

Assessment of Knowledge and Practice of Various Eye Diseases in Sulaimani: A Descriptive Study

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Abstract: Knowledge and practice of public, especially patients about eye diseases are important to reduce magnitude of human blindness. Vision and sight are very essential because they allow us to connect to each other's. In accordance to the recently published data; the estimation of 253 million people lives with vision impairment, 36 million are blind and 217 million suffer from moderate to severe vision impairment. A descriptive cross-sectional study was conducted at Shahid Dr. Aso Hospital in Sulaimani city-Iraq, from April to August 2017 by face-to-face interview through close ended questionnaire for data collecting. All data were analyzed by Statistical Package for Social Sciences version 22.0 software. P-value of < 0.05 was considered as a statistically significant. A total of 430 patients were randomly chosen to participate in the study. They were 254 (59.1%) males and 176 (40.9%) females. 76.7% of respondents was worrying about vision loss, 0.7% was worrying about hair loss. Of the participants, 32.8% was with a good knowledge level and 40.5% was with a poor knowledge level, as well as 3.1% was in a good practice and 58.8% was in a poor practice level. Female knowledge mean score was 9.53 ± 4.96 and male knowledge mean score was 8.42 ± 5.45 , the practice mean score of males was 4.33 ± 1.96 and mean practice score of females was 4.13 ± 1.93 . The study data indicate the worrying of participates about vision loss is in the highest proportion and the awareness and practice of patients about eye diseases is unsatisfactory. Health education campaigns are needed to improve personal awareness about vision related problems and for better eye health.

Keywords: Cataract, Glaucoma, Vision, Knowledge, Practice, Prevention.

1. INTRODUCTION

Globally, eye diseases and blindness are the important public health problem because they cause human disability that is resulting enormous social and economic consequences [1]. Vision and sight are very essential because they allow us to connect with each other's and also it is vital in how we view the world around us and interpret the colors, shapes, and dimension of objectives. Loosing of vision has a negative effect on the quality of life. It has been demonstrated in relation with different eye conditions such as cataract [2, 3], age related macular degeneration [4], and diabetic eye disease [5]. As by increasing the world population and average of life expectancy, the prevalence of visual impairment and blindness was increased [6]. In accordance to the recently published data, the estimation of 253 million people lives with vision impairment; 217 million suffer from moderate to severe vision impairment and 36 million are blind [7, 8]. An estimating 82% of all blind people are from those with 50 years old or older, and the major causes of visual impairment are uncorrected refractive errors by 43% and cataract by 33%; the most common cause of blindness is by cataract (51%) [9]. Good knowledge of people about eye related health and some practices such as a regular eye examination and using of appropriate treatment are necessary, and both of knowledge and practice are a good indicator to determine the community expectation about eye care [10]. Several studies have been conducted to assess and determine the level of awareness and practice through the developed and developing countries [11-14]. There is no available survey on the awareness and practice on eye disease in Iraq. Therefore, the objective of current study is to determine the level of knowledge and practice about various eye disease among eye patients at Sulaimani city in Iraq.

2. METHODS AND MATERIALS

Study population: A descriptive and cross-sectional survey based study was conducted from April to August 2017 in Sulaimani, Kurdistan region of Iraq. In this study, 430 eye patients were randomly selected, their ages were ranging between 10 and 87 years old from Shahid Dr. Aso Hospital. The data was collected by face to face interview through close-ended questionnaire. The participants were allowed to respond at their convenience and adequate time and in the consideration to their confidentiality. Also, the study's participation was completely voluntary. Oral consent was taken from each participant, patients were informed about the nature of the study and official permission was also taken from the hospital's ethics committee. The patients not willing to participate in the study are excluded. The study was reviewed and approved by an ethics committee at Technical College of Health in Sulaimani Polytechnic University.

