

**The International Journal of Health Sciences
Guidelines for Authors**

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Profile of IJHS

The *International Journal Health Science*, founded by Qassim University in 2006 (1427 H), is published bi-annually. Its purpose is to bridge diverse communities of medical and social scientists, working in different disciplines, from different parts of the world. It provides information and debate on subjects of interest to a broad international readership, written by an equally international range of authors. It serves as a forum for review, reflection and discussion informed by the results of relevant research.

Mission

The mission of The International Journal of Health Sciences (IJHS) is to promote excellence in the practice of medicine and in scientific research. IJHS publishes peer-reviewed scientific papers of significance in all areas of health sciences from basic research to clinical and experimental work.

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The IJHS will consider any original contribution that advances or illuminates health sciences or practice. The Journal invites original research and review articles, important case reports and analysis, short research communications presenting novel research ideas and timely research finding, and reports of new drug development and clinical trials. We are most interested in papers that will influence practice and that address important advances in Health Sciences. *The IJHS* gives priority to reports of original research that are likely to change clinical practice or thinking about a disease.

The Journal aims at establishing itself as the leading international journal in health sciences.

The IJHS's Content Editorial

The voice of *The IJHS*, editorials are written in house by the journal's editors. Editorials usually provide commentary and analysis concerning an article in the issue of the *Journal* in which they appear. They may include 1 figure or table. They are nearly always solicited, although unsolicited editorials may occasionally be considered. Editorials are limited to 1500 words, with up to 15 references.

Original Research

The IHSJ gives priority to reports of original research that are likely to change clinical practice or thinking about a disease. Studies of diagnostic accuracy must be reported according to STARD guidelines. Systematic reviews must be written according to the Cochrane Collaboration guidelines.

Manuscripts containing original material are accepted for consideration if neither the article nor any part of its essential substance, tables, or figures has been or will be published or submitted elsewhere before appearing in the *Journal*.

- **Original Articles** are scientific reports of the results of original clinical research. The text is limited to 5000 words, with an abstract, a maximum of 5 tables and figures (total), and up to 40 references.
- **Special Articles** are scientific reports of original research in such areas as economic policy, ethics, law, and health care delivery. The text is limited to 4000 words, with an abstract, a maximum of 5 tables and figures (total), and up to 40 references.

Review Articles

All review articles undergo the same peer-review and editorial process as original research reports. They may include material that might be considered too introductory for specialists in the field being covered.

Review articles should be structured in the same way as regular papers, but the restriction on the number of references does not apply. The procedure for the publication of systematic reviews is the preferred format.

Clinical Practice articles are evidence-based reviews of topics relevant to practicing physicians, both primary care providers and specialists. Articles in this series should include the following sections: the clinical problem, strategies and evidence, areas of uncertainty, guidelines from professional societies, and the authors' conclusions and recommendations. The text is limited to 2500 words and a small number of figures and tables. These articles do not include an abstract.

Clinical Therapeutics articles are evidence-based reviews of topics relevant to practicing physicians. The series focuses on clinically oriented information about specific forms of therapy, including drugs, devices, and procedures. The text is limited to 2500 words. These articles do not include an abstract.

Current Concepts/Recent Trends: provide comprehensive, scholarly overviews of important clinical subjects, with the principal focus on developments during the past five years. Each article details how the perception of a disease, disease category, diagnostic approach, or therapeutic intervention has evolved in recent years. The text is limited to 3500 words, with a maximum of 6 tables and figures (total) and up to 100 references. .

Drug Therapy articles detail the pharmacology and use of specific drugs or classes of drugs, or the various drugs used to treat particular diseases. The text is limited to 4000 words, with a maximum of 6 figures and tables (total) and up to 120 references. These articles do not include an abstract.

Mechanisms of Disease articles discuss the cellular and molecular mechanisms of diseases or categories of diseases. The text is limited to 3500 words, with a maximum of 6 figures and tables (total), and up to 100 references. These articles do not include an abstract.

Lifeline articles cover a wide variety of topics of current interest in health care, medicine, and the intersection between medicine and society. Perspective articles are limited to 1500 words and usually include one figure. There is a maximum of five reference citations.

Interactive Case Reports alert readers to potential clinical problems. They should be less than 1200 words long and accompanied by a single sentence of up to 15 words stating the lesson. A single interesting case, which should

not be a rarity but one that a clinician might encounter, in which there was some difficulty in reaching a diagnosis, and that provides a teaching point. Preferably the case should have a good illustration. Consent for publication in print and electronically must be obtained from the patient or, if this is not possible, the next of kin.

