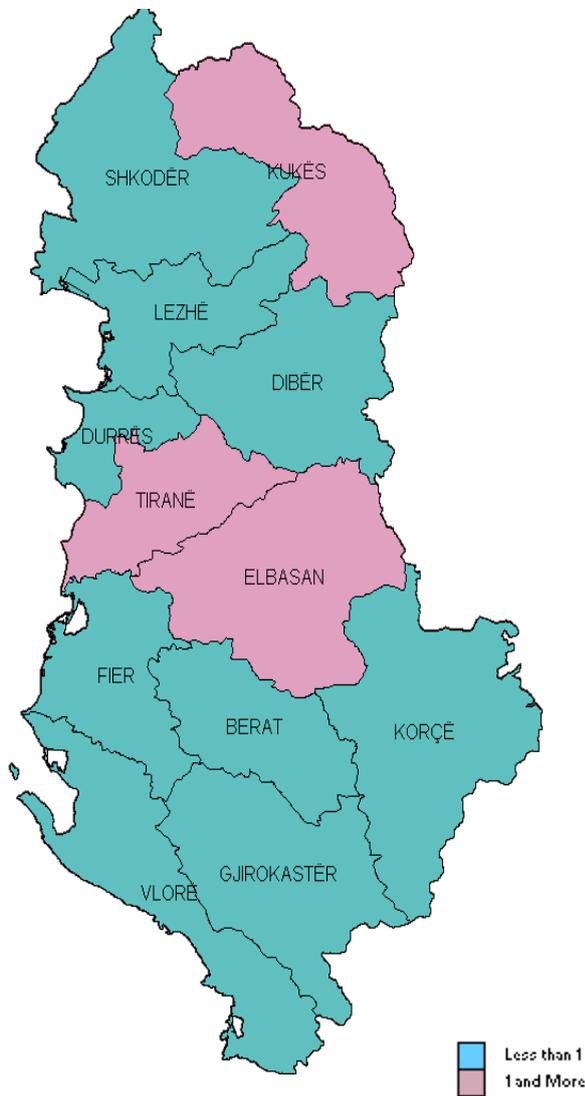
Poisoning
168.3 (2.7 – 1568.4)

Shigellosis
24.2 (2.9 – 65.8)

SHKODËR

KUKËS

LEZHË

DIBËR

DURRËS

TIRANË

ELBASAN

FIER

BERAT

KORÇË

GJIROKASTËR

VLORË

Less than 10
10 - 29
30 - 199
200 and More

SHKODËR

KUKËS

LEZHË

DIBËR

DURRËS

TIRANË

ELBASAN

FIER

BERAT

KORÇË

GJIROKASTËR

VLORË

Less than 10
10 - 59
60 and More
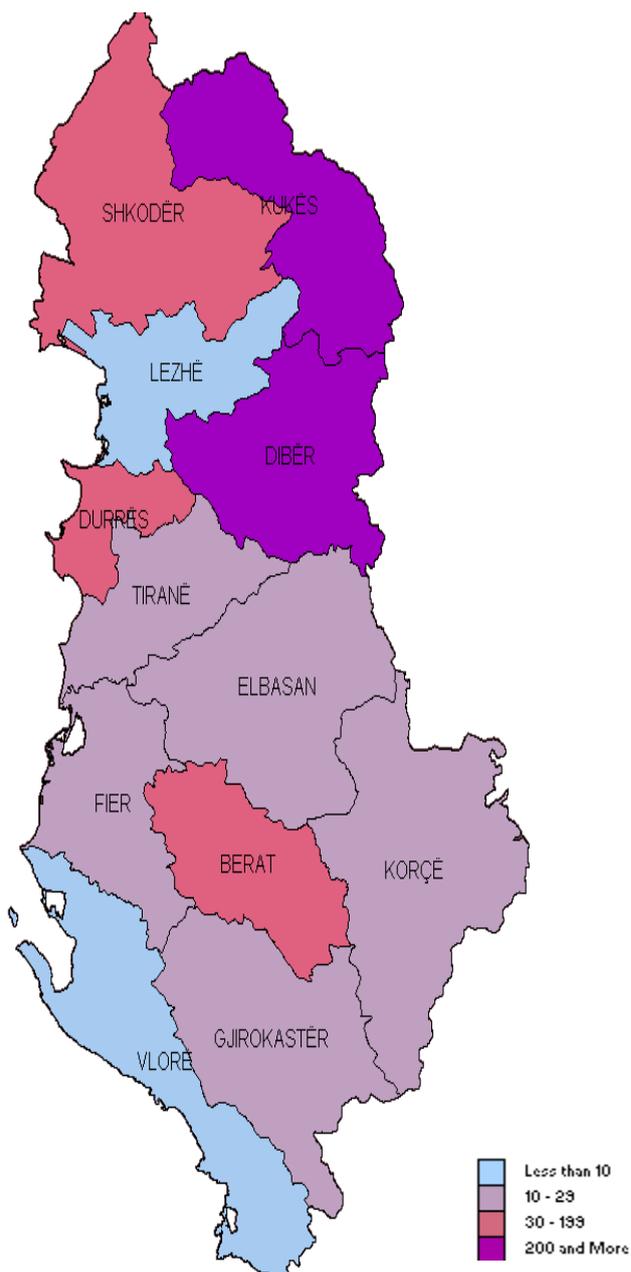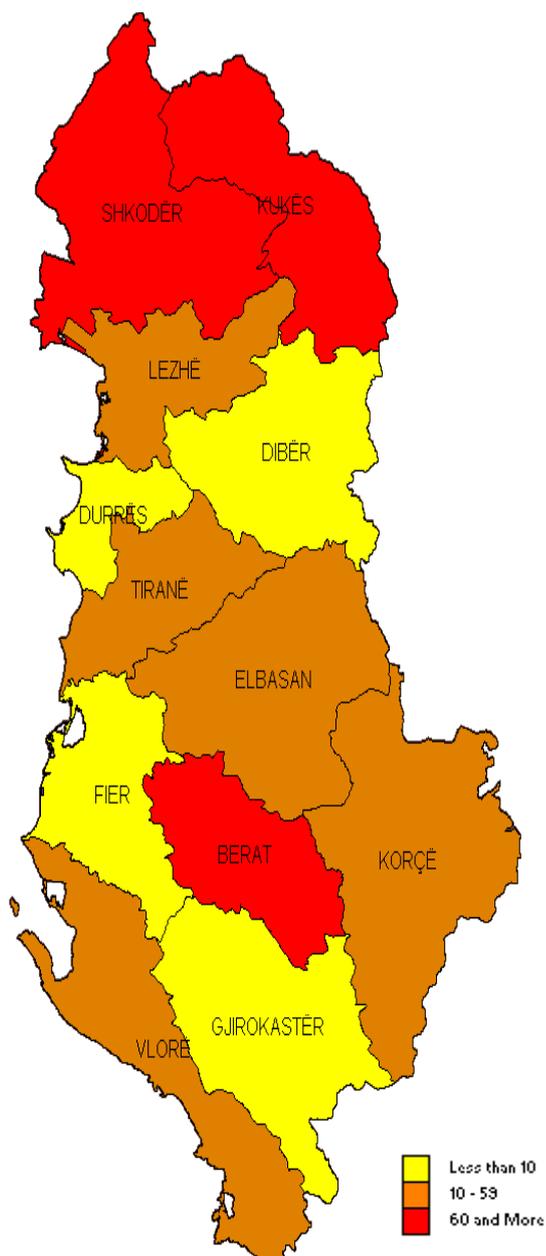
Table. 3 Distribution of diarrheal diseases case over the period 1998-2009 by age - group

