FIG. 1.—A new arrival in the camp prepares to set up his tent.

ARAB REFUGEES: MEDICAL RELIEF WORK IN JORDAN

BY

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At the time of writing (March, 1950) more than 300,000 Arab refugees from Palestine are dispersed through Syria, Lebanon, and Transjordan. The following remarks apply in particular to Transjordan, or, more currently, the Hashemite Kingdom of Jordan, which contains some 90,000 refugees. Here the medical service for refugees has been entrusted to the British Red Cross Society, working in conjunction with the League of the National Red Cross Societies.

A few of the refugees were professional men, business men, or wealthy landowners in Palestine, and some of these have found work in their new surroundings, often with the Red Cross. Many more were poor peasants, and most of these now find themselves workless and often penniless, with only the U.N. monthly food ration between them and starvation. Some are living in huge tented camps run by the Red Cross (Figs. 1 and 2), one such camp in the Jordan valley containing more than 15,000 persons. A larger number have been able to rent a room in the mud-brick villages, a family of twelve often sharing a single room. Others have rented caves, while the less fortunate exist in wretched patched-up tents on the outskirts of the villages. The Bedouin have perhaps suffered least, having simply moved their goat-hair tents across the border; but even they have lost land, grazing rights, or cattle.

So far, measures for the welfare of refugees have been confined to the immediate necessities of relief. The Red Cross distributes the monthly U.N. food ration, generous in flour but otherwise meagre, a limited amount of clothing, and provides a medical service. Supplementary food centres where hot meals are served have been set up at some points, as well as milk centres for infants, children, and maternity cases. The feeding and medical services have proved adequate to meet the emergency. Gross malnutrition is not now seen, and the standard of health of refugees is probably not lower than that of the local population. Supplies of clothing, however, fell short of demand, and many refugees went cold in winter. The winter of 1949–50 will long be remembered for the heavy fall of snow, which

was not as usual confined to the uplands but embraced even the shores of the Dead Sea itself.

Medical Service Provided

In Jordan two 50-bed hospitals—one at Irbed and one at El Salt—and two mobile medical units were set up. In addition, doctors and nurses were provided for the tented camps, and antimalarial work was carried out by a squad of D.D.T. sprayers, who worked under the supervision of a malariologist. In the camps schools are run by refugee teachers. The largest camp enjoys a mosque and a market, and generally shows signs of becoming a permanent settlement.

Each mobile unit comprises one ambulance, a doctor, two nurses, and an assortment of medical boxes. These units tour their districts, setting up clinics in the villages and generally visiting one or two villages in a day. Conditions of work are severe. Most of the roads of the country are rough stony tracks, suitable only for camels or horses. The motorist is half choked by dust in summer. In winter he must run the gauntlet of mud, and must be prepared for monstrous bumps at all times. On arrival in the village a mud-brick room is hastily converted into a clinic, and 300 patients may be seen in the next four hours. An attendance of 150 is common. Unfortunately, a number of patients attend to "take a look" or from natural reluctance to be absent from any free distribution—an aspect of relief work that has to be carefully watched. The mobile unit teams may be entertained to lunch by the village headman or by Bedouin tribesmen in their tents. In spite of the heavy work, the mobile units provide the best means of seeing the country and getting to know the people, and in consequence are popular with nursing personnel.

The Diseases Treated

The diseases seen are those general throughout the Middle East. In the present heyday of therapeutics it must always be remembered that the final remedy lies not in the application of specifics but in public-health measures and raising the general standard of living. Indeed, there is a

FIG. 2.—Refugee camp in the Jordan Valley.

FIG. 3.—The camp eye clinic.

danger that the unthinking application of specifics may actually hamper progress. Thus, infested clothing is now dusted with D.D.T. as an alternative to regular washing. Research workers continue to seek the ideal specific for schistosomiasis, while the proper remedy, the prevention of the discharge of urine and faeces into surface water, is already to hand. These examples could be multiplied indefinitely.