Evidence based case reports: show how evidence can be applied at all stages of patient care. They should not exceed 1500 words. Please define the clinical question in four parts; patient, intervention, comparison, and outcome. The report should show that you have searched for, cited, and summarised studies of appropriate relevance, design, and quality, and should state which bibliographic databases you have used.

Images in Clinical Medicine: are interesting Clinical Pictures submitted with a descriptive paragraph of 200 words. Authors must obtain informed consent from the patient.

Comment & Analysis articles are opinion essays that aim to stimulate discussion, raise debate, and air controversies. These can cover any aspects of medicine and health which are relevant to an international general medical audience including sociological and ethical aspects of medicine; polemical pieces; and educational articles. Most are commissioned, but spontaneous Comment pieces (about 1000 words and 10 or so references) are welcome on someone else's paper or other report published elsewhere within the past six months, or on an event in the near future. We will also consider longer Comments, especially on clinically relevant topics (about 1500 words, 15-20 references, 1-2 figures/panels/tables). They are similar to editorials but are not tied to a particular article. They often present opinions on health policy issues and are normally unsolicited. The text is limited to 2000 words.

Science, Medicine & the Future covers news about science medicine, policy issues, and people. The aim is to inform general readers about cutting edge research in medicine and science, and to discuss the potential clinical, ethical, economic, and psychosocial implications for the next 15 years or so. The summary box should highlight predicted developments, particularly in how clinical management may change over the next 5-15 years. 2000 words and 20 references are the general guidelines here. *Medical Ethics & Legal*

Aspects of healthcare are nearly always solicited, but we are willing to consider unsolicited manuscripts or proposals for manuscripts.

Letters to the Editor provide a forum for readers to comment about articles recently published in the *Journal*, and they are a place to publish concise articles, such as reports of novel cases. Letter should be no longer than 250 words. Letters of general interest, unlinked to earlier items in the journal, are also considered, and can be up to 500 words long. Only one table or figure is permitted, and there should be no more than five references and five authors. Letters will be edited for clarity and conformity to *Journal* style and may be shortened. Letters describing original research may be peer-reviewed under the moderation of the Correspondence Editor.

Clinical Guidelines and Position Papers: Summaries of official or consensus positions on issues related to clinical practice, health care delivery or public policy. Include procedures used to formulate guideline recommendations and a bibliography of sources upon which the guideline recommendations are based. Up to 5000 words.

Images in Clinical Medicine are classic images of common medical conditions. This feature is intended to capture the sense of visual discovery and variety that physicians experience. Images in Clinical Medicine are not intended as a vehicle for case reports.

Academic Medicine articles on progress in medical education focusing on recent advances and future trends are welcome.

Book Reviews are generally solicited. We are willing to consider proposals for book reviews.

Submitting articles to the journal

Please note these important points:

- all material submitted for publication must be submitted exclusively to the IJHS
- please send all submissions electronically to editor.IHSJ@Gmail.com
- you can upload your manuscript by logging on to www.qumedicine.org/journal

Research papers should follow the IMRaD style (introduction, methods, results and discussion) and should have a structured abstract and, preferably a structured discussion.

Please include in the results section of your **structured abstract** (and, of course, in the paper's results section) the following terms, as appropriate:

For a clinical trial:

- Absolute event rates among experimental and control groups
- RRR (relative risk reduction)
- NNT or NNH (number needed to treat or harm) and its 95% confidence interval (or, if the trial is of a public health intervention, number helped per 1000 or 100,000)

For a cohort study:

- Absolute event rates over time (eg 10 years) among exposed and non-exposed groups
- RRR (relative risk reduction)

For a case control study:

- OR (odds ratio) for strength of association between exposure and outcome

For a study of a diagnostic test:

- Sensitivity and specificity
- PPV and NPV (positive and negative predictive values)

Authors should number all of the pages of the manuscript consecutively, beginning with the title page.

Reporting Guidelines for Specific Study Designs

Initiative	Type of study	Source
CONSORT	randomized controlled trials	http://www.consort-statement.org
STARD	studies of diagnostic accuracy	http://www.consort-statement.org/stardstatement.htm
QUOROM	systematic reviews and meta-analyses	http://www.consort-statement.org/Initiatives/MOOSE/moose.pdf
STROBE	observational studies in epidemiology	http://www.strobe-statement.org
MOOSE	meta-analyses of observational studies in epidemiology	http://www.consort-statement.org/Initiatives/MOOSE/moose.pdf

Covering letter: use the covering letter to explain why your paper should be published in *The IHSJ*, a general medical journal, rather than elsewhere..

Title page

The title page should carry the following information:

- The title of the article. Concise titles are easier to read than long, convoluted ones. Authors should include all information in the title that will make electronic retrieval of the article both sensitive and specific.