| Disease		1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
		no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases
Typhoid fever	0-4	0	1	1	1	3	1	2	0	8	3	0	1
	5-14	10	6	3	7	10	18	5	8	4	10	0	5
	15-44	21	8	6	2	17	2	0	2	0	0	3	0
	45-59	5	1	3	1	2	2	0	0	2	0	1	17
	60 +	0	0	0	1	1	1	0	0	4	4	1	0
Salmonellosis (non-typhoid)	0-4	429	206	125	162	207	94	127	120	196	222	90	74
	5-14	106	62	54	58	57	43	61	59	56	113	69	39
	15-44	145	75	137	137	78	64	48	72	48	158	50	70
	45-59	53	34	56	40	39	29	26	28	41	68	25	43
	60 +	24	18	24	10	20	12	8	15	11	23	23	15
Shigellosis (bacillary dysentery)	0-4	386	343	301	437	347	349	339	301	317	313	158	127
	5-14	132	150	145	162	138	158	206	120	108	114	87	63
	15-44	207	198	154	155	117	169	120	96	93	104	74	46
	45-59	90	92	83	91	63	80	63	52	59	91	38	46
	60 +	33	34	45	40	29	39	36	38	37	30	33	18
Poisoning	0-4	264	176	209	164	296	269	282	197	220	399	342	325
	5-14	264	283	317	392	592	437	528	402	471	611	593	599
	15-44	472	583	957	1091	1217	1418	1264	877	1208	1391	1240	1657
	45-59	143	109	282	283	373	447	388	500	408	528	466	611
	60 +	33	35	61	57	123	94	74	224	108	138	123	178
Amoebiasis	0-4	11	28	11	1	2	0	3	3	4	0	1	0
	5-14	5	12	0	0	1	0	2	1	0	0	0	0
	15-44	21	8	6	2	17	2	0	2	0	0	3	0
	45-59	5	1	3	1	2	2	0	0	2	0	1	0
	60 +	3	0	0	0	2			0	1	0	0	1	0

Figure 2 the incidence rate of diarrheal diseases during the years 1998-2009 by age groups

Typhoid fever
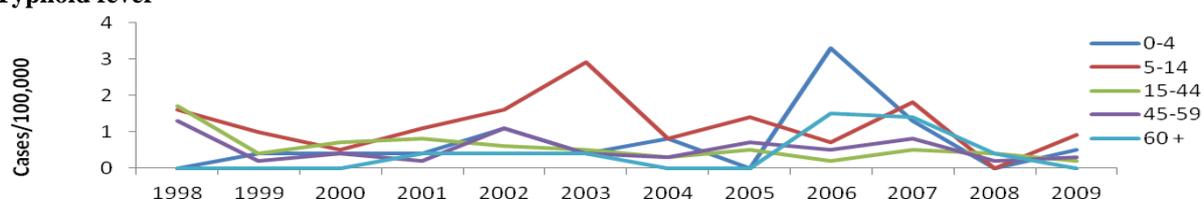
Salmonellosis (non-typhoid)
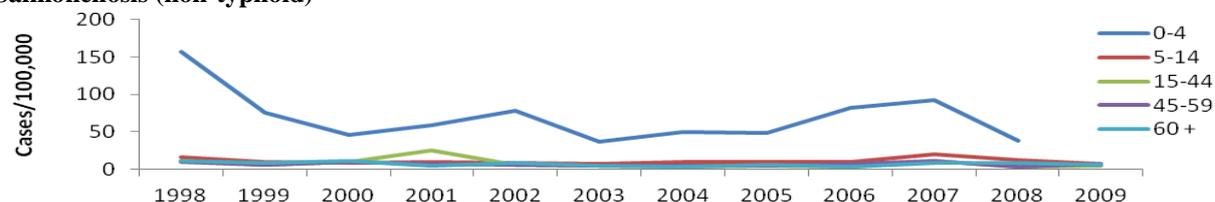
Shigellosis (bacillary dysentery)
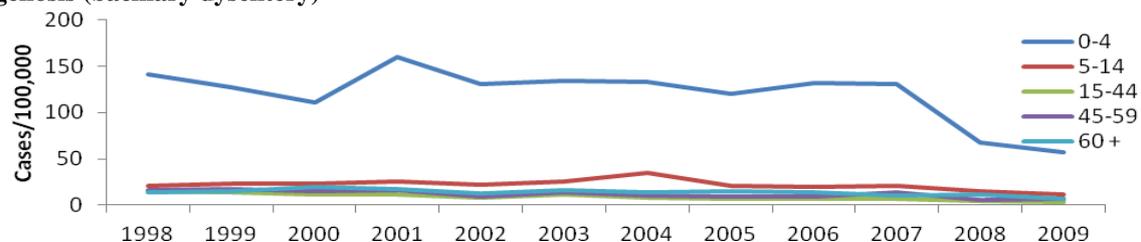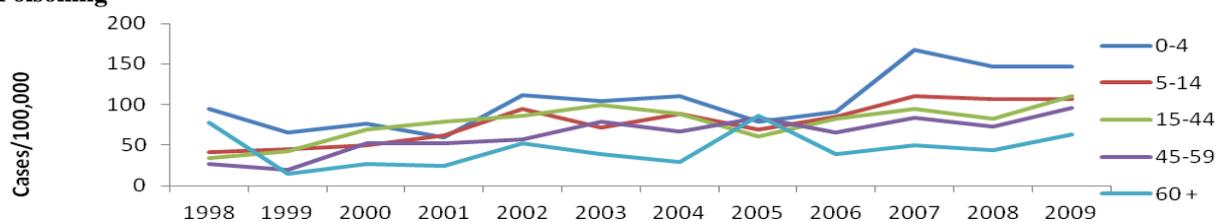
Poisoning