Among the refugees malaria and eye disease (Fig. 3) are the two great scourges, with dysentery third. The skins of the poorer refugees are speckled with haemorrhagic petechiae from flea-bites, and lousiness is general. Septic skin conditions are common, especially a crusty impetigo of the scalp or chin in children, favoured by contact with unlaundered head-cloths. Gingivitis is common, especially in the camps. Hysteria and neurosis are not infrequent, but neurological disease is rare. With the exception of diabetes mellitus, endocrine disease seems scarcely to occur. Peptic ulcer is common, the interminable cups of black coffee being perhaps a predisposing factor. Only one case of cerebral vascular catastrophe was seen in nearly six months of busy hospital and clinic work. In the same period there was only one case of gonorrhoea, and not a single fresh case of syphilis. This is the consequence of the strict sex morality of the Arabs. An unmarried girl who becomes pregnant must flee or risk death from her father's dagger. Two cases of cancrum oris were seen, both associated with splenomegaly, and one case of hydatid disease. Schistosomiasis and leishmaniasis were practically non-existent, but splenomegaly was extremely common, even in young children. One wonders if these cases were not too readily ascribed to chronic malaria. Of the infectious diseases, measles and whooping-cough were troublesome, typhoid fever occurred sporadically, while typhus was not seen. Mass inoculation against diphtheria, typhoid, and smallpox was attempted, but reached only a small proportion of the refugees in Jordan.

Tuberculosis was seen frequently in all its forms with the exception of miliary and meningitic. Abdominal and bone tuberculosis seemed especially common. Owing to the small number of hospital beds most of the cases diagnosed had to be returned to their crowded room or tent with only a bottle of cod-liver oil for succour. It is probably this lack of hospital treatment which made the incidence of tuberculosis appear so high to the medical observer. It was strange to see the spotless and efficient Scandinavian B.C.G. teams at work among ragged Arab children, and a surprise to learn their results. Only 13.5% of the children tested in Jordan were tuberculin-positive.

Antimalarial work has been confined to residual spraying of tents and houses with D.D.T. Undoubtedly this has

resulted in a reduction in the number of fresh cases. Clinical malaria, however, continued to be general throughout the villages of the Jordan valley in the malaria season. More than a hundred cases were sometimes seen at a single village clinic, often of a most virulent type. It seems that D.D.T. spraying of living quarters is not enough, and should be combined with spraying of breeding-grounds, as was done in Egypt and Cyprus. In the Jordan valley a campaign of this kind would founder if confined to one side of the narrow stream. This raises awkward problems of co-operation between Arab and Israeli health authorities. Probably the only way to achieve a quick result lies in the issue of proguanil to refugees in suppressive doses (mepacrine is likely to be used as a dye for head-dresses, and is therefore taboo). Ideally, chemists might be called in to advise on the possibility of mixing powdered proguanil with some item of the dry rations, thus obviating a black market in proguanil and ensuring that the drug is taken. Refugees sometimes keep tablets tightly wrapped in some corner of their clothing, and proudly display their hoard to the doctor weeks later.

The Arab's Attitude to Disease

To the Arab mind every disease has its remedy, injections and surgery being the two great avenues leading to cure. Tablets and medicines are usually scorned, and every third patient given these will demand an injection instead. On one occasion a father carried his sick son from doctor to doctor in a small town inquiring the price of "an injection" at each, until finally one was offered that suited his purse. This excessive reverence for the syringe is shared by the better-class Arabs. A wise old sheikh questioned on the matter did not hesitate to lay the blame for this attitude at the door of the medical profession. The situation has now reached such a pitch that many patients would refuse to pay their doctor unless treated by injection therapy.

If the Arab is told his disease is incurable he does not accept this decision, but resorts to remedies of his own. Indeed, these are often employed before consulting the Westernized doctor. The favourite remedy is some form of cautery applied to the skin, and the bodies of the poorer Arabs bear their medical histories literally branded on to their skins. Examples seen are branding over the spleen for splenomegaly, in the suprapubic area for menorrhagia, or over the leg for gangrene of the toes. Parallel rows of skin incisions are often inflicted on children for fever. Occasionally the services of an infamous type of witch-doctor are sought, who employ such methods as chaining and flogging, usually in cases of mental disease. Other Arab medicine men have achieved a considerable reputation in setting fractured bones. A mixture of goats' hair and white of egg is used to make a plaster, reinforced by pieces of bamboo. Ignorance regarding the limitations of surgery is general, and many people suffering from incurable medical diseases believe they could be cured by the knife.

The Arab Refugee

Refugee relief work inevitably carries some unpleasantness in its train. Resources of food, clothing, and hospital accommodation never seem equal to demand. The destitute refugee naturally resorts to every device at his command to obtain as much of the available bounty as possible for himself and his family. Ration cards and birth certificates multiply in geometrical progression, while notices of deaths are suppressed. The issue of new food cards or clothing is likely to end in free fighting. This constant undercurrent of suspicion, combined often with overwork, wears down

the nerves of many a relief worker, and may unfairly colour his judgment.

