

Awareness among a Saudi Arabian university community of Middle East respiratory syndrome coronavirus following an outbreak

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الوعي بين منسوبي جامعة سعودية بفيروس كورونا المسبب لتلازمة الشرق الأوسط التنفسية بعد حدوث وباء محلي مها عبد الرحمن المحيسن

الخلاصة: هدفت هذه الدراسة إلى قياس مستوى الوعي لدى أعضاء هيئة التدريس في إحدى الجامعات النسائية بالمملكة العربية السعودية وموظفيها وطلابها بفيروس كورونا المسبب لتلازمة الشرق الأوسط التنفسية بعد وقوع وباء محلي للفيروس. وتم توزيع استبيان ذاتي يحتوي على أسئلة معلومات واستكمالها من قبل المشاركين البالغ عددهم 1541 مشاركاً. وبلغت درجة المعلومات الكلية 43.2٪ وجاءت بنسبة مرتفعة فقط في صفوف المشاركين من المعاهد الصحية (50.6٪). وأقر أغلب المستجيبين (78.9٪) بالأعراض المعتادة لفيروس كورونا المسبب لتلازمة الشرق الأوسط التنفسية في حين لم يعرف سوى 67.1٪ منهم الممارسات الصحية الوقائية الموصى بها. وبلغ مستوى الوعي بوبائية المرض وشده ومعدّل الوفيات الناجمة عنه وعلاجه حداً منخفضاً للغاية. كما تبين ضعف معرفة العاملين في المجال الصحي والطلّبات بالاحتياطات الموصى بها والتي ينبغي تطبيقها عند التعامل مع المرضى (55.5٪). إن هذه النتائج تدعو إلى تحسين في البرامج التثقيفية المنفذة لكل من العاملين في الرعاية الصحية والعاملين في غير مجال الرعاية الصحية لا سيما في أماكن الدراسة أو العمل المزدحمة.

ABSTRACT This study aimed to measure the level of awareness of faculty members, staff and students in a female Saudi Arabian university community towards Middle East respiratory syndrome coronavirus (MERS-CoV) following an outbreak. A self-administered questionnaire containing knowledge questions was distributed and completed by the 1541 participants. The overall knowledge score was 43.2%. It was only significantly higher in participants from the health colleges (50.6%). The majority (78.9%) of the respondents recognized the typical symptoms of MERS-CoV but only 67.1% knew the recommended preventive hygiene practices. Awareness of disease epidemiology, severity, fatality rate and treatment was very low. The knowledge of health care workers/students of the recommended precautions that should be applied when dealing with patients was poor (55.5%). Significant improvement in educational programmes for both the health care and non-health care professionals is warranted, particularly in crowded educational institutions or workplaces.

Sensibilisation d'une communauté universitaire saoudienne au coronavirus du syndrome respiratoire du Moyen-Orient après une flambée

RÉSUMÉ La présente étude avait pour objectif de mesurer le niveau de sensibilisation du corps enseignant et étudiant, et du personnel d'une communauté universitaire saoudienne composée de femmes à l'égard du coronavirus du syndrome respiratoire du Moyen-Orient (MERS-COV) après une flambée. Un auto-questionnaire comprenant des questions de connaissance a été distribué et rempli par 1541 participants. Le score général de connaissance était de 43,2 % et n'était significativement plus élevé que chez les participants issus de facultés de santé (50,6 %). La majorité des répondants (78,9 %) était capable d'identifier les symptômes caractéristiques du MERS-COV, mais seulement 67,1 % connaissaient les pratiques d'hygiène préventives recommandées. La sensibilisation à l'égard de l'épidémiologie, de la gravité, des taux de létalité et du traitement de la maladie était très basse. La connaissance des agents de santé et des étudiants en soins de santé portant sur les précautions recommandées qui devraient être appliquées lors de la prise en charge de patients était faible (55,5 %). Une amélioration significative des programmes de formation mis en œuvre à la fois pour les professionnels des soins et les professionnels extérieurs au milieu de la santé est requise, en particulier dans les lieux d'étude ou les environnements de travail avec une forte concentration de personnes.