Amoebiasis
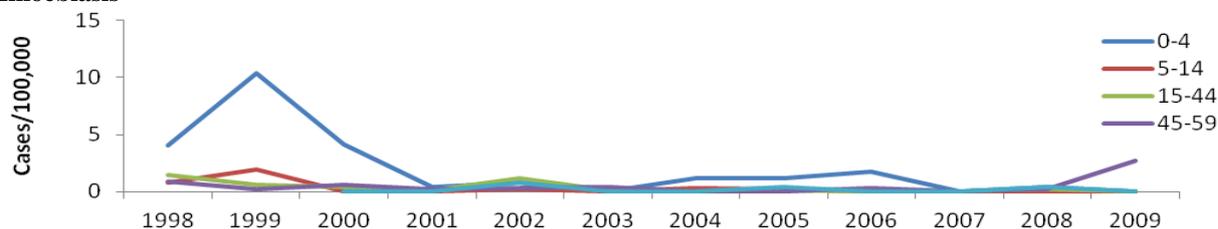
The results presented in Table and Figure 2 indicate that pediatric age groups (0-4 and 05-14 years) are most affected by this group of diseases. Poisoning incidence rate was higher for all age groups compared with others diarrheal diseases, showing increasing trend.

Table .4 Distribution of diarrheal diseases cases during the years 1998-2009 by gender

Disease		1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
		no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases
Typhoid fever	Total	41	13	15	21	30	29	13	19	22	29	8	11
	Male	23	6	6	15	16	17	7	11	8	14	4	6
	Female	18	7	9	6	14	12	6	8	14	15	4	5
Salmonellosis (non-typhoid)	Total	757	395	380	407	401	242	270	294	352	584	257	241
	Male	431	216	165	228	211	125	155	165	194	278	138	127
	Female	326	179	215	179	190	117	115	129	158	306	119	114
Shigellosis (bacillary dysentery)	Total	848	817	728	885	694	795	764	607	614	652	390	300
	Male	458	412	370	490	384	410	402	297	320	338	198	161
	Female	390	405	358	395	310	385	362	310	294	314	192	139
Poisoning	Total	1176	1186	1826	1987	2601	2665	2536	2200	2415	3067	2764	3370
	Male	617	591	902	976	1353	1452	1434	1101	1376	1661	1538	1880
	Female	559	595	924	1011	1248	1213	1102	1099	1039	1406	1226	1490
Amoebiasis	Total	45	49	20	4	24	4	5	7	6	0	6	0
	Male	29	25	9	3	17	2	3	4	4	0	1	0
	Female	16	24	11	1	7	2	2	3	2	0	5	0

Figure 3The incidence rates of diarrheal diseases during the years 1998-2009 by gender