- Authors' names, institutional affiliations, each author's highest academic degree(s)
- The name of the department(s) and institution(s) to which the work should be attributed.
- Corresponding authors. The name, mailing address, telephone and fax numbers, and e-mail address of the author responsible for correspondence about the manuscript
- Source(s) of support in the form of grants, equipment, drugs, or all of these.
- Word counts.

Title: should be clear and informative. Not too long, without quotation marks within it, and not in interrogative form. Give the main title and subtitle (if any). If the study is a randomized trial, systematic review, or meta-analysis, add that descriptor as the subtitle at the end of the title. Use titles that stimulate interest, are easy to read and concise (12 words or fewer), and contain enough information to convey the essence of the article. Also provide a short or "running" title of 7 or fewer words.

Authorship

Credit for authorship requires substantial contributions to (a) the conception and design or analysis and interpretation of the data, and (b) the drafting of the article or critical revision for important intellectual content. Authorship implies a significant intellectual contribution to the work, some role in writing the manuscript and reviewing the final draft of the manuscript, but authorship roles can vary. For all manuscripts, the corresponding author is required to provide information on the specific contributions each author has made to the article.

List authors in the order in which they are to appear in the byline of the published article. In the case of group authorship, identify one or more authors who will have responsibility for the publication. Give the institutional affiliation for each author, financial support information, contact information for the corresponding author, and contact information for the author to receive reprint requests.

Word Count: List the word count for the text of the manuscript. Don't include the abstract or the references in word counts.

Competing interests statements

The potential for conflict of interest exists when an author (or the author's institution or employer) has personal or financial relationships that could influence (bias) his or her actions. These relationships vary from those with negligible potential to influence judgment to those with great potential to influence judgment. Not all relationships represent true conflict of interest. Conflict of interest can exist whether or not an individual believes that the relationship affects his or her scientific judgment.

Authors must state explicitly whether potential conflicts do or do not exist. Financial relationships (such as employment, consultancies, honoraria, stock ownership or options, paid expert testimony, grants or patents received or pending, and royalties) are the most easily identifiable conflicts of interest and the most likely to undermine the credibility of the journal, the authors, and science itself. Authors must disclose all financial relationships (both personal and institutional) that could be viewed as presenting a potential conflict of interest. These include, but are not limited to, any financial relationship that involves conditions or tests or treatments discussed in the manuscript AND alternatives to the tests or treatments for those conditions. If authors are uncertain, they should err on the side of full disclosure. Disclosure of these relationships is essential not only for original research articles but also for editorials, letters, commentary, and review articles. Journal will publish conflict of interest disclosures. If the authors' work was independent of the funders (the funding source had no involvement), the authors should so state.

Abstract

Provide an abstract of not more than 250 words (MEDLINE allows a maximum of 4096 characters and will truncate longer abstracts). It should consist of four paragraphs, labeled Background, Methods, Results, and Conclusions. They should briefly describe, respectively, the problem being addressed in the study, how the study was performed, the salient results, and what the authors conclude from the results. Please ensure that the structured abstract is as complete, accurate, and clear as possible.

Introduction

Provide a context or background for the study (i.e., the nature of the problem and its significance). State the specific purpose or research objective of, or hypothesis tested by, the study or observation; the research objective is often more sharply focused when stated as a question. Use short introductions that concisely set-up the context of the research for readers. Always end the introduction section with a clear statement of the study's objectives or hypotheses. Both the main and secondary objectives should be made clear, and any pre-specified subgroup analyses should be described. Do not include data or conclusions from the work being reported.

Methods

For studies involving humans, describe in the Methods section how participants were assembled and selected, and the sites or setting from which they were recruited. Then describe study procedures including any interventions, measurements and data collection techniques. Use figures to diagram study processes including the flow of participants through the study. Provide the number of patients at each stage of recruitment and follow-up, including the number who declined to participate and the number who completed follow-up. State, if true, that an institutional review board approved the study or affirm that the protocol is consistent with the principles of the Declaration of Helsinki (World Medical Association), and state whether participants gave their informed consent. For studies that have numerical data and use statistical inference, include a section under Methods that describes the methods used for the statistical analysis and that states the specific statistical software. For all studies, include a statement at the end of the Methods section describing the role of the funding source for the study. If the study had no external funding source or if the funding source had no role in the study, state so explicitly.

Selection and Description of Participants

Describe your selection of the observational or experimental participants (patients or laboratory animals, including controls) clearly, including eligibility and exclusion criteria and a description of the source population. Authors should explain why only

subjects of certain ages were included or why women were excluded. The guiding principle should be clarity about how and why a study was done in a particular way.

