CONSULTATION REPORT
ON
CHILDREN IN EMEGENCY TRAINING
PESHWAR, PAKISTAN

FOR
INTERNATIONAL PEDIATRIC ASSOCIATION (IPA)
AMERICAL ACADEMY OF PEDIATRICS (AAP)
PAKISTANI PEDIATRIC ASSOCIATION (PPA)

FEBRUARY 2002

Mori Morikawa, MD, MPH
Assistant Professor
Department of Family Medicine & International Health
School of Medicine
Case Western Reserve University
10900 Euclid Avenue
Cleveland, OH 4406-4950
USA

Summary:

International Pediatric Association (IPA), American Academy of Pediatrics (AAP), Pakistani Pediatric Association (PPA) jointly conducted a training course, "the Management of Children in Emergencies", in Peshawar, Pakistan, between 1/28 and 1/31/02. As one of the faculty members for the course, I delivered seven lectures and facilitated the problem-based group discussions. After the course, I stayed another week for the follow-up visits and assisted the course participants with their practical needs. Through the discussions with many NGO personnel, it was obvious that there were perceived needs for high quality training and educational activities for this topic.

This was the first time for us to deliver the course in the situation where many participants were already serving for the refugees for a long time. In this particular situation, providing pre-packaged contents did not necessarily meet participants need. Their involvement in the planning was indispensable for the successful course. It was my honor to work with people serving for children in current crisis in Afghanistan.

1) Training Course "Management of Children in Emergencies"

We accommodated two different audiences in the group. One group was Afghani physicians who have been working for Afghans either inside Afghanistan or along the border. The other group was Pakistani pediatricians who have never worked for refugees in the camps. Their expectation for the course was different in terms of contents, the first group needs more practical knowledge which would be applied to their daily activities right away, the second group needed more conceptual background and theories before they take this course as a trainer training.

There was not enough time to prepare this course and the target group was uncertain until a week before the course. We brought our materials for our U.S. course without major changes but some of the cases were not relevant and participants have some difficulties to follow the context.

2) Peshawar: the Hub of International Relief

Peshawar is the capital of the North West Frontier Territory (NWFT) which is located next to the Afghan-Pakistan border. The population was about 300,000 twenty years ago but the Afghan refugees, international aid workers, mercenaries, and smugglers flooded into the city since early 80s and now the population is estimated about 1.5 million. In NWFT area, there are estimated 2.7 million refugees. It is obvious that the refugee problem has forced Pakistanis, particularly communities accomodating refugees to stretch out the health care resources. On the pediatric floor at the Khyber Teaching Hospital, for example, 1/3 of patients have been Afghan refugees. Dr. Mahr Taj, the chairperson for the pediatric department at the hospital witnessed that the EPI coverage plummeted in the past ten years as the war in Afghanistan escalated and no support was provided by the

international community to the Pakistani government. The governor of the NWFT as well as Dr. Shah, the CEO of the hospital also pointed out the scarcity of health care resources in the region due to the lack of funding support by the international agencies.

Twenty years of refugee problem obviously created two significant trends in the area. First of all, the poor Pakistanis have become poorer. While Afghan "refugees" are entitled to receive all the aid and relief, local Pakistanis are not qualified for any support. As it happened in many refugee crises in the past, the negative impacts of refugee crises for local communities are often neglected. Second, it created extremely wealthy "refugees". Peshawar seems to be a hub of many illegal businesses: drug, weapon, women trafficking, and cheap electric appliances. Hayatabad is the suburban residential area in Peshawar with huge houses. The area is expanding despite the fact that there are no major industries in the area. 70% of the residents in these houses are said to be rich Afghans. Not all Afghan refugees are poor or desperate.

3) Neglected Refugee Camps

Kacha Ghari and Jelozai camp are both among the oldest camps existing more than ten years in the Afghan border area. These old refugee camps do not have any tents or fences. Many of them live in mud houses and go to shop or work outside the camps. They look more like shantytowns than refugee camps. There are more than 100,000 people in each camp with schools, shops, busy street vendors and lots of public transportation coming into the camp. Jelozai camp is particularly notorious for chaotic conditions and lack of security. Al-Jihad Hospital in Jelozai camp has been functioning as the only referral hospital from the seven refugee camps in the area. However, it is suffering from the financial problem due to the budget cut by UNHCR. Their reasoning: "protracted emergency " is not an "emergency."