Typhoid fever

33
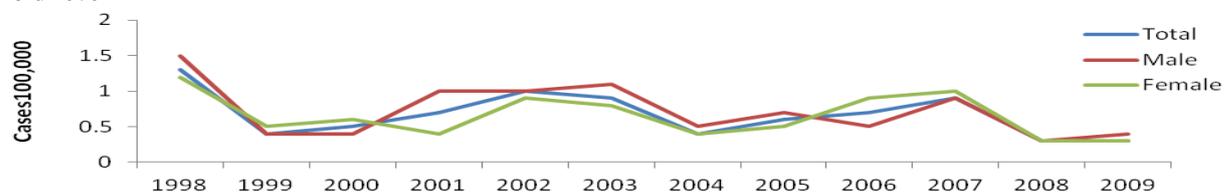
Salmonellosis (non-typhoid)
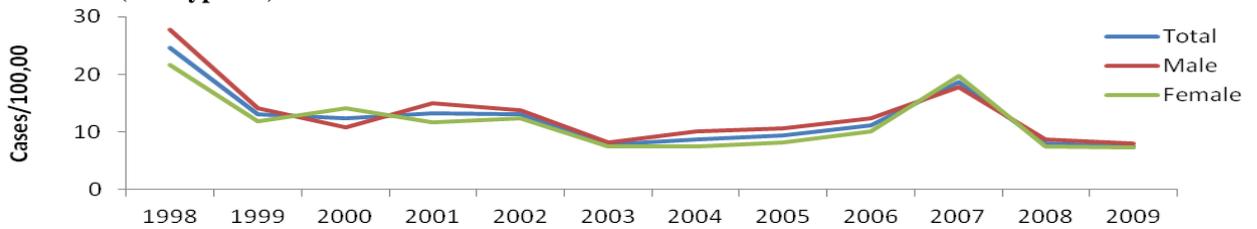
Shigellosis (bacillary dysentery)
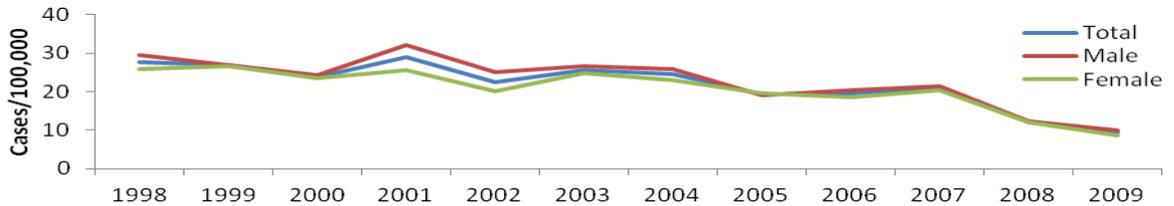
Poisoning
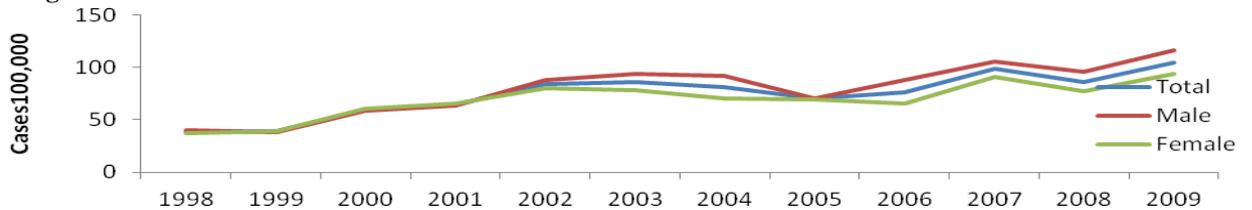
Amoebiasis
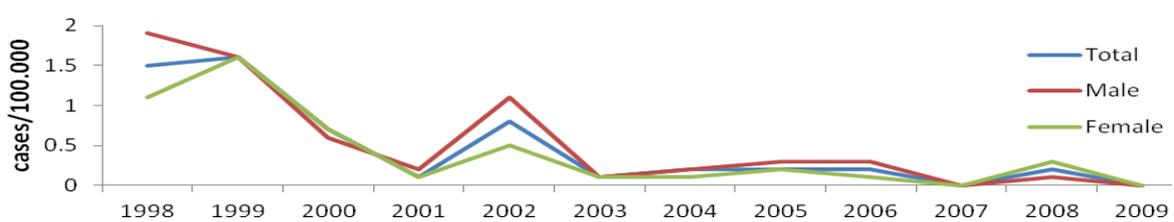
Epidemiological surveillance data for diarrheal diseases by gender are presented in detail in table 4 (number of cases), and in figure 3 is presented the incidence rate (cases/100.000 inhabitants). The incidence rate of these diseases showed a decreased trend without differences between the genders (male and female). The incidence rate of poising is presented with an increased trend from year to year.

Table 5 Distribution of ca diarrheal diseases cases over the period 1998-2009 by residence

Disease		1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
		no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases	no. cases
Typhoid fever	Total	41	13	15	21	30	29	13	19	22	29	8	11
	Urban	19	5	3	14	23	24	6	6	11	9	3	6
	Rural	22	8	12	7	7	5	7	13	11	20	5	5
Salmonellosis (non-typhoid)	Total	757	395	380	407	401	242	270	294	352	584	257	241
	Urban	370	208	236	254	249	136	167	144	195	379	155	155
	Rural	387	187	144	153	152	106	103	150	157	205	102	86
Shigellosis (bacillary dysentery)	Total	848	817	728	885	694	795	764	607	614	652	390	300
	Urban	441	471	399	509	336	373	442	320	325	388	210	234
	Rural	407	346	329	376	358	422	322	287	289	264	180	66
Poisoning	Total	1176	1186	1826	1987	2601	2665	2536	2200	2415	3067	2764	3370
	Urban	398	507	814	811	1117	1194	1309	979	1271	1706	1496	1639
	Rural	778	679	1012	1176	1484	1471	1227	1221	1144	1361	1268	1731
Amoebiasis	Total	45	49	20	4	24	4	5	7	6	0	6	0
	Urban	27	16	5	2	8		3	4	1	0	0	0
	Rural	18	33	15	2	16	4	2	3	5	0	6	0