Technical information

Identify the methods, apparatus (give the manufacturer's name and address in parentheses), and procedures in sufficient detail to allow other workers to reproduce the results. Give references to established methods, including statistical methods; provide references and brief descriptions for methods that have been published but are not well known; describe new or substantially modified methods, give reasons for using them, and evaluate their limitations. Identify precisely all drugs and chemicals used, including generic name(s), dose(s), and route(s) of administration.

Statistics

Describe statistical methods with enough detail to enable a knowledgeable reader with access to the original data to verify the reported results. When possible, quantify findings and present them with appropriate indicators of measurement error or uncertainty (such as confidence intervals). References for the design of the study and statistical methods should be to standard works when possible.

Results

Fully describe the study sample so that readers can gauge how well the study findings apply to their patients (external validity). Then present primary findings followed by any secondary and subgroup findings. Present your results in logical sequence in the text, tables, and illustrations, giving the main or most important findings first. Do not repeat in the text all the data in the tables or illustrations; emphasize or summarize only important observations. When data are summarized in the Results section, give numeric results not only as derivatives (for example, percentages) but also as the absolute numbers from which the derivatives were calculated, and specify the statistical methods used to analyze them. Restrict tables and figures to those needed to explain the argument of the paper and to assess its support. Use graphs as an alternative to tables with many entries; do not duplicate data

in graphs and tables. Where scientifically appropriate, analyses of the data by variables such as age and sex should be included.

Discussion

Consider structuring the discussion according to the following sequence:

- Provide a brief synopsis of key findings, with particular emphasis on how the findings add to the body of pertinent knowledge.
- Discuss possible mechanisms and explanations for the findings.
- Compare study results with relevant findings from other published work. Briefly state literature search sources and methods (e.g., English-language MEDLINE search to Jan 2007) that identified previous pertinent work. Use tables and figures to help summarize previous work when possible.
- Discuss the limitations of the present study and any methods used to minimize or compensate for those limitations.
- Mention any crucial future research directions.
- Conclude with a brief section that summarizes in a straightforward and circumspect manner the clinical implications of the work.

Emphasize the new and important aspects of the study and the conclusions that follow from them. Do not repeat in detail data or other material given in the Introduction or the Results section. For experimental studies it is useful to begin the discussion by summarizing briefly the main findings, then explore possible mechanisms or explanations for these findings, compare and contrast the results with other relevant studies, state the limitations of the study, and explore the implications of the findings for future research and for clinical practice.

Link the conclusions with the goals of the study but avoid unqualified statements and conclusions not adequately supported by the data. In particular, authors should avoid making statements on economic benefits and costs unless their manuscript includes the appropriate economic data and analyses.

References

Number references, using Arabic numerals in parentheses (in superscript), in the order in which they first appear in the text. References cited in a table/figure should appear in numeric order relative to the first citation of the table/figure in the text.

General Considerations Related to References

Small numbers of references to key original papers will often serve as well as more exhaustive lists.

For articles published in journals indexed in MEDLINE, the IHSJ considers PubMed (<http://www.pubmed.gov>) the authoritative source for information about retractions.

Reference Style and Format

The Uniform Requirements style is based largely on an ANSI standard style adapted by the National Library of Medicine (NLM) for its databases.

References should be numbered consecutively in the order in which they are first mentioned in the text. The titles of journals should be abbreviated according to the style used in Index Medicus.

Journals

1. Standard article (List all authors when there are 6 or fewer; when there are 7 or more authors, list only the first 6 and add "et al.")

Shapiro AMJ, Lakey JRT, Ryan EA, et al. Islet transplantation in seven patients with type 1 diabetes mellitus using a glucocorticoid-free immunosuppressive regimen. *N Engl J Med* 2000;343:230-8.

Vega KJ, Pina I, Krevsky B. Heart transplantation is associated with an increased risk for pancreatobiliary disease. *Ann Intern Med*. 1996;124:980-3.

2. Corporate author

Clinical exercise stress testing. Safety and performance guidelines. The Cardiac Society of Australia and New Zealand. *Med J Aust*. 1996;164:282-4.

3. Supplement

Shen HM, Zhang QF. Risk assessment of nickel carcinogenicity and occupational lung cancer. *Environ Health Perspect* 1994;102(Suppl 1):275-82.

4. Special format (also applies to abstracts and editorials)

Enzensberger W, Fischer PA. Metronome in Parkinson's disease [Letter]. *Lancet*. 1996;347:1337.

Books

List all authors or editors when 6 or fewer; when there are 7 or more authors, list only the first 6 and add "et al."

1. Author

Amin Tabish. *Hospital & Health Services Administration: Principles & Practice*. 2nd ed. Oxford University Press, New York; 2005.