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Received: 10/07/16; accepted: 20/10/16

Introduction

Middle East respiratory syndrome coronavirus (MERS-CoV) was first identified in 2012 in Saudi Arabia (1). Since then cases have been reported worldwide. The syndrome comprises a viral respiratory illness which ranges in clinical presentation from a mild upper respiratory illness to rapidly progressive pneumonia and multi-organ failure. The largest outbreaks have been linked to overcrowding, delay in diagnosis and poor infection control practices. Chains of transmission can be interrupted by the implementation of control measures (2).

Awareness among the Saudi Arabian community of this infection has not been well established. Available studies are few and are limited by the small number of participants (3), reporting on participants' personal practices rather than the individual's adherence to the current recommendations, and evaluating only minor aspects of public knowledge (3–5). In general, there is a lack of studies on the awareness and attitude of the Saudi Arabian public towards infectious diseases. Public awareness of infectious diseases aids significantly in infection control whereas a lack of reasonable knowledge leads to low detection rates, delayed treatment, discrimination and stigma (6).

It is important to assess the knowledge, attitudes and behaviour of the public towards important and prevalent infectious diseases. Such information provides baseline data for the prevention and control of these diseases through estimation of the impact of previous prevention efforts made by the government and guiding the need for further interventions (6). Additionally, measuring the awareness of the public is valuable during an outbreak as appropriate public response during an outbreak is governed by the public's understanding of disease transmission, availability of vaccines and effective medical treatment (7).

Furthermore, the information obtained would be crucial to improving the communication efforts of public health officials and clinicians among the population at risk (8). Appropriate changes in public behaviour in response to an outbreak can alter the progression of the infectious agent (9).

The spread of infection in close contact environments, including crowded work or study places, can be hazardous and a high level of knowledge, particularly on preventive strategies, is paramount. Recently an outbreak occurred at Princess Nourah bint Abdulrahman University, the world's largest all-female university: 4 cases of MERS-CoV infection were detected among the janitors (10). The 4 workers were quarantined and no MERS-CoV cases were reported amongst the students (11). The present study was designed to measure the awareness of MERS-CoV infection among the students, faculty members and other employees at the university following the outbreak.

Methods

Population

This prospective cross-sectional study was conducted between 10 December 2015 and 10 February 2016 at the all-female Princess Nourah bint Abdulrahman University. Students, faculty members and non-academic staff were invited to participate in the study. A previous study indicated that about 54% of the Saudi Arabian public had a good knowledge regarding MERS-CoV infection (5). With a margin of error of 5%, level of confidence of 95% and power of study of 80%, the minimum sample size required was calculated to be 606. As we used a convenience sample of participants (not randomized), the actual sample was much larger to minimize selection bias

Questionnaire and data collection

A questionnaire was developed using the frequently asked questions posted on the World Health Organization (WHO) and the Saudi Arabian Ministry of Health websites (12,13). The questions and their correct responses are available on the websites both in Arabic and in English. The Arabic version was used to ensure better understanding among the participants. The term MERS-CoV in the original questions was replaced by "corona infection" as this is the term commonly used to refer to the syndrome in the local community. One question was developed in English and translated to Arabic using a published reference (2). The final questionnaire was reviewed for face validity by the expert panel of the research centre at the college of medicine and was pilot tested on 20 subjects from the target population, who were not included in the study. It was modified as necessary. Cronbach's alpha was calculated to be 0.7.

The questionnaire contained questions on participants' demographic data, including age, level of education, occupation and college. There were 20 multiple choice knowledge questions that tested the following knowledge aspects in relation to MERS-CoV infection: disease epidemiology (3 questions); symptoms and incubation period (3 questions); possible infection sources, mode of transmission, and common places for outbreaks (6 questions), precautions and preventive strategies (4 questions); treatment and fatality rate (2 questions); and infection in special patient populations, including children and medically compromised individuals (2 questions). An additional question was addressed only to health care workers, including students or academic staff from the colleges of nursing, medicine, dentistry, pharmacy and health and rehabilitation sciences who were in contact with patients. This question was analysed separately.

The questions had 1 correct answer, 3 incorrect answers and a “don’t know” option.