Figure 5.1.4 The incidence rate of diarrheal diseases during the years 1998-2009 by residence
**Typhoid fever**
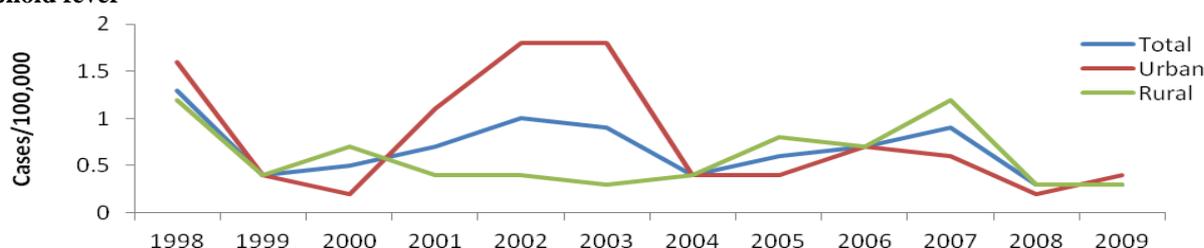
Salmonellosis (non-typhoid)
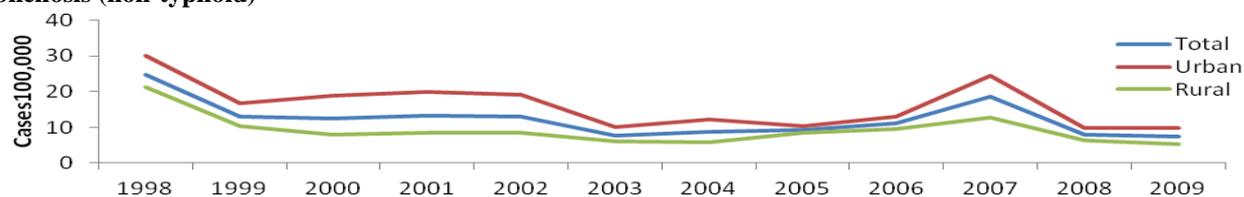
Shigellosis (bacillary dysentery)
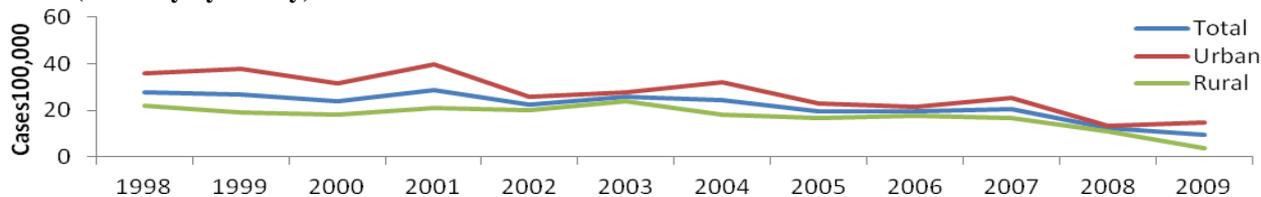
Poisoning
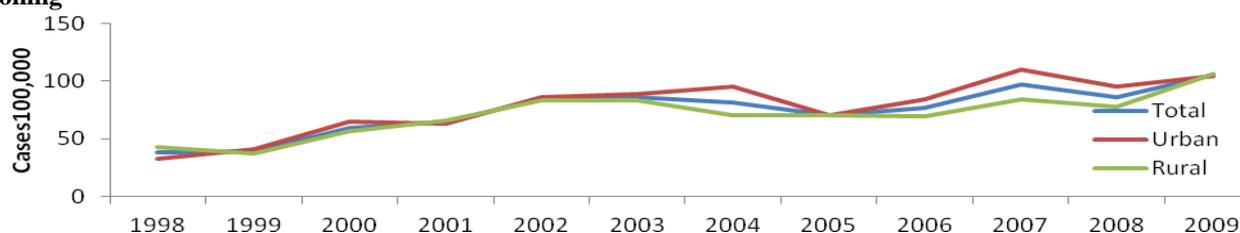
Amoebiasis
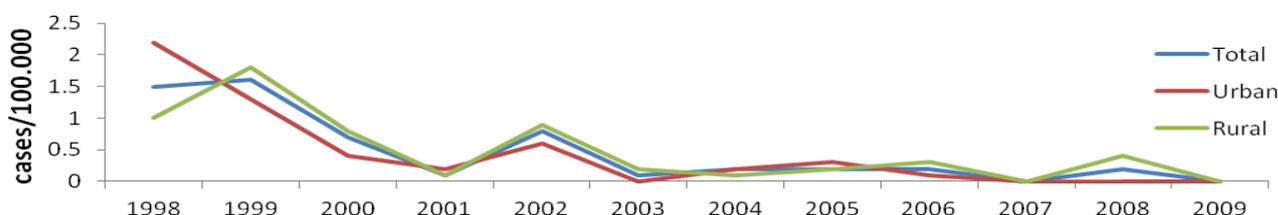
In the *table 5* and *figure 4* showed number of cases and incidence rate about the distribution of diarrheal diseases by residence. Our data showed that in urban areas the occurrence of these diseases (typhoid fever, salmonellosis, shigellosis, poising and amoebiasis) is about 1.5 times more than rural areas.

Individual notification schedule for diarrheal diseases

The individual notification form contains 5 parts with corresponding questions on the generalities of the patient, history of disease, laboratory diagnosis, epidemiological investigation of the case and the conclusions on the disease *(see annex 2)*.

Statistical analysis is based on the quality and reliability of the information of the system (individual and monthly data).

Indicators of general information about the patient are shown in *table 6*.The results obtained in section generalities patient showed a lack of "father's name" in over 40% of the notification forms.

- *Part I –" General information"*

   Table. 6The general information data from the individual form

- *Part II – "History of disease"*

The second part of the notification form contains indicators of: onset date, hospitalization data and the disease prognosis *(see table 7 and 8)*. The obtained results showed that the highest percentages of these indicators are known (compiled).

