

How Social Networks Can Affect Infectious Disease Control: An Experience From Northwest Iran

To the Editor—Social networks are a recent phenomenon of technology that affects all aspects of life, including infectious disease, and it has become increasingly important to understand their features and limitations.¹ Also, information, trends, behaviors and even health states may spread between contacts in a social network, similar to disease transmission. However, information that propagates through social networks can carry a lot of false claims. For example, rumors on certain topics can propagate rapidly, leading to a large number of nodes reporting the same (incorrect) observations.²

In February 2015, a 35-year-old fruit seller with acute respiratory infection was hospitalized with some sign of hemoptysis in a Tabriz health center in northwest Iran. Because of suspected contact with the Hajj [pilgrimage] makers who returned to Iran, specific measures were taken to deal with Ebola. In this period, an image of the patient and hospital staff wearing special clothing to protect against Ebola was released on social networks and spread quickly. In addition, the event occurred during an influenza pandemic, which caused spreading fear and horror of an Ebola epidemic among the public of the city or even the country. The public fear was reduced with repeated interviews, mobilizing of hospital staffs to accept suspected patients, and provision of a rapid test for the detection of influenza, actions that were appropriate in control of the disease. Thus consideration of social transmission and network effects is an important issue for health and policy professionals. Also, it is of great importance to educate employees about putting information and images of patients on social networks with respect to propagation velocity.

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National Survey of Infectious Diseases Physicians on Prevention Practices for Multidrug-Resistant *Acinetobacter baumannii* in Thailand

To the Editor—Multidrug-resistant *Acinetobacter baumannii* (MDRAB) has emerged as a major cause of healthcare-associated infection and has become an infection prevention and control (IPC) challenge.^{1–3} The results of a prior Thai national survey indicated that a physician leader in infection control and participation in a collaborative effort to prevent MDR organisms were associated with a reduction in drug-resistant *A. baumannii* infections.³ A paucity of data regarding effective infection prevention of MDRAB prompted a 2014–2015 national survey to evaluate practices aimed at minimizing endemicity and reducing the spread of MDRAB.

Between June 1, 2014, and March 1, 2015, board-certified infectious diseases physicians (IDPs) in Thailand were interviewed using a standardized questionnaire. Survey items included IPC hospital activities, policies, and outcomes associated with MDRAB control. All IDPs were invited to participate in this study, and 1 IDP per hospital with responsibility for MDRAB control was interviewed if consent was obtained. The study exclusion criterion was decline for interview. Data variables included hospital characteristics, IPC practices and MDRAB policies, and estimated rates of MDRAB infection. Hospital characteristics included type and level of hospital, medical school affiliation, and participation in a collaborative network to reduce multidrug-resistant organisms (MDROs), safety score, leadership support, and prevalence of MDROs. The rates of MDRAB before and after implementation of IPC policies were acquired from IPC databases, and implementation of IPC was defined as implementation of standard versus intensified IPC interventions to control MDRAB based on the recommendations of the Healthcare Infection Control Practices Advisory Committee.⁴ All data pertaining to IPC and compliance with each recommended measure were abstracted from each hospital's infection control (IC) database.