Data Collection Methods. A total of 43 study question was prepared and reviewed by two experts from Technical College of Health. The survey was originally created in the Kurdish language. The study questionnaire was divided into several sections which are: the socio-demographic characteristics of the participants, distribution of eye problems among participants, the most worry about losing of human body part, and their knowledge and practices about eye diseases. The participants' demographics are (age, gender, race, marital status, education and occupation). A pilot study was conducted to check questionnaire length and level of understanding of patients to study questionnaire. A questionnaire was anonymous and didn't require any identity and all data were kept confidential. Section regarding knowledge about diseases consists of 18 questions. The participants could choose between three predetermined options which were (Yes), (No) and (Do not know). Each correct answer received one points and zero point for incorrect and (Do not know) answers. The scale classified knowledge levels as: poor knowledge level from 0-6 points, moderate knowledge level from 7-12 points and good knowledge level from 13-18 points. Section about practices towards eye disease, which contains of 12 questions, the participants had two predetermined options to choose between which were (Yes) and (No). Each correct answer received one points and zero points for incorrect answers. The scores of practices were classified also into three levels: poor, moderate, and good level.

Statistical Analysis. Statistical analysis was performed using the SPSS program (SPSS for Windows, version 22.0). Descriptive statistics were used to illustrate respondents' demographic characteristics and the results were presented as the frequencies and percentage. The continuous variables were expressed as mean \pm standard deviation, while categorical variables were measured as percentages. Pearson chi-square test (χ^2) was used to determine if data were significant differences between the age groups in related to the history of some eye disease, compare knowledge and practice level and demographic characteristics as well as compare of some eye disease and

knowledge and practice level. Test results with p-value of <0.05 were accepted as statistically significant.

3. RESULTS

Socio-demographic characteristics

The individual characteristics of eye patients are presented Table 1. A total of 430 eye patients participated in the study. Of these, mean age of the study was 42.76 ± 21.25 years with age range of 77 years. Age groups of ≥ 60 years was the highest percentage 122 (28.4) and age groups of < 20 years old was the lowest percentage (22%). Males was the dominant gender 254 (59.1%) and female gender was (40.9%). One hundred and seventy (39.5%) were unemployed and vast majority 291(67.7) were from urban population and rural population was (21.6%). More than half of participants 256(59.6%) had both illiterate and primary level of education. Thirty (7.0%) currently every day smoker and 27(6.3%) currently someday drinking. Previous eye treatment and previous eye injury/surgery was 265 (61.6%) and 262 (60.9%) respectively.

Table1: Individual characteristics of participants
(No.= 430)

Characteristics	n	(%)
Age (Years)		
<20	95	(22.1)
20-39	103	(24.0)
40-59	110	(25.6)
≥ 60	122	(28.4)
Gender		
Male	254	(59.1)
Female	176	(40.9)
Occupation		
Unemployed	170	(39.5)
Government employee	59	(13.7)
Students	104	(24.2)
Others	97	(22.6)
Residence		
Urban	291	(67.7)
Semi Urban	46	(10.7)
Rural	93	(21.6)
Marital status		
Married	279	(64.9)
Unmarried	151	(35.1)
Education		
Illiterate	137	(31.9)
Primary	119	(27.7)
High school	112	(26.0)
University	62	(14.4)
Smoking history		
Every day smoking	30	(7.0)
Someday smoking	35	(8.1)
Former smoking	64	(14.9)
Never smoking	301	(70.0)
Drinking history		
Every day drinking	5	(1.2)
Someday drinking	27	(6.3)
Former drinking	7	(1.6)
Never drinking	391	(90.9)
Previous eye treatment	265	(61.6)
Previous eye injury/surgery	262	(60.9)

Distribution of eye diseases among participants

As shown in Table 2, the highest percentage of participants had Sunlight sensitivity 296 (68.8) and difference between the 4 groups was significant ($P < 0.05$), as age groups of ≥ 60 was in a higher percentage. Eye stain comes in second most prevalent by 244 (56.7). 219 (5.9) had itchy/watery eyes and the difference between age groups was significant ($P < 0.05$). Only 67(15.6%) of participants had conjunctivitis and difference between the 4 groups was significant ($P < 0.05$), as groups of ≥ 60 years had the highest percentage (8.01%). The study results show no significant difference between age groups and eye infection, eye strain and dry eye diseases.