Considering his wretched circumstances, the Arab refugee is often a fine and pleasant individual. In generosity, in religious devotion, and in the ability to play the part of host, he excels. Refugees show their gratitude by gifts of fruit, eggs, live pigeons, and even horses. Against these qualities their blind faith in destiny or Allah encourages a fatal *laissez faire* attitude of mind. In fact, their religion seems to perpetuate the natural inability of the nomad to organize or to help himself. For the simple nomadic or agricultural life this is perhaps no disadvantage. In the bitter struggle for existence which the present day has forced on the Arabs this attitude of mind may well prove their undoing.

To sum up, the immediate necessities of relief have been met, and, considering the magnitude of the operation, met well. Work for this mass of unemployed people must now be found, and is, in fact, overdue. A scheme for resettlement in their countries of adoption already exists on paper in the form of the proposals of the Clapp Commission. The eyes of all are now turned to the United Nations to provide financial backing for these long-term projects of lasting benefit.

If the opportunity is seized perhaps some benefit may still be won from the disaster of the Arab refugees.

I wish to express my thanks to Dr. C. Draper, late of British Red Cross, for the use of his photographs. I also wish to thank the unknown photographers whose prints have come into my possession.

MEDICINE IN YUGOSLAVIA

BY

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It is now almost five years since the foundations of an association between plastic surgery in Yugoslavia and in Britain were laid by Sir Harold Gillies. Shortly after his visit a team consisting of a surgeon, an anaesthetist, a dental surgeon, and a nursing sister was sent from this country to establish a unit at a relatively new hospital on the outskirts of Belgrade. This team was followed by others over a period of about two years, and during that time we had the opportunity of training several Yugoslavian surgeons in this country. They returned to carry on the good work after the withdrawal of our men. Periodic visits on a relatively small scale have been made since that time, and two of us have recently returned after a comprehensive tour of the country. This trip, like its predecessors, was arranged at the instigation of the Yugoslavian Ministry of Health, and the details of it were carried out through the good offices of the British Council in London and in Yugoslavia.

The itinerary included Zagreb in the north, Ljubljana in the north west, Split and Dubrovnik on the Dalmatian Coast, Sarajevo in Bosnia Herzegovina, and finally Belgrade, the capital. With the exception of the somewhat sparsely populated region in the extreme south east, we had the opportunity of seeing conditions throughout the greater part of the country. We were therefore made familiar with the many facets of the problem of providing hospital services under differing circumstances.

We made contact with the local practitioners, usually through their own association but also through the academies which correspond in part with the senate of

Dubrovnik (Ragusa) in Dalmatia.

a university in this country. We were enabled to visit hospitals and clinics, some of which we saw by arrangement and others without previous warning. Lectures were given in both anaesthesia and plastic surgery, and these proved to be extremely popular—it was indeed not uncommon to have more than 95% of the available doctors present at any lecture. Everywhere we met with overwhelming hospitality and with good will.

Problems of Medical Practice

It would be invidious to suppose that such a visit could give an accurate and clear-cut picture of all medical problems facing Yugoslavia. It would be an impertinence to draw conclusions of a major character from such a kaleidoscope of impressions. Indeed, we are too close as yet to our experiences to do much more than record what has been seen and done.

The first outstanding problem is that of providing a population of 16,000,000 with a full-scale, full-time, medical service when there are only about 4,000 qualified medical men. A great number of them serve in military hospitals, but no distinction is made between any hospital in the country over the admission or treatment of patients. Although the administration of two adjacent hospitals may differ, the function of these hospitals and the types of patients seen in them will be much the same. Wherever such a group of hospitals exists it is usually served by a large polyclinic which relieves the hospitals of practically all their out-patient work. The staff of the polyclinics and the hospitals is the same, and such an arrangement appears to result in continuity of treatment.

The great proportion of the doctors appear to have received at least part of their training in Austria or in Germany. A few have worked in France or Switzerland. For the past ten years all of them have been completely cut off from any opportunity for postgraduate refresher work, and they have lacked current literature from the countries in which they were trained. Apart from this, most of them were actively engaged in military work, and in many cases they were not employed as doctors; even if they were, their doctoring was occasionally subsidiary to active military commitments. As a whole the practitioners are relatively young men with an extremely sound basic training, but all suffer (and are aware of the defect) from having been unable to keep up with the detailed developments of the past ten years.

The next problem is that "middle staff," as nurses and other ancillary workers are called, is almost completely lacking. In common with many other European countries,