2. Editors

Norman IJ, Redfern SJ, eds. *Mental Health Care for Elderly People*. New York: Churchill Livingstone; 1996.

3. Chapter in a book

Phillips SJ, Whisnant JP. Hypertension and stroke. In: Laragh JH, Brenner BM, eds. *Hypertension: Pathophysiology, Diagnosis, and Management*. 2nd ed. New York: Raven Pr; 1995:465-78.

4. Published proceedings paper

Bengtsson S, Solheim BG. Enforcement of data protection, privacy and security in medical informatics. In: Lun KC, Degoulet P, Piemme TE, Rienhoff O, eds. *MEDINFO 92. Proceedings of the 7th World Congress on Medical Informatics*; 6-10 September 1992; Geneva, Switzerland. Amsterdam: North-Holland; 1992:1561-5.

Kuczmariski RJ, Ogden CL, Grammer-Strawn LM, et al. CDC growth charts: United States. Advance data from vital and health statistics. No. 314. Hyattsville, Md.: National Center for Health Statistics, 2000. (DHHS publication no. (PHS) 2000-1250 0-0431.)

Citations of Electronic References

Cisler S. MediaTracks. *Public Access Comput Syst Rev* [serial on-line] 1990;109-15. Accessed at Public Access Computer Systems Forum PACS-L at www.pubaccess.com on 29 November 1997.

U.S. positions on selected issues at the third negotiating session of the Framework Convention on Tobacco Control. Washington, D.C.: Committee on Government Reform, 2002. (Accessed March 4, 2002, at http://www.house.gov/reform/min/inves_tobacco/index_accord.htm.)

File Formats

All text, references, figure legends, and tables should be in **one double-spaced** electronic document (WORD doc or PDF). You may either insert figures in the text file or upload your figures separately. We accept figures inserted in the same document WordPerfect (.wpd), text (.txt) documents, and .rtf file format. Acceptable formats for pictures, photos, and figures are PDF, DOC, PPT, JPG, GIF, TIF. Legends for all figures should be included in the file with the text and should not appear on the figures.

Medical Illustrations

Actual photographs at least 5 by 7 inches but no larger than 8 by 10 inches should be submitted for review and color match purposes. If a photograph was taken with a digital camera please include an electronic file (EPS, TIF, or JPG at 266 dpi or higher). All electronic photographs must be submitted along with a print of the photograph. Electronic files can be submitted by e-mail or can be sent by mail along with the hard. The author must explicitly acquire all rights to the illustration from the artist in order for us to publish it.

Tables

Number tables with Arabic numerals in the order in which they appear in the text. Tables that are meant as appendix material should be numbered as Appendix Table 1, Appendix Table 2, and so on. Use titles that concisely describe the content of the table so that a reader can understand the table without referring to the text. Tables may contain abbreviations that we do not permit in the text, but the table should contain a footnote that explains the abbreviation. Give the units of measure for all numerical data in a column or row. Place units of measure under a column heading or at the end of a side heading only if those units apply to all numerical data in the column or row.

Figures

Number figures with Arabic numerals in the order in which they appear in the text. Figures that are meant as appendix material should be numbered as Appendix Figure 1, Appendix Figure 2, and so on. Each figure should have a figure legend that begins with a short title. Reduce the length of legends by using phrases rather than sentences. Explain all abbreviations and symbols on the figure, even if an explanation appears in the text. For pictures of histologic slides, give stain and magnification data at the end of the legend for each part of the figure. If no scale marker appears on the figure, give the original magnification used during the observation, not that of the photographic print.

Ethics Committee Approval

Research that involves human participants includes investigations that use only human blood, tissue, or medical records. The authors must confirm review of the study by the appropriate institutional review board or affirm that the protocol is consistent with the principles of the Declaration of Helsinki (see World Medical Association). If the authors did not obtain institutional review board approval before the start of the study, they should so state and explain the circumstances. If the study was exempt from review, the authors must state that such exemption complied with the policy of their local institutional review board. They should affirm that study participants gave their informed consent or state that an institutional review board approved conduct of the research without explicit consent from the participants. If patients are identifiable from illustrations, photographs, pedigrees, case reports, or other study data, the authors must submit the release form for each such individual (or copies of the figures with the appropriate release statement) giving permission for publication with the manuscript.

When reporting experiments on animals, authors are required to indicate whether the institutional and national guide for the care and use of laboratory animals was followed. Experimental research involving human or animals should have been approved by author's institutional review board or ethics committee. This information can be mentioned in the manuscript including the name of the board/committee that gave the approval. Use

of animals in experiments will have observed the *Interdisciplinary Principles and Guidelines for the Use of Animals in Research, Testing, and Education* by the New York Academy of Sciences, Ad Hoc Animal Research Committee.

