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REPORT ON COMMUNICABLE EYE DISEASES AMONG ARAB REFUGEES IN JORDAN

by

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A SUMMARY OF THE ACTIVITIES OF THE HEALTH DIVISION OF THE UNITED NATIONS RELIEF AND WORKS AGENCY IN JORDAN IN RESPECT OF COMMUNICABLE EYE DISEASES

With the start of the UNRWA Mandate in 1950, the state of affairs in the field was as follows:-

- 1. No statistics were available on the incidence of infection of eye diseases amongst the Arab Refugees.
 - 2, Poor sanitary condition in camps, with a meagre supply of water.
- 3. Lack of qualified ophthalmic nursing personnel (few trained persons from the time of the British Mandate).
- 4. The Public Health Activities were not fully organized and much was to be done for health education and creation of health awareness.
- 5. The majority of refugee population was not yet settled and were mostly living under tents.

The statistical reports from climics, received by the Field Health Office until 1954 could only show new eye cases - "total eye cases."

The treatment adopted for infected eye cases (acute conjunctivitis and complicated trachoma cases) was as follows:-

Silver Nitrate- Copper Sulphate

Argyrol - Sulfathiazol Ointment

Protargol - Sulfacetamide Solution

Field Health Officer UNRWA **Jo**rdan

The first scientific report on Eye Diseases sent to this field for guidance was Maxwell-Lyons' Report on Eye Diseases in Egypt - March 1951.

At the end of 1950, Professor Bietti of the University of Parma-Italy on behalf of WHO made a clinical survey on incidence of trachoma amongst Arab Refugees. Professor Bietti reported that the incidence of trachoma varied between sixty-six and ninety-four per cent in Jordan.

Classification of cases was according to McCallan classical four stages - he found that younger children suffer from stages I and II and older ages from stages III and IV.

No conjunctival smears were taken. The actual cause of blindness according to him was acute conjunctivitis - the latter disease is often superimposed on trachoma.

Professor Bietti quoted his impression that better food and hygiene are followed by improvement in clinical picture and even spontaneous recovery.

Trials of different Antibiotics and Chemotherapeutic agents, both locally and/or systematically were made by him and were repeated in schools on his recommendations under the supervision of Dr. Ferraris de Gaspere.

The findings, though very promising, were not conclusive. However, on the recommendation of Professor Bietti, the P.S. Ointment (Penicillin 2500 Un. and Streptomycin 2500 UN/Gm.) was introduced in therapy of trachoma and conjunctivitis in the Jordan Field since the end of 1951 and has been kept up to the present date.

The state of affairs has gradually improved in the field and personnel in charge of eye treatment have gained experience.

In 1954, the need was felt for more trained male nurses especially after some trained persons had resigned to join other organizations.

Arrangements were made with the St. John's Ophthalmic Hospital, Jerusalem, to give theoretical and practical training (three months' course) for male nurses from the Health Division.

This has continued satisfactorily and up to the present date twenty ophthalmic tamarjis have been trained and plans for further training are being made.

In 1956, Dr. Jamal Abdin, WHO Ophthalmic Consultant, EMRO, made a trachoma survey in Jordan (Refugees and non-refugees) and he submitted a plan for an anti-trachoma campaign. In this report, Dr. Jamal reports a high incidence of clinical trachoma (from fifty-three to ninety-three per cent).

However, the results of conjunctival smear examination in cases of clinical trachoma (T.I and T.II) revealed a low incidence of trachoma and a higher incidence of conjunctivitis due to other organisms (Morax Axenfeld, Koch-Weeks, Pneumococci, Gonococci, Staphylococci and Kerosis).

Late in 1956 a small group set up by the Medical Research Council and the Order of St. John's of Jerusalem in an attempt to isolate the virus by tissue culture carried on some work in trachoma (Dr. M. Gilkes) and came to the revolutionary conclusion that trachoma is not prevalent in Jordan and that when present it is relatively mild, and that the clinical picture of other communicable eye diseases could simulate the different stages of trachoma.