	Typhoid fever		Salmonellosis (non-typhoid)		Shigellosis (bacillary dysentery)		Poisoning		Amoebiasis	
	Yes	Missing	Yes	Missing	Yes	Missing	Yes	Missing	Yes	Missing
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No.(%)	No.(%)	No. (%)	n (%)
Father's name	16 (59.3)	11(40.7)	132 (50.2)	131(49.8)	251(79.2)	66 (20.8)	57 (30.8)	128 (69.2)	6 (60)	4 (40)
Gender	27 (100)	0	263 (100)	0	317 (100)	0	185 (100)	0	10 (100)	0
Age	25(92.6)	2 (7.4)	261(99.2)	2 (0.8)	309 (97.5)	8 (2.5)	185(100)	0	10 (100)	0
Profession	27 (100)	0	263 (10)	0	317 (100)	0	185(100)	0	10 (100)	0
Address	26 (96.3)	1(3.7)	203(77.2)	60 (22.8)	288 (90.8)	29 (9.2)	154(83.2)	31(16.8)	10 (100)	0

Table 7. The data of the disease history by individual form of notification

	Typhoid fever		Salmonellosis (non-typhoid)		Shigellosis (bacillary dysentery)		Poisoning		Amoebiasis	
	Yes	Missing	Yes	Missing	Yes	Missing	Yes	Missing	Yes	Missing
	No (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Date of onset	26 (96.3)	1 (3.7)	229 (87.1)	34 (12.9)	303 (95.6)	14 (4.4)	181 (97.8)	4 (2.2)	10 (100)	0
Hospitalized	27 (100)	0	255 (96.9)	8 (3.1)	312 (98.4)	5 (1.6)	185 (100)	0	10 (100)	0

Table 8. The disease prognosis

	Typhoid fever		Salmonellosis (non-typhoid)		Shigellosis (bacillary dysentery)		Poisoning		Aomebiasis	
	No.	%	No.	%	No.	%	No.	%	No.	%
Cured	25	92.6	225	85.6	260	82	164	88.6	10	100
Deceased	0	0	0	0	0	0	0	0	0	0
Missing	2	7.4	38	14.4	57	18	21	11.4	0	0
Total	27	100.0	263	100.0	317	100.0	185	100.00	10	100.0

- *Part III- "Laboratory diagnosis"*

Case definition is based on case confirmed by specific laboratory tests. Different diseases have different laboratory for their confirmation. Our results about the laboratory confirmation in some individual forms are blank (or missing); in some forms case confirmation is carried out by wrong laboratory (not applicable) see *table 9.*

Table9 Case confirmationbylaboratory

Disease		Direct	Culture	Serology
		No. (%)	No. (%)	No. (%)
Typhoid fever	**Positive**	2 (7.4) **not applicable**	15 (55.6)	12 (44.5)
	negative	0	2 (7.4)	0
No. = 27	Missing	25 (92.6)	10 (37)	15 (55.5)
Salmonellosis (non-typhoid)	**Positive**	5 (1.9) **not applicable**	237 (90.1)	1(0.4) **not applicable**
	negative	0	0	0
	Missing	258 (98.1)	26 (9.9)	262 (99.6)
No. =263				
Shigellosis (bacillary dysentery)	**Positive**	10 (3.2) **not aplicable**	280 (88.3)	1 (0.3) **not applicable**
	negative	0	3(0.9)	0
	Missing	307 (96.8)	34 (10.7)	316 (99.7)
No. =317				
Poisoning	**Positive**	22 (11.9) **not applicable**	65 (35.1)	1(0.5)
	negative	0	0	0
No. =185	Missing	163 (88.1)	120 (64.9)	184(99.5)
Amoebiasis	Positive	0	3(30)**not applicable**	0 **not applicable**
	negative	0	0	0
No. =10	Missing	10 (100)	7(70)	10 (100)

Notapplicable – meanswronglaboratory

- *Part IV – "Epidemiologicalinvestigation"*

The fourth section contains indicators of the nature of outbreaks and origin of infection. In over 40% of individual forms, the nature of infectious outbreaks is blank (or missing).Results on the origin of infection showed that the largest number of cases is "blank" and "unknown".

Table10 Outbreaknature of disease

	Typhoid fever		Salmonellosis (non-typhoid		Shigellosis(bacillary dysentery)		Poisoning		Amoebiasis	
	Yes	Missing	Yes	Missing	Yes	Missing	Yes	Missing	Yes	Missing
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No.(%)	No. (%)
Sporadic	14 (51.9)	12 (44.4)	114 (43.3)	129 (49.1)	233 (73.5)	71(22.4)	60 (32.4)	107(57.9)	10 (100)	0
Endemic	1(3.7)		20 (7.6)		13 (4.1)		18 (9.7)		0	

Table 5.1.11 Origine of infectiousforeachdisease

	typhoid fever	salmonellosis	shigellosis	poisoning	amoebic dysentery	Total
Known	1	23	35	5	0	64
Unknown	13	82	156	55	6	312
Missing	13	158	126	125	0	422
Total	27	263	317	185	6	798

- *Part V – " Conclusion"*

The fifth part contains the conclusions of the diagnosis, classification of the case as: a suspected or confirmed case. The "confirmed cases" are over 60% of cases with diarrhea diseases, except the poisoning cases which in 57% of them are "suspected".The data of *table 9* compared with the case classification data *(table 12)* represent a difference between the positivity of the case by appropriate laboratory tests and confirmation of diagnosis.

Figure 12 Case classification

Disease	Confirmed		Suspected		Missing		Total
	No.	%	No.	%	No.	%	
Typhoid fever	18	66.7	3	11.1	6	22.2	27
Salmonellosis (non-typhoid)	230	87.5	18	6.8	15	5.7	263
Shigellosis (bacillary dysentery)	272	85.8	12	3.8	33	10.4	317
Poising	73	39.5	107	57.8	5	2.7	185
Amoebiasis	10	100.0	0	0	0	0	10

Discussion

The incidence rate of diarrhea diseases in Albania even though presenting a decreasing trend during the study period were higher than in the countries of Europe and the neighboring country Greece[8].

Table 13 Incidence rate of reported cases of infectious diseases in Albania, European Country especially Greece, (year 2009)[8]

Diseases	Albania	European	Greece
	incidence rate/100.000 population	Incidence rate/100.000 opulation	incidence rate/100.000 population
Typhoid fever	0.3	0.16	0.16
Salmonellosis (non-typhoid)	7.5	34.16	6.3
Shigellosis (bacillary dysentery	9.4	2.08	0.44

Diarrheal diseases in Albania appear as unresolved problems associated with drinking water to urban and rural populations' use[9].