4) Health Care Training in Protracted Conflicts

Fifteen Afghani interns working in Al-Jihad Hospital have not received any organized bedside teaching rounds. Their patient management skills and diagnosis of some cases were questionable. Dr. Amin, the director of the hospital asked me to come back to do bedside teaching rounds for interns as well as house staff.

Dr. Shabom, the deputy country director of IMC (International Medical Corp), told me that clinical training organized by the UN agencies is skewed towards a few basic pathologies, e.g. ARI or diarrhea. Even though it is true that a few of the diseases are the major killers for the population, health care providers also have to deal with relatively rare diseases in a situation where there is no referral system. Many people still take their families and children to *Mullarh*, priests, for desperate cases such as convulsive disorders. In protracted conflicts, therefore, health care providers should learn comprehensive management skills for secondary or less frequent diseases.

5) Profound Psychological Trauma among Afghans

Psychological and psychiatric problems are major issues in the Afghan community as any other emergencies. Psychological support for victims of landmines and cluster bombs is much needed but currently not enough programs are available, according to Dr. Shabom. Although suicide rates might not soar up immediately, many health care workers have noticed the increasing incidence of family problems and domestic violence. None of the NGO have the answer how to address the problem when the entire nation is traumatized.

6) Health Education

Ibnsina, a local Afghan NGO, and IMC are keen to provide training for health educators in Afghanistan. Dr. Akram, the chief trainer for Ibnsina, complied a large volume of teaching materials which covers comprehensive topics from contraception to infertility, erectile dysfunction. However, with its too much information and the didactic teaching method, the program does not provide information relevant to the trainees' level.

7) War Surgery in Practice

Many Afghani surgeons have practiced war surgery. Dr. Sohail, associate professor in the department of traumatology in Abbottabad Medical College, is one of those surgeons with field experiences in war surgery. He never learned any septic surgery during his training in UK, but more than 50 percent of his practice in trauma is still old infected wounds. A female surgeon in IMC had almost 100% success rate in the repair of colon injuries in war in the past ten years, as long as the wound is fresh within two hours.

8) Surveillance System and Dissemination of Information

Ibnsina started infectious disease monitoring and reporting at their primary care clinics in 11 provinces in Afghanistan. They will also start nutritional surveillance system soon. However, the dissemination of the surveillance results is not established. These valuable results submitted to the donors are often well utilized to improve health programs.

Major Activities:

I. Training Course "Management of Children in Emergencies"

This course was made possible by a collaborative effort by the US and Pakistani organizations, IPA, AAP and PPA.

Training Purpose: To provide practical knowledge and skills for Afghan health care professionals who are working in the refugee camps in the current Afghan crisis. For actual course schedule, please refer to appendix 1.

Participants: Total of 50 physicians working for non-governmental organizations (NGOs) as well as members of PPA. 31 of them were Afghans working in refugee camps and the rest of them traveled from Afghanistan including four people who walked for three days to cross the Afghan-Pakistani border to attend this course. The rest of the participants were Pakistanis who have no experiences in refugee situations.

Results: Many participants are satisfied by the course for it was a rare opportunity for formal training on CHEs and helped them have better understanding of the management of children and families affected by a CHE. However, they also expressed their dissatisfaction that the course did not enhance their day-to-day management skills very much. The course contents were too general and superficial for some participants.

Problems: 1) Methodological relevance of the problem-based learning

It seemed difficult for them to engage in theoretical cases we used to improve abstract thinking. Many of them were frustrated for the relevance of these theoretical cases since the scenario is quite different from their daily activities. It seems difficult for them to work on cases particularly if English is not their first language. They needed more practical and hands-on skills that are useful for the day-to-day management of refugee problems. Few participants suggested that we should take field trip for facilitating discussions on practical side of management.

2) Relevance of the discussion material

In each topic, we have to consider its relevance to this particular community. In malnutrition sessions, for example, many NGO workers wanted more specific discussions for public nutrition e.g. including, discharge and monitoring criteria for feeding program. Many people also asked quick overview of how to calculate Z-score, percentile in anthropometric measurement. We could have provided more specifics rather than general introductory discussions.