(In our opinion other regions than Jerusalem should be investigated on the same lines before any final plan for a campaign on trachoma is made).

Therefore for practical purposes and for scientific safeguard communicable eye cases should be taken as a total for statistical purposes.

CLINICAL FEATURES

(Trichiasis and ectropion).

Clinical features are those usually described in textbooks.

However patients only seek treatment when complications supervene

EPIDEMIOLOGICAL INFORMATION - ROLE OF ENVIRONMENTAL SANITATION AND RELEVANT STATISTICS

No information is available about the prevailing organisms except from the surveys of Dr. G. Abdin and Dr. M. Gilkes; these are:

Morax Axenfeld

Koch Weeks

Pneumococci

Gonococci

Staphylococci and Xerosis

Dr. M. Gilkes states that:

- (1) During the annual epidemic of acute conjunctivitis (from May to September) the already small number of inclusion positive cases was severely reduced.
- (2) No case was found with inclusions where a clinical purulent of mucopurulent conjunctivitis was present.
- (3) In cases with clinically free conjunctive and clinical trachoma IV, no inclusions were found.
 - (4) The virus was not isolated in Jordan.

Seasonal variations: Communicable eye diseases are present in Jordan all over the year, but the incidence is greatly increased in summer months, the peak being in August or September.

SOCIO ECONOMIC FACTORS AND SANITATION

Communicable eye diseases are associated with dirt and one wonders whether the fly plays as important a role as that of personal hygiene (usually both go together). It is certain that many still ignore the essentials of hygiene, frequent washing of hands, face, each using his own towel (if there is a towel at all) are definitely practised only by few. Dirty handkerchiefs are still used to wipe the face and eyes. The scene of a mother wiping her bables! eyes with the edge of her dress or cloth covering her head is still a common one. Covers for cushions are not the rule and if existing are not washed frequently and are usually shared by different members of the family. Rubbing the eyes with dirty fingers is a common practice. Uncovered faces of babies exposed to flies is also a common sight. Poverty is definitely an important factor, but many of the better off do not practise healthy habits either. Dr. Boase reports that measles is the main cause of blindness in Jordan. The current belief is that water should not come in contact with the sick child and many leave the children's faces unwashed for a long time where all the filth accumulates. Also applying of eye shadow (Kohl) by a bone rod to the eyes of babies is a common practice.

It is true that the majority of refugees in camps are at present living in built units (quite a lot having private latrines) with an increase in the number of public latrines but:

- (1) Promiscuous defaecation is still common.
- (2) Very few have got running water and have to fill in tins their daily needs from the main source or from open canals. In many localities water supply is very poor.
 - (3) In many places water is not chlorinated.

It should be mentioned that sanitation in camps has improved tremendously over the past few years and is far superior to the condition in villages but much remains to be done.

HEALTH EDUCATION

Seven Health Education workers are engaged by the Agency, one in each area (except Nablus area having two). These have had at least a three months! theoretical and practical training in Health Education and in the

major problems of the population. Many have got experience in community work.

The Health Education programme has been greatly developed over the past few years. Now most of the other Agency staff and many people know what is Health Education; cooperation of all concerned is easily sought.

It is no exaggeration to say that the sanitary conditions of camps in many aspects have been greatly improved due to this influence. Every year at the start of summer the so-called Anti-Fly Campaign and Clean-up Campaign are carried out in all camps.

Organized efforts are made to educate the public on the life cycle of the fly, on diseases transmitted by same and on how to prevent its breeding. Amongst other things the causes of ophthalmias and how to prevent them is taken care of very faithfully.

Activities go on in schools, general clinics, ophthalmic clinics, Maternal and Child Health Centres, market places, Community Development Centres, etc.