Patient Consent

If photographs of patients are used, either they should not be identifiable or the photographs should be accompanied by written permission to use them.

Abbreviations and units

All abbreviations must be spelt out on first usage and only widely recognized abbreviations will be permitted. The generic names of drugs should be used. Generally, SI units should be used; where they are not, the SI equivalent should be included in parentheses. Units should not use indices: i.e. report g/ml, not gml.

Units of Measurement

Authors should express all measurements in conventional units, with Système International (SI) units given in parentheses throughout the text. Figures and tables should use conventional units, with conversion factors given in legends or footnotes.

Abbreviations

Except for units of measurement, abbreviations are strongly discouraged. Except for units of measurement, the first time an abbreviation appears, it should be preceded by the words for which it stands.

Drug Names

Generic names should be used. When proprietary brands are used in research, include the brand name and the name of the manufacturer in parentheses after the first mention of the generic name in the Methods section.

Statistical Guidelines

Presentation	
Issue	Notes
Percentages	Report percentages to one decimal place (i.e., xx.x%) when sample size is ≥ 200 . To avoid the appearance of a level of precision that is not present with small samples, do not use decimal places (i.e., xx%, not xx.xx%) when sample size is < 200 .
Standard deviations	Use "mean (SD)" rather than "mean \pm SD" notation. The \pm symbol is ambiguous and can represent standard deviation or standard error.
Standard errors	Report confidence intervals, rather than standard errors, when possible.
P values	Report exact p-values to two decimal places except when $p < 0.001$, in which case "p<0.001" is sufficient.
"Trend"	Use the word trend when describing a test for trend or dose-response. Avoid the term "trend" when referring to p-values near but not below 0.05. In such instances, simply report a difference and the confidence interval of the difference (if appropriate) with or without the p-value.
Statistical software	Specify in the statistical analysis section the statistical software—version, manufacturer, and manufacturer's location—used for analyses.
Cox models	When reporting the findings from Cox proportional hazards models: <ul style="list-style-type: none"> Do not describe hazard ratios as relative risks. Do report how the assumption of proportional hazards was tested, and what the test showed.
Descriptive Tables	In tables that simply describe characteristics of two or more groups (eg Table 1 of a clinical trial): <ul style="list-style-type: none"> Report averages with standard deviations, not standard errors, when data are normally distributed. Report median (minimum, maximum) or median (25th, 75th percentile [interquartile range, or IQR]) when data are not normally distributed. Avoid reporting p values as there can be imbalance when p's are not significant (because of small sample size) and balance when p's are significant (because of large sample size).
Tables Reporting Multivariable Analyses	Authors sometimes present tables that compare one by one an outcome with multiple individual factors followed by a multivariable analysis that adjusts for confounding. If confounding is present, as is often the case, the one-way comparisons are simply intermediate steps that offer little useful information for the reader. In general, omit presenting these intermediate steps in the manuscript and do not focus on them in the Results or Discussion.
Tables and Figures (general)	The following references give useful information about the design and format of informative tables and figures: Tufté ER. <i>The Visual Display of Quantitative Information</i> . Cheshire CT: Graphic Press; 1983, p 178. ISBN: 0961392142 Wainer H. How to display data badly. <i>The American Statistician</i> 1984; 38:137-147. Google Scholar Wainer H. <i>Visual Revelations: graphical tales of fate and deception from Napoleon Bonaparte to Ross Perot</i> . New Jersey: Lawrence Erlbaum Associates, Inc.; 1997. ISBN: 038794902X Pocock SJ, Clayton TC, Altman DG. Survival plots of time-to-event outcomes in clinical trials: good practice and pitfalls. <i>Lancet</i> 2002; 359:1686-89. PMID: 12020548 Also, follow a few simple rules of thumb: <ul style="list-style-type: none"> Avoid pie charts. Avoid simple bar plots or histograms that do not present measures of variability. Provide raw data (numerators and denominators) in the margins of meta-analysis forest plots. Depict numbers of people at risk at different times in survival plots. (see Pocock et al. above).

Multivariable Analysis Screening covariates

Approaches that select factors for inclusion in a multivariable model only if the factors are “statistically significant” in “bivariate screening” are not optimal. A factor can be a confounder even if it is not statistically significant by itself because it changes the effect of the exposure of interest when it is included in the model, or because it is a confounder only when included with other covariates.

Model building

Authors should avoid stepwise methods of model building, except for the narrow application of hypothesis generation for subsequent studies. Stepwise methods include forward, backward, or combined procedures for the inclusion and exclusion of variables in a statistical model based on predetermined p value criteria. Better strategies than p-value driven approaches for selecting variables are those that use external clinical judgment. Authors might use a bootstrap procedure to determine which variables, under repeated sampling, would end up in the model using stepwise variable selection procedures. Regardless, authors should tell readers how model fit was assessed, how and which interactions were explored, and the results of those assessments.