Some of the cases during the course were not relevant to this audience. For example, compassion fatigue discussions, there are many participants complaining their situation as a refugee by themselves can not provide any freedom to take vacations or leaving this situations.

Some of the problems could be avoided next time if we spent more time on needs assessment and the course participants were given an opportunity to participate in the preparation of the training program.

II. Consultation for NGOs

1) IMC (International Medical Corp)

IMC, an US-based NGO, has grown rapidly since 1980s. IMC now has the biggest presence in health care programs inside Afghanistan, providing numerous programs for primary care clinics, health education training, immunization, and supplementary feeding in 24 out of 28 provinces. They just started their program in feeding and primary care on the Iran-Afghan border. My discussion with them focused on the possible collaboration among CWRU, Kinderberg USA and IMC in bedside clinical training for Afghan health professionals. As a first step, IMC asked me to help the medical school in Kabul University improve their bedside training in August or September 2002.

IMC has a field clinic for female in Kacha Ghari camp, which is the oldest refugee camp along the border and still provides ambulatory care for free. There are two exam rooms, health education room, dental clinic, and growth monitoring room. There are 5 female physicians including a surgeon and 10 TBAs working in the clinic. Each of the TBA delivers 10-15 babies per month. The surgeon had worked inside Afghanistan during the war in 80s, and told me she had almost 100% success rate for primary colon repair as long as the wound is less than 2 hours old. She employs Connel and Lambert sutures.

The deputy-country director, Dr.Shabom talked about the pitfall of vertical training programs conducted by UN agencies. It is true that majority of morbidity and mortality comes from the most common diseases, e.g. ARI, diarrhea and Malaria. However, the training programs offered by WHO and UNICEF focused too much on these diseases while totally ignoring other illnesses. Epilepsy or convulsive disorders, for example, although the prevalence is much lower, was never been taught to health professionals and health educators. Consequently, most people still take their children to *Mullah,* a priest. They also lock patients in dark rooms in case of tetanus induced convulsions and let them die. As the conflict prolongs and reconstruction of the society takes for long steps, it is important training programs cover comprehensive topics.

Dr. Shabom believes one of the urgent problems among Afghan communities is the care of psychological trauma in the entire society. It is hard to evaluate the significance of the problem in terms of suicide rates, but certainly he senses that there are increasing problems among families and domestic violence. The entire community was torn by the conflicts for more than twenty years. Majority of the people in Afghanistan hasn't had any opportunities for appropriate education during this period and fighting against their enemies is the only training they've got. The significance of psychological and

psychiatric trauma is profound and serious. Unfortunately, there are not enough mental health professionals in Afghanistan.

2) Ibnsina

Ibnsina and IMC sent twenty participants for our training course. Ibnsina is one of the oldest and biggest local health care NGOs established by Afghan physicians in 1996. Operating in 11 provinces in Afghanistan in close collaboration with IMC, their activities include health education, free clinic and supplementary feeding programs. They established surveillance system in the clinics and the epidemiology section has been putting monitoring report together every month. The newly established communication section will be in charge of dissemination of information, survey and surveillance results to donors and other NGOs.

I observed their trainers' training in reproductive health The teaching methodology of the 8-day course with 17 participants including 15 from Afghanistan was simply didactic. In seven refugee camps along the Afghan-Pakistan border, the fertility rate is high reflecting the cultural and societal norm of Afghan community, in which there are usually seven to eight children per family. Four of the participants in our course saw at least one maternal death during pregnancy in the past three months. The reasons of the deaths seem to be postpartum hemorrhage and probable congestive heart failure due to severe chronic anemia.

According to Dr. Akram, the chief trainer in Ibnsina, it is critical to see the dynamics of the community you would like to intervene in selecting community health educators. In case of rural Afghan villages, they select barbers as health educators since they are the primary source of information. The barbers play a significant role in bringing news from out side world to the village where there is no TV or radio. People are eager to listen to the barbers.

I visited Jelozi camp, one of the oldest refugee camps along the Afghan-Pakistani border, and Al-Jihad hospital in the camp. Ibnsina/IMC has been supporting the hospital in the past six months financially and logistically. There are estimated 200,000 people in the camp but the actual number is unknown. The camp looks more like a shantytown since there is no fence or gate and the residents can go out freely. The hospital with 100 beds is more than 15 years old. There are two ORs, ER, X-ray facility, blood bank and central laboratory capable of CBC, basic chemistry and U/A. They receive 15 interns from various Afghan medical schools for rotation. The female ward for OB/Gyn and pediatrics are supported by IMC. Medicine and surgery section lost support from UNHCR just recently. There are serious financial concerns for the future of the hospital.