The study followed the principles of the Helsinki Declaration and ethics approval was obtained from our institutional review board before data acquisition. The questionnaire was distributed by 2 research coordinators. A convenience sample was taken. Completion was voluntary and anonymous. Consent was verbal and implied by the participant completion and returning the questionnaire.

Statistical analysis

Data were analysed using SAS, version 9.4. Only complete questionnaires were included in the analysis. The results of the knowledge questions were analysed using the answer key. The knowledge score for the whole sample was expressed as the percentage of correct answers of the 20 questions in the questionnaire. The last question was analysed only for participants from the 5 health colleges. Categorical variables are reported as number and percentage, and continuous variables are expressed as mean and standard deviation (SD). Comparison of scores between groups was based on analysis of variance, Kruskal–Wallis test, chi-squared test or Fisher’s exact test, as appropriate. The Bonferroni correction was applied to P-values obtained from pairwise comparisons between groups. P-value ≤ 0.05 was considered statistically significant.

Results

Demographic characteristics of the study population

A total of 1541 questionnaires were complete and were included in the study; 91 were returned incomplete and were excluded from the analysis. The demographic data of the study participants are summarized in Table

1. The mean age of the respondents was 23 (SD 5.8) years (80.6% were < 24 years old). The majority of the participants were students (82%).

Knowledge scores of the participants

The overall knowledge score was 43.2%. The scores of the assessed knowledge aspects were as follows: epidemiology (53.3%), symptoms recognition (45.5%), sources and mode of transmission (43.5%), precautions (43.2%), treatment and fatality rate (28.5%) and infection in special populations (38.4%) (Table 2).

Awareness of MERS-CoV symptoms, contagiousness and fatality rate

The responses to the knowledge questions are displayed in Table 3. The majority of the respondents (76.8%) were aware that MERS-CoV comprises a viral respiratory illness, and 78.9% correctly identified its typical symptoms. Most of the participants overestimated the contagiousness and fatality rate of MERS-CoV. 53.3% of the participants

thought that the infection was highly contagious, and 22% thought it was moderately contagious. Only 14.3% correctly responded that it is contagious to a limited degree. 3.6% considered the syndrome non-contagious. 66.1% of the respondents exaggerated the infection fatality rate (6.6% considered the disease fatal in all cases, 31.3% thought it is fatal in 75% of the cases and 28.2% believed it was fatal in 50% of the cases).

Knowledge of precaution measures and travel recommendations

Around two thirds of the participants knew the recommended general infection control precautions (Table 3); 7.6% thought that the latest medical consensus advice was not to touch surfaces and objects directly, 8.4% believed that they should wear a mask when leaving their home and 6.0% thought they should take antibiotics daily to avoid getting infected. Among the health care workers, only 55.3% correctly identified the precautions that should be applied when dealing with

Table 1 Demographic characteristics of the study participants (n = 1541), Riyadh, Saudi Arabia, 2016

Characteristic	No.	%
Age (mean \pmSD) years	23 \pm (5.8)	
Level of education		
Less than high school	14	0.9
High school	1145	74.3
Bachelor degree	313	20.3
Masters degree	35	2.3
PhD or board certified	34	2.2
College		
Humanities and community colleges	375	24.3
Science colleges	458	29.7
Health colleges	510	33.1
Nonspecific* and preparatory year students	198	12.8
Occupation		
Student	1264	82.0
Non-academic staff	210	13.6
Faculty member	67	4.3

*Includes employees in the associate deanships, office workers, security personnel and janitors.

patients to prevent the transmission of infection (Table 3).

Regarding travel recommendations, 30.8% thought that the WHO recommends screening of all travellers arriving from countries that have reported MERS-CoV cases and only 18.0% knew that the WHO does not recommend travel restrictions for MERS-CoV (Table 3); 7.8% thought that the WHO advises some travellers to cancel Hajj and Umrah travel plans due to concerns regarding MERS-CoV and 7.5% believed that the WHO prohibits travellers from Saudi Arabia from entering certain countries.