Table 2: Distribution of eye diseases among participants by age groups.

Eye diseases	Age groups								P-Value	Total	
	<20		20-39		40-59		≥ 60			n	%
	n	%	n	%	n	%	n	%			
Sunlight Sensitivity											
Yes	38	(8.8)	66	(15.3)	81	(18.8)	111	(25.8)	<0.05	296	(68.8)
No	57	(13.3)	37	(8.6)	29	(6.7)	11	(2.6)		134	(31.2)
Conjunctivitis											
Yes	6	(1.4)	10	(2.3)	16	(3.7)	35	(8.1)	<0.05	67	(15.6)
No	89	(20.7)	93	(21.6)	94	(21.9)	87	(20.2)		363	(84.4)
Cataract											
Yes	1	(0.2)	15	(3.5)	44	(10.2)	90	(20.9)	<0.05	150	(34.9)
No	94	(21.9)	88	(20.5)	66	(15.3)	32	(7.4)		280	(65.1)
Glaucoma											
Yes	0	(0)	5	(1.2)	18	(4.2)	52	(12.1)	<0.05	75	(17.4)
No	95	(22.1)	98	(22.8)	92	(21.4)	70	(16.3)		355	(82.6)
Eye Infection											
Yes	10	(2.3)	23	(5.3)	18	(4.2)	18	(4.2)	0.149	69	(16.0)
No	85	(19.8)	80	(18.6)	92	(21.4)	104	(24.2)		361	(84.0)
Blurred vision/Distant											
Yes	12	(2.8)	23	(5.3)	37	(8.6)	72	(16.7)	<0.05	144	(33.5)
No	83	(19.3)	80	(18.6)	73	(17.0)	50	(11.6)		286	(66.5)
Blurred vision/Near											
Yes	14	(3.3)	33	(7.7)	71	(16.5)	96	(22.3)	<0.05	214	(49.8)
No	81	(18.8)	70	(16.3)	39	(9.1)	26	(6.0)		216	(50.2)
Eye Strain											
Yes	30	(11.6)	35	(12.8)	39	(13.7)	80	(18.6)	0.143	244	(56.7)
No	45	(10.5)	48	(11.2)	51	(11.9)	42	(9.8)		186	(43.3)
Dry eye											
Yes	44	(10.2)	51	(11.9)	50	(11.6)	70	(16.3)	0.252	215	(50.0)
No	51	(11.9)	52	(12.1)	60	(14.0)	52	(12.1)		215	(50.0)
Itchy/watery eyes											
Yes	26	(6.0)	41	(9.5)	61	(14.2)	91	(21.2)	<0.05	219	(50.9)
No	69	(16.0)	62	(14.4)	49	(11.4)	31	(7.2)		211	(49.1)

Worrying about loss human body part

Figure 1 shows the most worrying about loss human body part by participants, of these 330(76.7%) was worry about vision loss and then worry about memory loss by 39(9.1%). The smallest percentage was about hair loss by 3(0.7%).

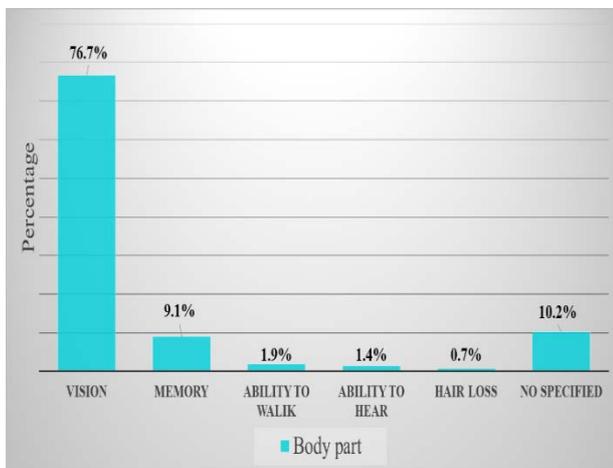


Figure 1: Most worry about losing body parts

Knowledge and practice level about eye disease

Figure 2 shows level score knowledge and practice of participants, as figure shows 32.8% of participants had good knowledge regarding various eye disease and 40.5% with poor knowledge. As well as only 3.1% of participants had good practice level score and 58.8% of participants had poor practice level toward eye disease. The result of our study shows that almost one quarter of participants had medium knowledge level and nearly one third of patients had moderate practice score level about eye diseases.