Measurement Error

If several risk factors for disease are considered in a logistic regression model and some of these risk factors are measured with error, the point and interval estimates of relative risk corresponding to any of these factors may be biased either toward or away from the null value; the direction of bias is never certain. In addition to potentially biased estimates, confidence intervals of correctly adjusted estimates will be wider, sometime substantially, than naïve confidence intervals. Authors are encouraged to consult the references below for strategies to address this problem.

Measures of Effect and Risk

Clinically meaningful estimates

Authors should report results for meaningful metrics rather than reporting raw results. For example, rather than reporting the log odds ratio from a logistic regression, authors should transform coefficients into the

appropriate measure of effect size, odds ratio, relative risk, or risk difference. Don't give readers an estimate, such as an odds ratio or relative risk, for a one unit change in the factor of interest when a one unit change lacks clinical meaning (age, mmHg of blood pressure, or any other continuous or interval measurement with small units). All estimates should reflect a clinically meaningful change, along with 95% confidence bounds.

Between group differences

For comparisons of interventions (e.g., trials), focus on between- group differences, with 95% confidence intervals of the differences, and not on within-group differences. State the results using absolute numbers (numerator/denominator) when feasible. When discussing effects, refer to the confidence intervals rather than p values and point out for readers if the confidence intervals exclude the possibility of significant clinical benefit or harm.

Odds ratios and predicted probabilities

Authors often report odds ratios for multivariable results when the odds ratio is difficult to interpret or not meaningful. First, the odds ratio might overstate the effect size when the reference risk is high. For example, if the reference risk is 25% (odds = 0.33) and the odds ratio is 3.0, the relative risk is only 2.0. Statements such as “threefold increased risk” or “three times the risk” are incorrect. Second, readers want an easily understood measure of the level of risk (and the confidence intervals) for different groups of patients as defined by treatment, exposure, and covariates. Consider providing them a table of predicted probabilities for each of the factors of interest, and confidence intervals of those predicted probabilities. Moreover, a multiway table that cross classifies predicted probabilities by the most important factor and then adjusts for the remaining factors will often be more meaningful than a table of adjusted odds ratios. Standard commercial software can produce predicted probabilities and confidence bounds.

Missing Data

Missing variables

Always report the frequency of missing variables and how the analysis handled missing data. Consider adding a column to tables or a row under figures that makes clear the amount of missing data. Avoid using a simple indicator or dummy variable to represent a missing value.

Replacing missing predictors with dummy variables or missing indicators generally leads to biased estimates.

Missing Outcomes

Always report the frequency of missing outcomes and follow-up data; reasons and any patterns for the missing data; and how you handled missing data in the analyses. Do not use a last observation carried forward approach (LOCF) to address incomplete follow-up even if the original protocol pre-specified that approach for handling missing data. LOCF approaches understate variability and result in bias. The direction of the bias is not predictable. Although the method of addressing missing data may have little import on findings when the proportion of missing data is small (e.g. <5%), authors should avoid using out-dated or biased methods to address incomplete follow-up. Appropriate methods for handling missing data include imputation, pattern-mixture (mixed) models, and selection models. Application of these methods requires consideration of the patterns and potential mechanisms behind the missing data.

Longitudinal Analyses

Consider using longitudinal analyses if outcome data were collected at more than one time point. With an appropriate model for longitudinal analysis, you can report differences within groups over time, differences between groups, and differences across groups of their within-group changes over time (usually the key contrast of interest). You can control for any confounding that might emerge, such as a difference in a variable (e.g., body weight) among those who remained in the study until completion. Longitudinal analysis options include a population averaged analysis (GEE, for example) that estimates the time by treatment interaction and adjusts variance for the repeated measures within individuals over time. Another option is a mixed effects model, with random effects for patient, and the estimate of interest being the time by treatment interaction. In choosing a model, consider whether any missing data are missing at random (i.e. "ignorable" missing data) or missing dependent on the observed data (i.e. informative missing data). In GEE analyses, missing data are assumed to be missing completely at random independent of both observed and unobserved data. In random coefficient analysis,

missing data are assumed missing at random dependent on observed data but not on unobserved data.