Factors associated with knowledge of MERS-CoV

Table 4 shows the correlation between the participants' occupation and knowledge score. There was no significant difference in the total mean knowledge score between students, non-academic staff and faculty members, (43.3% (SD 15.0), 41.8% (SD 16.7) and 46.4% (SD 20.3) respectively, ($P = 0.104$) although significant variability in some knowledge aspects was noted. The students had better knowledge of MERS-CoV symptoms and incubation period than the non-academic staff (Table 4) while the faculty members had better knowledge regarding treatment and fatality rate compared with both students and non-academic staff: 44.0% (SD 36.4), 28.2% (SD 33.1), and 25.7% (SD 30.2) respectively ($P < 0.001$). There was no significant difference in regard to knowledge of the recommended precautionary measures against MERS-CoV infection, including the recommended daily precautions ($P = 0.376$).

Table 5 shows the correlation between MERS-CoV knowledge scores and the participants' college. Participants from the health colleges had significantly better awareness in all tested knowledge aspects with a total score of 50.6% compared with 40.8%, 38.2% and 39.4% for the science,

Table 2 Knowledge scores of the participants ($n = 1541$), Riyadh, Saudi Arabia, 2016

Item	Total score	
	Mean	SD
Total	43.2	15.5
Epidemiology	53.3	27.1
Symptoms and incubation period	45.5	26.2
Infection sources, mode of transmission and common places for outbreaks	43.5	20.8
Precautions and preventive strategies	43.2	26.9
Treatment and fatality rate	28.5	33.1
Infection in special populations	38.4	33.9

SD = standard deviation.

humanities/community colleges and non-specific college/preparatory year students respectively ($P < 0.001$). Participants from the science colleges had slightly better scores compared with their counterparts from the humanities and community colleges [40.8% (SD 15.1) versus 38.2% (SD 13.3), $P = 0.028$], however this was mainly due to better knowledge of the epidemiology of the infection.

Table 6 details the impact of the participant's education level on their knowledge score. Participants with less than high school education had the lowest knowledge scores (27.5%) compared with the other participants [completed high school (43.2%), bachelor's degree (44.3%), masters' degree (43.4%), PhD or board certified (40.3%) ($P = 0.002$)]. Participants with less than high school education had the lowest knowledge scores for symptoms and incubation period of MERS-CoV, 11.9% (SD 16.6), compared with the other groups ($P < 0.001$).

When analysed by age, no significant difference was noted in the total scores of participants (Spearman correlation coefficient = 0.04). When participants aged < 24 years were compared with those ≥ 24 years, there was little difference in the total knowledge scores, 43.2% (SD 15.1) versus 43.1% (SD 17.2) ($P = 0.185$). The younger participants were, however, more aware of MERS-CoV symptoms and incubation period, 46.6% (SD 25.7) versus

40.9% (SD 27.8) ($P = 0.001$), whereas the older participants had better knowledge of infection in special populations, 44.1% (SD 37.2) versus 37.0% (SD 32.9) ($P = 0.004$) (data not shown).

Discussion

This is the largest study to date on the awareness of MERS-CoV infection in Saudi Arabia. This study shows that the awareness of a sample of a Saudi Arabian university community regarding MERS-CoV infection following a recent outbreak is very poor. Knowledge of disease symptoms and recommended daily protective measures was relatively better, but remained suboptimal. The understanding of potential infection sources, fatality rate, treatment and WHO travel recommendations was deficient. Most of the respondents had a very low level of knowledge and some misconceptions were detected. The results also demonstrate that, although some variability was noted in knowledge about certain aspects of MERS-CoV between the groups, the total knowledge scores were similar. The total knowledge score was not affected by level of education (with the exception of in those with less than high school education) or age and was not significantly different between students, faculty members and non-academic staff. Only the college type significantly affected the total knowledge score,

Table 3 Responses to the knowledge questions (n = 1541), Riyadh, Saudi Arabia, 2016