• Drinking water supply non quality safety in both of areas.
• Temporary supply of tap-water (1-3 hours/day) at the urban areas.
• Disinfected drinking water for urban areas and non-disinfected drinking water for rural areas.

The food safety remains a common problem of a country in transition from the former centralized and limited economy to the current free-market one. The sanitation of human and animal excrements represent another urgent problem in both urban and rural settlements because the development of communal feeding, catering, tourism etc., for which there is not sufficiently strict sanitary inspection[10].

As everywhere, even in Albania, infectious diseases have their flow necessarily related to other factors such as economic development, migration and emigration of population seeking their close supervision on a continuous effort to improve the existing system in order to exercise control over the spread of infectious diseases, to overcome the problems of underreporting, which underestimate the true impact of these diseases in the population health[11].

Our results obtained show that the data collected by the surveillance system of infectious diseases in Albania are not reliable as a result of incompatibility with the requirements relating to the attributes of a surveillance system, such as simplicity, flexibility, acceptability and quality of data expressing a major discrepancy between the informations[6, 12, 13]. This discrepancy and discordance is because of:

• Lack of qualified personnel in public health services
• No estimation of the laws by public and private health structures
• Lack of periodic analysis of epidemiological service activity (central level – IPH) related to discrepancy between notified and monthly reported data of infectious disease.
• Lack of communication between hospital institutions and public health structures
• Reforms in health, health insurance introduction (primary and secondary level) made impossible the full declaration of infectious diseases cases.

Recommendation

Setting up the infrastructure. Completion of medical training. Organizing training courses for health staff responsible for completing the reporting forms. Improvement and equipping of laboratories for laboratory confirmation of cases.

Annex 1

Monthly reporting form of the infectious diseases		Region_____ District_____						Months_____ /Year_____							
Nr	DIIAGNOSI	Cases					SEX	AGE								HOSPITAL	Deaths
		TOTAL	URBAN	RURAL	SUSPECTET	CONFIRMED		0-1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65+		
1	Typhoid fever						M											
							F											
2	Salmonellosis						M											
							F											
3	Shigellosis						M											
							F											
4	Poising						M											
							F											
5	Amoebiasis						M											
							F											

SKEDA INDIVIDUALE 14-2/SH

Skeda individuale e raportimit të sëmundjeve infektive të GRUPIT B/1

Në <u>GRUPIN B/1</u> përfshihen <u>SEMUNDJET INFEKTIVE QE SPIKATIN PER FREKUENCEN (INCIDENCEN) E TYRE TE LARTE DHE PER TE CILAT INTERVENTET E KONTROLLIT JANE SHUME TE MUNDSHME.</u>

<u>Ato deklarohen me fletë deklarimi (skedë individuale) sikurse sëmundjet e grupit A.</u> Skeda individuale e plotësuar që nga fillimi deri në fund dërgohet në <u>Institutin e Shëndetit Publik (IShP) - Departamenti i Epidemiologjisë dhe Biostatistikës (DEB).</u>

Plotësimi i skedës bëhet vetëm në pjesën e majtë të saj : përgjegja jepet duke vënë kryq në atë kutizë (katror i vogel) i cili përfaqëson përgjegjen e saktë dhe duke plotësuar me shkrim në rastin kur pyetja kërkon përgjegje me shkrim. Kujdes, pjesa e djathtë gri e skedës duhet të mbetet e paprekur, dmth pa asnjë shënim.

Viti ⊔⊔⊔⊔⊔

Nr. rendor ....

Nr. skedës ⊔⊔⊔⊔

Rrethi _____

Bashkia / Komuna _____

Qyteti / Fshati _____

Emri, atësia, mbiemri i të sëmurit _____

Rast me _____

Kriteret **1 2 3 4** (*)

Të shkruhet emri i plote i sëmundjes infektive të GRUPIT B/1 edhe të shënohet me kryq kutia përkatëse më poshtë

Kodi sipas ICD-9

- ☐ 002.0 Tifo abdominale
- ☐ 002.9 Paratifo
- ☐ 003 Salmonelozë jotifoide (☞)
- ☐ 004 Shigelozë (dizenteri bacilare)
- ☐ 005 Toksikoinfeksione alimentare bakteriale (të tjera veç atyre që bëjnë pjesë në 003) (☞)
- ☐ 006 Dizenteri amebike
- ☐ 036 Meningit meningokoksik
- ☐ 320 Meningit bakterik jo-meningokok.
- ☐ 006 Dizenteri amebike
- ☐ 022 Plasje
- ☐ 023 Brucelozë
- ☐ 027.0 Listeriozë
- ☐ 033 Pertussis
- ☐ 034.1 Skarlatinë
- ☐ 035 Erizipelë
- ☐ 037 Tetanoz (jo neonatal)
- ☐ 047 Meningit viral (aseptik)
- ☐ 323.9 Encefalit i paspecifikuar
- ☐ 323.5 Encefalit pas vaksinimit

Kodi sipas ICD-9

- ☐ 052 Varicelë
- ☐ 055 Fruth
- ☐ 056 Rubeolë
- ☐ 487 Grip me izolim të virusit (⧸⧸)
- ☐
- ☐ 070.1 Hepatit viral A
- ☐ 070.3 Hepatit viral B
- ☐ 070.59 Hepatit viral as A as B
- ☐ 072 Parotit epidemik
- ☐ 081.0 Tifo murine endemike
- ☐ 082.1 Ethe butonoze
- ☐ 83.0 Ethe Q
- ☐ 081-083 Rikecioza të tjera
- ☐ 085.0 Leishmaniazë viscerale
- ☐ 085.1 Leishmaniazë kutane
- ☐ 100 Leptospirozë
- ☐ 126 Ankilostomiazë
- ☐ 136.9 Legionelozë