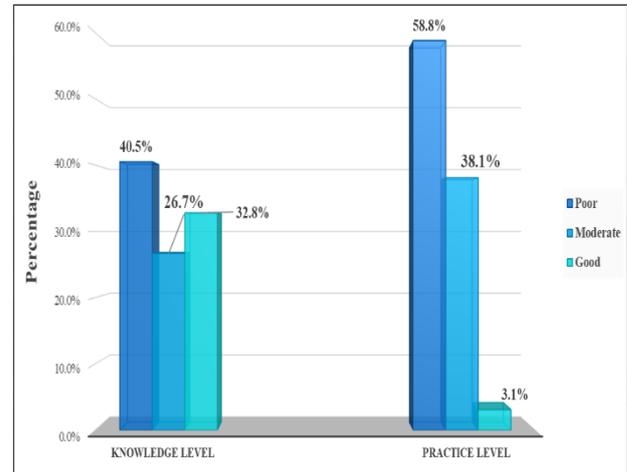


Figure 2: Knowledge and practice level score.

Association between individual variables with knowledge and practice level

Table 3 shows the differences between personal characteristic of participants with knowledge and practice level score. As table shows there are significant difference (P -value = < 0.05) between knowledge level and age groups, as the age group of 20-39 years had more knowledge than other groups and group of < 20 years had higher percentage of poor knowledge level. Also, the table shows that non-employed personal had higher knowledge level (10.2%), while group of governments employed personal had lowest knowledge level (2.8%) and the difference is significant (P -value < 0.05).

Participant those with higher school and university education had more knowledge than others, but illiterate and primary education had less knowledge and the differences are also significant.

Participants with both previous eye treatment and previous eye injury had poor knowledge with percentage of (23.7%) and (23.3%) respectively, while good knowledge percentages are (18.8%) and (18.4%) respectively, also the differences are statistically significant (P -value < 0.05). Regarding practice level score, table 3 shows that very small percentage of participants had good practice toward eye disease, while majority of patients had either poor or moderate practice level score and there are statistical significant different (P -value < 0.05) between practice level and type of occupation, residency, level of education, previous eye treatment and previous eye injury. On the other hand, the

study results did not find any differences between practice level and other individual variables such as age groups, gender, marital status, and both of smoking and drinking history.

Table 3: Association between individual variables with knowledge and practice level.