There are approximately 10 deliveries a day, 50-70 cases of elective surgery per month, 100-150 ER visit per month (only male side). The female ER also has similar number of patients per month. Many ARI, asthma and diarrhea cases, minor wounds, infected wounds, common fractures, and blunt trauma due to traffic accidents are seen at the ER.

There is no monitors or defibrillator at the ER, but there are oxygen masks, Ambu bags, suctions, and endotracheal intubation.

There are a lot of "stone" surgeries such as bladder, kidney, and GB stones. There are also a few cases of laparotomy for appendicitis, intestinal obstructions. Many of them were done by Ketamine. There are two gas anesthesia machines with Halothene. Septic surgeries, drainage of various abscesses are common.

At the medicine floor, there are many regular cases of pneumonia with pleural effusion, many of them were suspicious for TB. There were a few cases of asthma exacerbation and congestive heart failure. Management of these patients was somehow questionable in our standard. For example, two cases they diagnosed as congestive heart failure had no clinical signs and X ray findings go with CHF. House officers from Afghanistan were in charge of managing these patients. However it was obvious that there were no formal bedside teaching rounds.

Currently they are planning to implement community nutritional surveillance program in 11 provinces where they operate. They have been organizing supplementary feeding program based on primary health care clinic in these provinces and provide dry ration. Currently, their inclusion criteria/discharge criteria are based on MSF guidelines. Some of the staff members in the nutrition section attended intensive training in sampling survey and use of SPSS. I encouraged them to conduct community base survey for the prevalence of malnutrition and publish the result in medical journals. We also discussed that surveillance system can be applied to other conditions such as injuries or domestic violence.

3) ORA (Orphan-Refugees and Aid)

Dr. Farid Bazger explained to me that their activities go back to in mid 1990s when they started detoxification facility for addiction in Peshawar. They have been published many health education materials particularly for HIV/AIDS and sexually transmitted diseases (STDs). They also conducted ethnic and linguistic composition survey in Afghanistan that revealed that the Pakhtana is the biggest ethnic composition in the area.

4) **IRC (International Rescue Committee)**

Dr. Tila, the medical director for Afghanistan, sent four of their health care professionals for our training program. I had a long discussion with the medical director of IRC HQ, Dr. Rick Brennan, who was in Peshawar during my stay. IRC currently is not directly involved in health care programs inside Afghanistan. But there is a outbreak report on micronutrient deficiency from Mazar-i-Sharif area and Dr. Brennan will conduct rapid assessment and will determine whether they will start new emergency medical interventions. I expressed my concerns about the quality of care among Afghan physicians from my observation in the hospital and we agreed to continue to work on

developing curriculum stressing on bedside practical training for health professionals in the field.

5) PMS (Pakistan Medical Service)

PMS is one of the Japanese NGOs working in Peshawar since early 80s to provide medical care for leprosy, one of the most prevalent conditions in the area. They have a 75-bed hospital in Peshawar. 25 Pakistani physicians are working with Dr. Tetsu Nakamura, the founder of the organization. After the current crisis in Afghanistan, they extended their services inside the Afghanistan and currently conducting various public health programs including sustainable agriculture program and drilling wells in rural communities. I met Dr. Nagata, an orthopedic surgeon from Japan. He volunteered his time for four weeks to conduct ATLS training for physicians in the organization. He brought resuscitation doll from Japan.

III. Other activities

1) Visiting the Governor of NWFT

All the faculty members of our course made a respectful visit to the governor of North Western Frontier Territory (NWFT) on 1/27 at the governor's mansion. We discussed the significance of refugee problem along the border. He estimates there are 2.7 million refugees in the province. And this number might be a serious underestimation since the border between Afghanistan and Pakistan is fluid. He insisted the impact of refugee crisis to Pakistani community. Accepting 2.7 million refugees is a serious economical burden for the province, however none of the international organizations support the province since they only support refugees. The burden to the affected local communities accepting refugees has been always a problem in refugee crisis. The "refugees" are entitled to receive all the international aid, while local communities are neglected from the assistance. In fact, there are several papers clearly documented that in Africa for example, malnutrition is more prevalent in surrounding communities rather than refugee camps.