(☞) *Kodi 003 i ICD-9 janë infeksione dhe toksikoinfeksione alimentare të shkaktuara nga salmonelat jo-tifike. Kodi 005 janë toksikoinfeksione alimentare nga baktere të tjerë (Staphylococcus, etj). Kodi 008 nuk përmban toksikoinfeksione alimentare, por vetëm infeksione intestinale nga baktere (E.coli, Arizona, Proteus, Staphylococcus, Pseudomonas, Campylobacter, Yersinia, etj) dhe viruse (Rotavirus, Adenovirus, Enterovirus, etj) ; për këto infeksione intestinale identifikimi laboratorik i shkaktarit mikrobik është i domosdoshëm. Kur konfirmimi laboratorik mungon, raportimi për këto infeksione intestinale nuk bëhet me skedën individuale 14-2/SH, por sipas pasqyrës 14/SH (në Grupin C të saj) (shih).*

(⧸⧸) *Kodi 487 përfshin vetëm rastet e gripit me konfirmim laboratorik (izolim virusi) nga IShP ; praktikisht ata janë rastet e para të fillimit të një epidemie gripi, për të cilat raportimi në IShP duhet bërë menjëherë ; laboratori i gripit (qendra kombëtare e gripit) në IShP kryen menjëherë prelevimet prej rasteve të suspektuara për izolimin dhe identifikimin e virusit të gripit. Pas këtij konfirmimi laboratorik, rastet e tjera të epidemisë së gripit, si dhe të gjitha rastet e Common cold, dmth sindromi i rrufës i ngjashëm klinikisht me gripin, por i shkaktuar jo nga viruse gripi, raportohen sipas pasqyrës 14/SH (nëGrupin C të saj) (shih).*

(*) *Sheno me kryq ate (ato) kuti qe i korespondon (korespondojne) kritereve te paraqitura ne instruksionin shoqerues te skedes individuale (shih).*

PJESA I (TE DHENA TE PERGJITHSHME)
Emri, atësia, mbiemri i të sëmurit _____
Seksi   ☐ M   ☐ F
Mosha në muaj, nëse është më i vogël se 1 vjeç   ⊔⊔⊔
        në vjeç, nëse është 1 vjeç e lart   ⊔⊔
Shtetësia _____
Profesioni _____
Adresa e banimit të të sëmurit : Rrethi _____
                  Bashkia / Komuna _____
                  Qyteti / Fshati _____
Prej sa kohësh banon në atë vend :   ⊔⊔⊔   ⊔⊔⊔
                            muaj   *vjet*

PJESA II (HISTORIA E RASTIT)
Vendi ku të sëmurit i filluan simptomat e para të sëmundjes :
                  Rrethi _____
                  Bashkia / Komuna _____
                  Qyteti / Fshati _____
Data e fillimit të simptomave të para   ⊔⊔⊔ ⊔⊔⊔
                              dita   *muaji*
Shtruar në spital   ☐ jo   ☐ po
Nëse po, data e shtrimit në spital   ⊔⊔⊔ ⊔⊔⊔ , në Rrethin _____
                              dita   *muaji*
Ecuria e sëmundjes :   ☐ shërim
                   ☐ vdekje
Nëse ekziston vaksinë kundër sëmundjes, i sëmuri :   ☐ ka qenë i pavaksinuar
     ☐ nuk dihet mbi vaksinimin
     ☐ ka qenë i vaksinuar, data e dozës së fundit të vaksinës   ⊔⊔⊔ ⊔⊔⊔
                                           muaji   *viti*

PJESA III (TE DHENAT E DIAGNOZES LABORATORIKE MIKROBIOLOGJIKE)
1. Ekzaminimi direkt : kryer më datë .... në ....
       Rezultati :   ☐ negativ   ☐ pozitiv
2. Kultura : kryer më datë .... në ....
       Rezultati :   ☐ negativ   ☐ pozitiv
3. Serologjia : kryer më datë .... në ....
       Tipi i reaksionit serologjik ....
       Rezultati :   ☐ negativ   ☐ pozitiv
Emri Mbiemri dhe firma e mjekut Mikrobiolog ....

PJESA IV (HULUMTIMI EPIDEMIOLOGJIK)
Është rast sporadik   ☐   apo është rast në vatër   ☐
Nëse është rast në vatër, numri i rasteve në atë vatër ku pacienti u infektua   ⊔⊔⊔
Për infeksionet intestinale origjina e infeksionit është :
    hidrike ☐   jo-hidrike ☐   e panjohur ☐
Numri i personave që mendohet të jenë infektuar :
   personat e kontaktit të ngushtë familjar, numri   ⊔⊔⊔
   personat e kontaktit në institucion nëse i sëmuri ka qenë në institucion, numri   ⊔⊔⊔

KONKLUZION
Bazuar në të dhënat klinike, laboratorike, epidemiologjike, të jepet emërtimi
përfundimtar mbi rastin :   ☐ **rast i suspektuar** (mbetur i dyshimtë)
                 (është rasti kur nuk plotësohen të gjitha kriteret e parashikuara për patolo-
                 gjinë në shqyrtim) (shih (*))
              ☐ **rast i konfirmuar plotësisht dhe përfundimisht**
                 (është rasti kur plotësohen të gjitha kriteret e parashikuara) (shih (*))
Shënim : *Përkufizimi për secilin emërtim jepet në instruksionin shoqërues të skedës individuale (shih).*

Emri Mbiemri dhe firma e mjekut Klinicist ....
Emri Mbiemri dhe firma e mjekut Epidemiolog ....
Data e plotësimit të skedës ....

(*) *Sheno me kryq ate (ato) kuti qe i korespondon (korespondojne) kritereve te paraqitura ne instruksionin shoqerues te skedes individuale (shih).*

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