Variables	Knowledge level			P-Value	Practice level			P-Value
	Poor n (%)	Moderate n (%)	Good n (%)		Poor n (%)	Moderate n (%)	Good n (%)	
Age group								
< 20	63 (14.7)	13 (3.0)	19 (4.4)		66 (15.3)	27 (6.3)	2 (0.5)	
20-39	16 (3.7)	27 (6.3)	60 (14.0)		53 (12.3)	46 (10.7)	4 (0.9)	
40-59	38 (8.8)	33 (7.7)	39 (9.1)	< 0.05	63 (14.7)	43 (10.0)	4 (0.9)	0.304
>60	57 (13.3)	42 (9.8)	23 (5.3)		71 (16.5)	48 (11.2)	3 (0.7)	
Gender								
Male	113 (26.3)	63 (14.7)	78 (18.1)		153 (35.6)	90 (20.9)	112 (6)	
Female	61 (14.2)	32 (12.1)	63 (14.7)	0.124	100 (23.3)	74 (17.2)	2 (0.5)	0.086
Occupation								
Non employed	80 (18.6)	46 (10.7)	44 (10.2)		92 (21.4)	76 (17.7)	2 (0.5)	
Government	12 (2.8)	10 (2.3)	37 (8.6)	< 0.05	22 (5.1)	32 (7.4)	5 (1.2)	< 0.05
Student	55 (12.8)	15 (3.5)	34 (7.9)		70 (16.3)	31 (7.2)	3 (0.7)	
Others	27 (6.3)	15 (3.5)	34 (7.9)		69 (16.0)	25 (5.8)	3 (0.7)	
Residence								
Urban	105 (24.4)	73 (17.0)	113 (26.3)		155 (36.0)	124 (28.8)	12 (2.8)	
Semi urban	18 (4.2)	16 (3.7)	12 (2.8)	< 0.05	31 (7.2)	14 (3.3)	1 (0.2)	< 0.05
Rural	51 (11.9)	26 (6.0)	16 (3.7)		67 (15.6)	26 (6.0)	0	
Marital status								
Married	100 (23.3)	84 (19.5)	95 (22.1)		155 (36.0)	115 (26.7)	9 (2.1)	
Un married	74 (17.2)	31 (7.2)	46 (10.7)	< 0.05	98 (22.8)	49 (11.4)	4 (0.9)	0.171
Education								
Illiterate	70 (16.3)	47 (10.9)	20 (4.7)		98 (22.8)	38 (8.8)	1 (0.2)	
Primary	54 (12.6)	33 (7.7)	32 (7.4)	< 0.05	76 (17.7)	41 (9.5)	2 (0.5)	< 0.05
High school	42 (9.8)	25 (5.8)	45 (10.5)		55 (12.8)	33 (12.3)	4 (0.9)	
University	8 (1.9)	10 (2.3)	44 (10.2)		24 (5.6)	32 (7.4)	6 (1.4)	
Smoking history								
Current smoking	13 (3.0)	11 (2.6)	6 (1.4)		18 (4.2)	10 (2.3)	2 (0.5)	
Current non smoking	15 (3.5)	6 (1.4)	14 (3.3)	0.497	15 (3.5)	20 (4.7)	0	0.222
Former smoker	25 (5.8)	20 (4.7)	19 (4.4)		41 (9.5)	21 (4.9)	2 (0.5)	
Never smoker	121 (28.1)	78 (18.1)	102 (23.7)		179 (41.6)	113 (26.3)	9 (2.1)	
Drinking history								
Current drinking	2 (0.5)	3 (0.7)	0		1 (0.2)	4 (0.9)	0	
Current non drinking	8 (1.9)	6 (1.4)	13 (3.0)	0.175	15 (3.5)	10 (2.3)	2 (0.5)	0.436
Former drinking	1 (0.2)	3 (0.7)	3 (0.7)		4 (0.9)	3 (0.7)	0	
Never drinking	163 (37.9)	108 (24.0)	125 (29.1)		233 (54.2)	147 (34.2)	11 (2.6)	
Previous eye treatment								
Yes	102 (23.7)	82 (19.1)	81 (18.8)	< 0.05	138 (32.1)	118 (27.4)	9 (2.1)	< 0.05
No	72 (16.7)	33 (7.7)	60 (14.0)		115 (26.7)	46 (10.7)	4 (0.9)	
Previous eye injury								
Yes	100 (23.3)	83 (19.3)	79 (18.4)	< 0.05	136 (31.6)	116 (27.0)	10 (2.3)	< 0.05
No	74 (17.2)	32 (7.4)	62 (14.4)		117 (27.2)	48 (11.2)	3 (0.7)	

Association of various eye disease with knowledge and practice level

As table 4 shows the association of eye disease of participants with their knowledge and practice level score, glaucoma patients had (20%) good knowledge level, while (49.3%) had poor knowledge and the difference is statistically significant (P-value < 0.5). In addition, good knowledge for blurred vision/distant, dry eye and itchy/watery eye was (24.3%), (23.3%), and (27.4%) respectively, as well as their poor knowledge was (39.6%), (24.2%), and (41.1%) respectively; the results also was statistical significant (P-value < 0.5).