2) Khyber Teaching Hospital

This is the teaching hospital for Khyber Medical College. After the five years of medical school education in Pakistan, all medical graduates are assigned to a "house job" which is a rotating internship at the teaching hospital affiliated to the medical school. Showing me the pediatric floor, Dr. Mahr Taj explained that at least 1/3 of inpatients on pediatric floor is always Afghans. The service is free of charge at the teaching hospital.

Dr. Shah, the CEO of the hospital, also insisted the lack of resources to support the influx of refugees from Afghanistan. Subsequently, Pakistani society is suffering from the drop of immunization coverage in the past decade due to the serious shortage of budget in health sector. International agencies again have provided no support for the Pakistani

government. He asked us how we continue this training course and we expect PPA will take over and duplicate this course either in Pakistan or in Afghanistan.

3) "Medical Education in the US", Lecture at Khyber Medical College

On 2/7, I talked about medical education in the U.S. for an hour to 150 final year medical students in the college. Many of them seemed interested in pursuing their clinical training overseas including the U.S. Currently, about half of those who go overseas are trained in UK.

4) "Evidence-based Medicine in Primary Care", Lecture at Department of Pediatrics, Khyber Teaching Hospital

I talked about evidence-based medicine in primary care to residents and medical staff in the pediatric department of the teaching hospital. The EBM movement obviously is quite new for them. I asked questions about the definition and methodologies.

5) Discussion with Professor Mahr Taj MD, the Chairperson of the Department of Pediatrics

Dr. Mahr Taj, the Chairperson for the Pediatric Department in the past few decades, is very disappointed to see the immunization and other general condition for Pakistani children along the border deteriorating over twenty years of refugee crisis. The EPI coverage plummeted from above 80% to less than 50% during this refugee crisis. She criticized the vertical approach employed by various international organizations since their training programs have not helped enhance local capabilities of managing local resources. Rather, it will create more confusion by introducing additional bureaucracy to existing systems.

We also discussed with the strong influence of multinational industry to solicit commercial weaning food for indigenous communities in Pakistan. She will discuss the pro and cons of introducing commercial weaning foods to Pakistan in international pediatric nutrition conference on February 14th in Karachi. We discussed how to argue against the commercial food over indigenous weaning food.

Log:

Date	AM	PM
1/25 Fri		Left Cleveland for JFK (NYC) JFK to London
1/26 Sat	Connecting flight from London to Dubai	Dubai to Peshawar
1/27 Sun	Arrived to Peshawar Visited the governor of NWFT	Faculty meeting Dinner at the Peshawar Club
1/28 Mon	Day 1 Opening ceremony	Delivered lectures on • Rapid Health Assessment • Triage • Water and Sanitation Dinner at Dr. Ashfaq's brother's house
1/29 Tue	Day 2 • Delivered a lecture on surveillance	Day 2 Official Dinner party
1/30 Wed	Day 3	Day 3 Dinner at Dr.Ashfaq's home
1/31 Thu	Day 4 Delivered a lecture on • Emergency obstetrics	Day 4 Delivered lectures on • Minor surgical skills in CHEs • Landmines / UXO Closing ceremony at Khyber Medical College
2/1 Fri	Visited Afghan Refugee Committee and obtained permission to visit refugee camps	Visited Kacha Ghari camp and visited IMC field clinic for female patients
2/2 Sat	Visited Khyber teaching hospital Meeting with Dr. Shah, CEO of the hospital	Visited Bala Hisar Fort Visited Peshawar Museum