Question	Correct answer	Accurate responses	
		No.	%
What is Middle East respiratory syndrome "corona infection"?	A viral respiratory illness caused by a corona virus.	1184	76.8
When and where, corona infection was first identified?	In 2012, in Saudi Arabia.	602	39.1
How spread out is corona infection throughout the world?	It has been reported in multiple countries worldwide.	679	44.1
How severe is the infection by corona?	It is variable ranging from mild to severe disease. Some infected individuals may be asymptomatic.	582	37.8
What are the typical symptoms of corona infection?	Fever, cough, difficulty in respiration and occasionally diarrhoea.	1216	78.9
What is the incubation period (time from infection to symptom onset)?	The average is 5 days (2-14 days)	307	19.9
Is infection by corona contagious?	Yes to a limited degree.	221	14.3
If you think corona infection is contagious, what are the potential routes of infection transmission?	Animals, infected family members and from patients to health care professionals.	932	60.5
In your opinion where do infected cases cluster most?	In the health care setting.	710	46.1
How do people get infected with corona?	It is not yet fully understood how people become infected with corona.	182	11.8
What is the source of infection by corona?	Camels	1120	72.7
What are the common causes for spread of infection by corona?	Overcrowding, delay in diagnosis and poor infection control practices.	854	55.4
What precautions should be taken to avoid getting infected by corona?	According to the latest medical consensus, it is advised to wash hands with water and soap or with other disinfectants, especially after coughing, sneezing and using toilets. Use a handkerchief when coughing or sneezing to cover your mouth and nose. Avoid touching your mouth, nose and eyes before washing your hands and avoid eating raw meat, liver and raw or unpasteurized milk.	1034	67.1
Is it safe to consume raw or insufficiently cooked animal products, including dairy products and meat?	Camel meat and camel milk are nutritious products that one can continue to consume after pasteurization, cooking or other heat treatments.	449	29.1
Is it safe to visit farms, markets, or camel fairs?	Yes: with precautions, including regular hand-washing before and after touching animals and avoiding contact with sick animals.	904	58.7
Does the WHO impose restrictions on travel or trade due to corona infection?	The WHO does not recommend travel or trade restrictions with regard to corona infection.	278	18.0
Is there a vaccine against corona infection? What is the treatment?	There are no vaccines and no specific treatment available. Treatment is supportive.	491	31.9
What is the fatality rate of corona infection?	The infection is fatal in 35% of the cases.	388	25.2
Which groups are likely to have severe disease?	Patients with diabetes, renal failure, chronic lung disease and immunodeficiency.	866	56.2
Regarding corona infection in children ...	They are less likely get the infection compared with adults.	317	20.6
What precautions should health care professional take to prevent the transmission of corona infection when dealing with patients?	Universal precautions should be applied with all patients. In confirmed or suspected cases, respiratory precautions, eye protection and special precautions for aerosol-generating procedures should be added.	282	55.3*

*Result for participants from the health colleges only.

Table 4 Correlation between knowledge scores and participants' occupation (n = 1541), Riyadh, Saudi Arabia, 2016

Item	All (n = 1541)		Students (n = 1264)		Non-academic staff (n = 210)		Faculty member (n = 67)		P1	P2	P3	P4
	No.	%	No.	%	No.	%	No.	%				
Total score									< 0.001	1.000	< 0.001	0.003
80-89	8	0.5	5	0.4	0	0.0	3	4.5				
70-79	73	4.7	52	4.1	10	4.8	11	16.4				
60-69	200	13.0	164	13.0	27	12.9	9	13.4				
50-59	355	23.0	294	23.3	50	23.8	11	16.4				
<50	905	58.7	749	59.3	123	58.6	33	49.3				
Correct for Q5	1216	78.9	1013	80.1	159	75.7	44	65.7	0.009	0.423	0.013	0.317
Correct for Q11	491	31.9	397	31.4	64	30.5	30	44.8	0.065	1.000	0.067	0.094
Correct for Q17	1034	67.1	858	67.9	133	63.3	43	64.2	0.376	0.581	1.000	1.000
Total score	Mean	SD	Mean	SD	Mean	SD	Mean	SD				
	43.2	15.5	43.3	15.0	41.8	16.7	46.4	20.3	0.104	0.627	0.519	0.297
Epidemiology	53.3	27.1	53.2	26.6	53.3	29.7	54.7	28.2	0.927	1.000	1.000	1.000
Symptoms and incubation period, infection sources, modes of transmission, common places for outbreaks	45.5	26.2	46.6	25.8	39.7	25.9	4	33.0	0.002	0.001	1.000	0.873
	43.5	20.8	43.8	20.8	40.6	21.3	46.3	19.9	0.049	0.114	0.755	0.114
Precautions and preventive strategies	43.2	26.9	43.1	26.5	43.6	26.9	44.0	33.2	0.949	1.000	1.000	1.000
Treatment and fatality rate	28.5	33.1	28.2	33.1	25.7	30.2	44.0	36.4	< 0.001	1.000	< 0.001	< 0.001
Infection in special populations	38.4	33.9	37.1	32.9	44.0	38.2	44.8	35.0	0.019	0.057	0.230	1.000