Statistical Methods

Guidelines for statistical reporting in articles for this journal include:

- Exact methods should be used as extensively as possible in the analysis of categorical data. For analysis of measurements, nonparametric methods should be used to compare groups when the distribution of the dependent variable is not normal.
- Results should be presented with only as much precision as is of scientific value. For example, measures of association, such as odds ratios, should ordinarily be reported to two significant digits.
- Measures of uncertainty, such as confidence intervals, should be used consistently, including in figures that present aggregated results.
- Except when one-sided tests are required by study design, such as in noninferiority trials, all reported P values should be two-sided. In general, P values larger than 0.01 should be reported to two decimal places, those between 0.01 and 0.001 to three decimal places; P values smaller than 0.001 should be reported as $P < 0.001$.
- In manuscripts that report on randomized clinical trials, authors should provide a flow diagram in CONSORT format and all of the information required by the CONSORT checklist.

Methods of statistical analysis should be described in language that is comprehensible to the numerate psychiatrist as well as the medical statistician. Particular attention should be paid to clear description of study designs and objectives, and evidence that the statistical procedures used were both appropriate for the hypotheses tested and correctly interpreted. The statistical analyses should be planned before data are collected and full explanations given for any *post hoc* analyses carried out.

Randomized controlled trials

The *Journal* recommends to authors the CONSORT guidelines (1996, *Journal of the American Medical Association*, **276**, 637-639) and their basis (2001, *Annals of Internal Medicine*, **134**, 663-694) in relation to the

reporting of randomized controlled clinical trials; also recommended is their extension to cluster randomized controlled trials (2004, *BMJ*, **328**, 702-708). In particular, a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) must be included.

Qualitative research

The *Journal* welcomes submissions of reports of studies that have used qualitative research methods. These may, for example, be based on fieldwork notes, interview transcripts, recordings or documentary analysis. Such studies may be judged using criteria that differ from those used to judge reports based on statistical evidence. The following checklist should serve as a useful guide.

- Is the research question clearly defined?
- Are the theoretical framework and methods used at every stage of the research made explicit?
- Is the context clearly described?
- Is the sampling strategy clearly described and justified?
- Is the sampling strategy theoretically comprehensive to ensure the generalisability of the conceptual analysis (diverse range of individuals and settings, for example)?
- How was the fieldwork undertaken? Is it described in detail?
- Could the evidence (fieldwork notes, interview transcripts, recordings, documentary analysis, etc.) be inspected independently by others? If relevant, could the process of transcription be independently inspected?
- Are the procedures for data analysis clearly described and theoretically justified? Do they relate to the original research questions?
- How were themes and concepts identified from the data?
- Was the analysis repeated by more than one researcher to ensure reliability?
- Is quantitative evidence used to test qualitative conclusions where appropriate?
- Have observations that might have contradicted or modified the analysis been sought out and reported?
- Is sufficient of the original evidence presented systematically in the written account to satisfy the skeptical reader of the relation between the interpretation and the

evidence (for example, were quotations numbered and sources given)?

General Guidelines

For standard original research papers please provide the following headings and information:

- **objectives** - a clear statement of the main aim of the study and the major hypothesis tested or research question posed
- **design** - including factors such as prospective, randomization, blinding, placebo control, case control, crossover, criterion standards for diagnostic tests etc
- **setting** - include the level of care eg primary, secondary; number of participating centres. Be general rather than give the name of the specific centre, but give the geographical location if this is important
- **participants** (instead of patients or subjects) - numbers entering and completing the study, sex, and ethnic group if appropriate. Give clear definitions of how selected, entry and exclusion criteria
- **interventions** - what, how, when and for how long. This heading can be deleted if there were no interventions but should normally be included for randomised controlled trials, cross over trials, and before and after studies.
- **main outcome measures** - those planned in protocol, those finally measured (if different, explain why)
- **results** - main results with (for quantitative studies) 95% confidence intervals and, where appropriate, the exact level of statistical significance and the number need to treat/harm.
- **conclusions** - primary conclusions and their implications, suggesting areas for further research if appropriate. Do not go beyond the data in the paper. Conclusions are important because this is often the only part that readers look at.

Abstracts for meta-analyses and systematic reviews should have these headings:

- objective** - what the review set out to determine
- design** - type of meta-analysis, systematic review
- data sources** - where included studies were retrieved from

- **review methods** ~ inclusion and exclusion criteria
- **results** ~ main findings with 95% confidence intervals
- **conclusions** ~ primary conclusions and their implications

Key Points [What this paper adds] box

Please produce a box offering a thumbnail sketch of what your paper adds to the literature, for readers who would like an overview without reading the whole paper.

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Good research should be well justified, well planned, and appropriately designed, so that it can properly address the research question. Statistical issues, including power calculations, should be considered early in study design, to avoid futile studies that produce subject risk without enrollment sufficient to answer the research question. Outcomes should be specified at the start of the study. Research should be conducted to high standards of quality control and data analysis. Data and records must be retained and produced for review upon request.

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