2/3 Sun	Visited Old City	Meeting with Dr. Ismaili and Dr. Huma discussing about community medicine training
2/4 Mon	Visited Ibnsina for Dr. Akram, Dr. Jan to discuss surveillance program in Afghanistan. Visited IMC met with Dr. Anwar, Dr. Shabom, Mr. Tomlin to discuss bedside training program.	Visited ORA with Dr. Farid Visited PMS discussed the importance of ATLS training for health care professionals working landmine prone countries.
2/5 Tue	Visited Ibnsina observing reproductive health training	Discussed with nutritional surveillance in Ibnsina
2/6 Wed	Visited Jelozi camp and Al-Jihad hospital	Discussed with Dr. Anwar about our collaboration with CWRU, Kinderberg USA and IMC/Ibnsina Dinner with Dr. Ashfaq and Dr. Jasime
2/7 Thu	Delivered a lecture at Khyber medical college Delivered a lecture at Khyber teaching hospital	Discussed with Dr. Mahr Taj about weaning food and vertical program by UNICEF Met with Dr. Amin to discuss future of this training program Went to Peshawar airport
2/8 Fri	Flight from Peshawar to Dubai Dubai to London Heathrow	Heathrow to JFK Discussed with IRC HQ about the importance of bedside training program
2/9 Sat	Discussed with Dr. Roy Brown, Kinderberg USA for bedside training program in Kabul, Afghanistan	Flight from JFK to Cleveland

Appendix 1: Course Schedule

Day 1: January 28, 2002

8:00 – 9:15 Registration – Pretest
9:15 – 10:00 Inauguration (Opening Ceremony)
10:00 – 10:30 Break
10:30 – 11:30 Getting to know you *Pulsuk Siripul, PhD*
Definition and Overview *Karen Olness, MD*
11:30 – 12:45 Introduction to Case History: Case History 1
Napa Limratana, MSc
12:45 – 13:30 Lunch
13:30 – 15:15 Rapid Epidemiological Assessment: Practical Guidelines:
Case History 2, *Masahiro Morikawa, MD, MPH*
15:15 – 15:30 Break
15:30 – 16:00 Triage, *Masahiro Morikawa, MD, MPH*
16:00 – 17:30 Water, Shelter, and Sanitation: Logistics and Resource
Management: Case History 3, *Masahiro Morikawa, MD, MPH*
17:30 – 18:00 Facilitator meeting

Day 2: January 29, 2002

8:30 – 10:15 Vulnerable Populations: Psychological Effect of Disease:
Case History 4, *Karen Olness, MD*
10:15 – 10:30 Break
10:30 – 10:50 Communicable Diseases *Srivieng Pairojkul, MD*
10:50 – 11:10 Guidelines for Surveillance, *Mashiro Morikawa, MD, MPH*
11:10 – 12:10 Case History 5
12:10 – 13:00 Experiences of Communicable Diseases in the Camps
14:00 – 16:00 Infectious Diseases in Emergency Situation: Case History 6,
Srivieng Pairojkul, MD
16:00 – 16:15 Break
16:15 – 17:30 Immunization: Case History 7, *Srivieng Pairoikul, MD*
17:30 – 18:00 Facilitator meeting
20:00 Dinner Reception

Day 3: January 30, 2002

8:30 – 10:00 Malnutrition, Including Micronutrient Deficiencies: Case
History 8(A), *Kusuma Chusilp, MD*
10:00 – 10:15 Break
10:15 – 12:00 Malnutrition (continued): Case History 8(B), *Kusuma Chusilp, MD*
12:00 – 13:00 Lunch
13:00 – 14:45 International Humanitarian Law and Geneva Convention:
Focus on Women, Children, and Human Rights: Case History 9, *Karen Olness, MD*
14:45 – 15:00 Break

15:00 – 16:45 Sex and Gender Based Violence, Ethical Issues: Case History 9, *Karen Olness, MD*
16:45 – 17:15 Psychosocial Problems in refugee children, *Souhail*
17:15 – 18:00 Facilitator Meeting

Day 4: January 31, 2002

8:00 – 8:30 Emergencies Obstetrics, *Masahiro Morikawa, MD, MPH*
8:30 – 9:00 Basic Newborn Resuscitation, *Srivieng Pairojkul, MD*
9:00 – 9:45 Case History 11
9:45 – 10:00 Break
10:00 – 11:30 Breastfeeding and Stress: Case History 12, *Kusuma Chusilp, MD*
11:30 – 12:30 Managing Minor Wounds, Surgery in a Refugee Camp, Unexploded Ordinance, *Masahiro Morikawa, MD, MPH*
12:30 – 13:30 Risk to Health Care Provider and How to Avoid Them: Case History 13, *Pulsuk Siripul, PhD*
13:30 – 14:00 Post Test
14:00 – 15:00 Lunch
15:00 – 17:00 Closing Ceremony including entertainment