The study results show that no statistical significant differences between knowledge level score of patients with sunlight sensitivity, conjunctivitis, cataract, eye infection, blurred vision/near and dry eye diseases. Regarding practice level score, patients with sunlight sensitivity had higher percentage with poor practice (56.8%), while only (2%) had good practice score level and the difference was significant (P-value < 0.05).

Eye infection patients had zero practice score, while (49.3%) with poor practice level and the result is statistically significant (P-value < 0.05). Furthermore, patients with blurred vision/distant and dry eye had good practice level (3.5%) and (1.4%) respectively, and their poor practice level with percentage of (48.6%) and (63.7%) respectively, the results are also significant (P-value < 0.05). The detail of other results was shown in table 4.

Table 4: Association of eye disease patients with knowledge and practice score.

Disease	Knowledge level			P-Value	Practice level			P-Value
	Poor n (%)	Moderate n (%)	Good n (%)		Poor n (%)	Moderate n (%)	Good n (%)	
Sunlight sensitivity	116 (39.2)	86 (29.1)	94 (31.8)	0.274	168 (56.8)	122 (41.2)	6 (2.0)	< 0.05
Conjunctivitis	30 (44.8)	16 (23.9)	21 (31.3)	0.719	35 (52.2)	30 (44.8)	2 (3.0)	0.471
Cataract	64 (42.7)	46 (30.7)	40 (26.6)	0.120	90 (60.0)	59 (39.3)	1 (0.7)	0.112
Chorreas	37 (49.3)	23 (30.7)	15 (20.0)	< 0.05	38 (50.7)	34 (45.3)	3 (4.0)	0.279
Eye infection	29 (42.0)	14 (20.3)	26 (37.7)	0.381	34 (49.3)	35 (50.7)	0	< 0.05
Blurred vision/ Distant	57 (39.6)	52 (36.1)	35 (24.3)	< 0.05	70 (48.6)	69 (47.9)	5 (3.5)	< 0.05
Blurred vision/ Near	51 (42.5)	56 (26.2)	67 (31.3)	0.676	123 (57.5)	87 (40.7)	4 (1.9)	0.257
Eye strain	104 (42.6)	62 (25.4)	78 (32.0)	0.565	146 (59.8)	92 (37.7)	6 (2.5)	0.699
Dry eye	113 (52.6)	52 (24.2)	50 (23.3)	< 0.05	137 (63.7)	75 (34.9)	3 (1.4)	< 0.05
Itchy/ Watery eyes	90 (41.1)	69 (31.5)	60 (27.4)	< 0.05	129 (58.9)	85 (38.8)	5 (2.3)	0.650

4. DISCUSSION

To the best of our knowledge, our study is the first study examined the knowledge and practice about common eye disease amongst eye patients in Iraq. People at different age groups facing differently many vision disorders [15]. Although eye problems may affect anyone but several eye problem are more common as people age like; cataract, glaucoma, diabetic retinopathy, retinal detachment and conjunctivitis [16]. Part of this study is to determine distribution of various eye diseases among participants, the result of this study revealed that increase of eye problem with increasing of age as age from 40 and older had higher proportion of all type of eye disease, the study result is consistent with the study assessed age-related diseases in United State [17] and the study conducted in India [18]. There is major impact on people from all ages in our community as a result of vision disorders. Young children, adolescents, teenagers, adults, and the elderly people all are affected. The proportion, types of eye problem and their effect on human vary among different age groups, but to decrease the deterioration or secondary outcomes mostly needs special management.

Most of people think that vision is so important to see objects from front us, vision helps us to sew, read, write, paint and watching everything. William Shakespeare once said "The Eyes are the window to your soul ". Many people worry about their health so sight is being more worrying about losing. The study result show that vast majority of patients (76.7%) worried about vision loss rather than loss of other human parts. No relevant study was found in Eastern Mediterranean Region, but numerous researches conducted in developed world to examine the impact of sight loss on human life [19-21].