Talks, discussions by Health Education workers, medical officers, nurses, sanitary, food and welfare workers, camp leaders, ophthalmic tamarjis, demonstration of fly breeding (in jars), cinema shows, posters, slogans and other audio-visual aid materials are used liberally everywhere.

The efforts are very promising and we would venture to refer here to the table (A) we attribute the diminution of infection of eye cases in 1958 to these efforts. The decline so far obtained in 1959 is still more impressive.

School children are given special attention because of their influence on their families, and hence in summer courses for teachers some of the time is devoted to teaching the latter health education and its importance on the health of a nation.

During the winter months a campaign on "Nutrition" is carried out on the same lines.

RELEVANT STATISTICS AND EVALUATION OF THE PROGRAMME

The table attached hereto shows the incidence of all infections of eye diseases amongst refugees attending ophthalmic clinics per month over the past five years. From the table the following conclusion could be made. The 1958 attendance to clinics was lowest (vide above). In 1959 the number of cases so far is declining. The high peak of 1957 could be partly explained by the very hot summer and shortage of water.

A separate survey on the incidence of trachoma amongst school children was done during the present scholastic year by the School Medical Officer who worked in Nablus and Amman. Our comments on this Medical Officer is that he is efficient and that he has had lately a refresher course on eye diseases in St. John's Ophthalmic Hospital

The following are his findings:

Area	Month	Number Examined	Trachoma Incidence	Percentage
Nablus	October	2441	1272	52.1
ıı	November	3945	1144	29
11	December	4261	11.50	26.9
Amman	January	2955	1163	39•3
tt	February	1769	812	40
(I	March	4953	1674	33.7
IJ	Aprıl	3080	941	30.5
n	May	5348	236	4.4

This shows a smaller percentage of incidence "clinical" trachoma than was reported by Dr. Abdin in 1956.

ADMINISTRATION OF THE PROGRAMME

Forty-six ophthalmic clinics operate in Jordan of which twenty are in official camps for a total population of 214,000 and twenty-six clinics are in villages served by a mobile medical team twice a week.

In each of the ophthalmic clinics an orderly trained in eye diseases (ophthalmic tamarji) is posted there giving daily care for eye cases (full-time job). The work is directly supervised by the camp or district nurse. All eye cases come directly to the ophthalmic tamarji, only very serious cases are referred to the Medical Officer for further prescription of systemic drugs, or referred to the ophthalmologist or ophthalmic hospital for specialized treatment or operation.

Unfortunately medical officers who usually have a great amount of clinical work are unable to supervise constantly the work of the ophthal-mic tamarjis.

Ophthalmic tamarjis occasionally (whenever free) assume some duties in schools where they examine the eyes of school children and either give treatment in school or ask the head teacher to send the students to the clinic. They also take the opportunity while at school to give some talks on eye infections and how to prevent them.

As far as specialists and hospitalization are concerned, East and West Jordan have special arrangements.

In West Jordan, the St. John's Ophthalmic Hospital with its specialists serve the relugee population as well as the non-refugee population.

The <u>School Health Teams</u> have been contributing for diagnosis and treatment of eye cases among school children especially in remote village schools (where no Agency Medical Services are available). The suggestion that the orderly attached to the School Health Team should have ophthalmic training will be given full consideration.

<u>Laboratories</u> play no role in diagnosis or treatment of communicable eye diseases - neither in the clinic nor at the more specialized hospitals.

METHODS OF TREATMENT

At the St. John's Ophthalmic Hospital: Aureomycin Ophthalmic Ointment is used routinely for all cases.

At Agency Clinics:

For purulent cases: Boric Acid swabs)
Argyrol or Protargol) Several applications
P.S. Ointment)

For trachoma cases: Copper Sulphate or Zinc Sulphate drops
Penicillin-Streptomycin Ointment
Sulfacetamide Ointment
Yellow Oxide of Mercury Ointment

Argyrol Eye Ointment.

Severe c_{ℓ} ses or cases with complications are given aureomycin on recommendation of ophthalmologists.