P1 = comparison between the 3 groups.

P2 = comparison between student and non-academic staff (with Bonferroni correction).

P3 = comparison between student and faculty member (with Bonferroni correction).

P4 = comparison between non-academic staff and faculty member (with Bonferroni correction).

which was higher among members of the health colleges.

Additionally, this study measured the participants' awareness towards disease aspects that are scientifically valid yet within public reach and knowledge level. The study explored new knowledge aspects, including disease epidemiology, infection sources, treatment and fatality rate, and used the WHO and Ministry of Health recommendations as the reference standard to gauge proper infection control practices. Our results are in accordance with previous studies. However, in addition to testing more knowledge aspects, we used a multiple choice question format rather than a true/false format, which may have posed some difficulty to the participants and this may explain the overall lower knowledge score observed in our sample (43.2%) compared with the findings of Al-Mohrej et al. (54%) (5).

Previous studies evaluating the awareness of the Saudi Arabian public towards MERS-CoV infection are limited (3–5). A study involving 1147 adult subjects in Riyadh reported a low level of knowledge of MERS-CoV incubation period, period of communicability and availability of vaccine, but a high level of knowledge on hygienic practices (4). Similar findings were reported in a study involving 1149 residents of Riyadh (5). That study, however, reported on the personal practices and precautions of the participants towards

for proper participant awareness and practices (3).

The good level of knowledge of proper hygienic practices observed in our sample and in other studies (3–5) is reassuring but remains suboptimal. Saudi Arabian communities still lack awareness of recommended protective measures that help prevent the transmission of the virus (14). It is estimated that 44 951 individuals older than 15 years may be seropositive for MERS-CoV in Saudi Arabia, and may be a source of infection for patients who have not been exposed to camels previously (15). A positive correlation has been demonstrated between contact with infected persons and infection risk, i.e. contacts are most in need of education on MERS-CoV to avoid spread of infection (14). Precautionary activities are therefore of great importance in avoiding infection and should be strengthened.

Health care workers/students, on the other hand, had poor knowledge of the recommended infection control precautions in the health care setting. This observation has important clinical implications as it may explain the high incidence of outbreaks and clustering of cases observed in the medical field. Our results on the health care workers/students' awareness are in accordance with those reported previously by Al-Ghamdi et al. who reported a very low level of awareness (32.9%) regarding the preventive measures against influ-

patient care. The workers had no previous contact with animals (17). The close proximity of health care workers to patients and the handling of human biologic material (sputum, respiratory secretions, etc.) likely increase their infection risk and consequently infection transmission in hospitals (17). Our results suggest that the lack of proper hygiene practices may be primarily due to poor awareness rather than noncompliance.

There are limited data on public awareness of infectious diseases in Saudi Arabia. The available studies, however, are consistent in reporting low knowledge level and poor adoption of protective measures (7,18–20). In a study on the awareness of the Saudi Arabian public towards H1N1 infection, 43.7% of the studied population were reported to have low knowledge level, and 60.8% had taken no or minimal precautionary measures (7). Potential explanations for the poor awareness include the lacking of proper health education among the Saudi Arabian people (21) and people's neglect of Ministry of Health recommendations (7).

Following the outbreak at the university, awareness programmes were implemented (10) and educational posters and banners were distributed on campus. Our results, however, indicate that these measures may be inadequate. The Saudi Arabian public commonly derive their information from the internet, but physicians and other health care

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