Similarly, a study conducted in USA, reported worrying about loss eyesight is greater than loss of limb, memory, hearing and speech[22]. Both temporary and long term psychopathology have been reported as a result of visual restoration and blindness [23]. Many eye disease appears without any previous symptom and become more complicated at stage when there is limited effective of treatment. Some of eye diseases produce as a result of systemic disease such as diabetic retinopathy in diabetic patients and some others such as glaucoma appear in helpless family [24]. This study was undertaken to identify the level of knowledge and practice of participants. The main findings of this study were that the

overall knowledge related common eye diseases in Sulaimani was poor, in which 40.5% of participants within poor knowledge level about eye disease, this results is similar to other study result assessed knowledge level of eye disease among Hong Kong Chinese population [25] and India [26]. This result of our study disagree with other study results in Saudi Arabia [27] and Yamen [28]. Poor knowledge about common eye disease and their complication cause delay of chance of early diagnosis and treatment, thus more prone to increase rate of blindness. The finding of this study indicates that there is poor practice level regarding common eye disease, in which 58.8% of participants within poor practice level. This result is agree with the results of study conducted in Pakistan [29] that indicate poor practice level among participants about various eye disease and different with other study result conducted in Australia [10].

The result of current study show that age group of 20-60 years old, non-employed people, urban population, married person, higher level of education, those with previous history of eye treatment and previous eye injury had significantly higher proportion of knowledge level about various eye diseases. Consistent result was obtained in the study conducted in Melbourne-Australia [30], in which revealed those with higher educational level more likely to have higher knowledge of eye related disease. Michielutte *et al* [31] found that people with higher education level had the highest levels of knowledge of eye disease. Similarly, population based study on knowledge of glaucoma from a rural area in China [32], and rural [33] and urban areas of India [34] have shown poor knowledge among rural communities. Individuals who were higher level of education were much aware about the various eye diseases. Whereas the study conducted in Iran reported no significant relation between age groups and knowledge level[35]. The study result show no significant relation between gender, smoking history, drinking history and their knowledge of participants. Similar to this study, Al Zarea revealed on a study in Saudi Arabia there is no correlation between age group and knowledge of eye diseases [36].

This result of this study show that more than half of respondent within poor practice regarding eye disease such as; regular eye check, wearing sunglass and taking visual break during watching TV or mobile phone. Current result display significant correlation between practice levels of respondent and the occupation, residency, level of education, previous eye treatment and previous eye injury of participants. Meanwhile, participants with previous eye treatment and previous eye injury have more knowledge and practice level because it could be learnt when they an ocular disease from books, magazines, TV or medical staff. Whereas, there is no significant correlation of age group, sex, marital status, smoking and drinking history. Unlike our study results, Livingston, PM *et al* reported that females more likely to have practice toward eye disease[10]. Further research is required to identify the reason why people practice is not sufficient.

Concerning the relationship of knowledge and practice with various eye disease of respondents, the study results

show significant relation between knowledge level and glaucoma, blurred vision/distant, dry eye and itchy/watery eye. Similarly relation between participant knowledge and cataract was revealed in other studies [11, 36]. Furthermore, practice of our participants toward sunlight sensitivity, eye infection, blurred vision/distant and dry eye was also statistically significant. It is extremely important to educate people about eye diseases and took information to minimize the accountability of eye related disease and inform them to make practice that help to protect eye from the hazards.

Limitations of the study should be in consideration, the questionnaire in closed ended questions format, which mean some time the respondent choose the first answer and closed end questionnaire can be influenced by recall bias and there is no space for respondent idea. There are no published studies in our setting in which to compare the study findings. In addition, we only studied patients that visited the Shahid Dr. Aso hospital, which indicates that the results of data from a single location and would obviously need to be repeated in a random sample of different location in order for the results to be more representative.

5. CONCLUSION

This study concluded that the sunlight sensitivity and eye strain are in a higher proportion among respondents. In addition, the worrying about sight loose is also in a high range. Knowledge of the participants are found to be low in eye patients and especially those who were less educated in comparison to married people and those who were with a higher education. A Huge gap of participants' practice regarding eye care was also reported from this study. The current study strongly recommends proper health education campaigns are needed to improve personal awareness about vision related problems and for better eye health.

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