EVALUATION OF WORK CARRIED OUT AT PRESENT

In fact, no proper evaluation of the work in the field has been done. But from the statistics discussed above, it is suggested that all the work of the past years is starting to bear fruit.

General recommendations for improvement are to promote all the preventive measures, to stimulate health education and to find cases with communicable eye diseases.

I think it appropriate to point out that the virus involved has recently been isolated and that it is hoped that a vaccine will soon be available.

GENERAL TOTAL OF ACUTE CONJUNCTIVITIS & TRACHOMA EYE DISLASES PER MONTH

YEAR	JANUARY	FEBRUARY	MARCH	APRIL	MAY	June	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMB ER
1954					11179	16968	26124	31806	35960	35477	18080	13884
1955	15825	12470	13396	14413	12420	22760	22817	32192	41716	28338	24097	14110
1956	11189	14886	11941	15233	14473	13878	16961	38141	32451	27528	14411	8875
1957	9130	10566	9973	10681	13784	15040	25099	30284	32006	27702	13292	7629
1958	8680	6922	8022	12866	15061	13589	18365	24633	33045	21042	15164	11869
1959	9413	8370	9928	9065	6703							

RECORD OF TRACHOMA & CONJUNCTIVITIS INCIDENCE FROM 1954 - 1959

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Amman Area	329	915	267	458	457	616	1053	1989	1277	1215	2890	2310	1066	1624	5253	5149
Irbed Area	184	93	207	111	292	150	683	354	286	260	346	439	476	535	1108	1234
FOTAL	4786	3894	4091	2831	4466	3556	13343	10281	7142	5724	7898	7163	6576	7013	21636	19900

	Ju	цу	Augu	ıst	Sep	otember	ਪੁ	uarter	00	tober	No	vember	$\overline{\mathbf{D}}$	ecember	Quar	rter		
	Trac	h.Conj	.Trach	.Conj	Track	o. Conj.	Tra	ch.Conj.	Trac	h.Conj.	Trac	h.Conj.	Trac	h. Conj.	Trach.	Conj.	GRANI Trach.	Conj.
195 J	<u>8</u> 366	553	429	992	587	1255	1382	2800	376	716	327	438	308	335	1011	1489	4181	6112
11	3401	3682	4125	5083	4156	5619	11682	14384	2870	309 2	3386	2670	2898	2101	9154	7863	35497	31207
H	207	420	241	1237	334	1860	782	3517	264	1013	158	367	107	272	5 29	1652	2150	6534
J	1922	2623	1832	3554	1800	4275	5554	10452	1098	2676	851	2055	881	1722	2830	6453	17978	26212
A	1197	2483	1615	3875	3082	8741	5894	15099	1784	6032	`1105	3098	1227	1494	4116	10624	16316	32861
I	576	935	540	1110	524	812	1640	2857	595	526	386	323	330	194	1311	1043	4742	548 8
************	7669	10696	8782	15851	10483	22562	26943	49109	6987	14055	6213	8951	5751	6118	18951	29124	80864	108414

AREA & YEAR		nuary h.Conj		bruary h.Conj		r <u>ch</u> n •Conj	4 '	arter n.Conj.	Apr Trach	ul .Conj.	<u>M</u> e Track	y .Conj.
1959					***************************************	······································				···		
Jerusalem Area	293	179	225	166	172	181	690	526	283	235	135	76
Nablus Area	2243	989	1849	852	2423	1263	6515	3104	2336	1224	1694	741
Hebron Area	126	148	117	152	129	189	372	489	126	191	76	87
Jericho Area	2059	1345	1056	1434	994	1798	5907	4577	875	987	1204	834
Amman Area	8 38	897	983	1185	1107	1181	2928	3263	1101	1326	936	713
Irbed Area	219	77	178	173	211	280	608	530	259	122	174	33
TOTAL	5778	3635	4408	3962	5036	4892	17020	12489	4980	4085	4219	2484