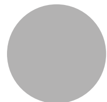

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PAEDIATRIC EMERGENCY CARE;

HEALTH PROFESSION RELATED ISSUES & SUGGESTIONS FOR IMPROVEMENT IN RURAL AREAS OF PAKISTAN.

Dr. Intisar Ulhaq

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INTRODUCTION AND BACKGROUND

Pakistan is an agricultural country and 2/3rd of its population resides in rural areas.[1] Total population of Pakistan is estimated to be approximately 18 million with a gross national income (GNI) per capita of $1360 and poverty headcount ratio of $1.25 a day PPP % of population of 12.7 %. [2]

A significant data has been published in both national and international journals on the issues of common and preventable paediatric health problems. Similarly international health organisations have published extensive statistics on common paediatric problems in developing countries such as high infant and child mortality rates.[3]

Poverty, lack of health education, political instabilities and lack of basic health needs such as clean drinking water and proper sanitation all have been discussed at length as the major contributory factors to the poor state of health in children of developing countries. Although these factors play an important role in improving child health care, less emphasis has been put on the factors which are directly related to health professionals, health institutions, health governing bodies and medical training organisations.[4]

Author's personal experience:

The author is a UK based Paediatrician and has nearly 8 years of experience of studying medicine as well as working in rural areas of Pakistan. The journey of being a part of the health profession in Pakistan started as a medical student for 5 years and finished as a medical officer in a rural health centre for 3 years. This experience has provided enough insight into the factors specifically pertaining to health profession which are contributing to inadequate health care in the field of Paediatrics in these areas. A summary of these issues are discussed below:

a) Inadequate basic requirements:

First port of contact for sick and injured children in rural areas is either a "basic health unit" (BHU) or a "rural health centre" (RHC). A medical officer who is a registered medical practitioner is usually in charge of such centre. Other allied health professionals include midwives, lady health workers, a dispenser and a paramedic. In some RHCs additional professionals such as radiographer, laboratory technician and ambulance driver may be available. The average number of patients seen in these centres vary from 50-100 per day.

There are no designated Paediatric resuscitation or treatment areas in these centres. Necessary

equipment and lifesaving medications are either unavailable or insufficient. It has been observed that there is a lack of oxygen supply, resuscitation equipment and vital medications.

b) Inadequate paediatric trained health professionals:

Often the medical, paramedical and nursing staffs in rural areas are not adequately trained to deal with the children's health problems and paediatric emergencies effectively. This in turn may lead to inefficient care, delay in seeking further help and delay in transferring the child to a secondary care hospital. These factors eventually lead to increased mortality and morbidity.

The issue of lack of adequately trained professionals in these areas is due to various factors such as lack of Paediatric trained professionals, inadequate or lack of arrangements for continuous professional development, lack of regular appraisal and clinical audit of medical practice.

c) Lack of effective Communication among health professionals and health centres:

Effective communication among health professionals is not always adequate. Among health professionals in remote areas the concept of primary, secondary and tertiary care in the management of sick children needs significant improvement in order to provide better care, make timely transfers, prevent complications and save lives. Similarly communication among health professionals and the patients is inadequate which results in lack of continuity of care and poor follow up arrangements.

Suggestions for improvement:

It is acknowledged that in order to improve the provision of health care of paediatric population in remote areas the efforts must start at the government level to improve infrastructure and funding.

However, responsibility partly lies on the health professionals, medical education and training institutions and licensing bodies to improve the child care in remote areas and disadvantaged populations. Following are some suggestions which have the potential to improve the state of child health in Pakistan:

a) Responsibilities of individual health professionals:

The health professionals based in rural health centres are required to make efforts to be responsible for their own training needs in dealing with sick children. They should be up to date with their Paediatric resuscitation skills. The in charge of such centres must make sure that rest of the team members are adequately trained in providing child health care. One way of achieving this is by running regular simulation scenarios, such as basic resuscitation techniques for neonates and older children. Simulation exercises for other paediatric emergencies have proven benefit in patient management. A constructive feedback should be provided at the end of each session. There should be adequate supervision of less trained and less experienced professionals. Regular clinical supervision and appraisals for all health professionals are the best tools to improve health care.

b) Role of Medical institutions and training governing bodies:

Principles of adult learning, reflective practice, clinical supervision, constructive feedback and clinical audit should be a part of both undergraduate and postgraduate training curriculum. The responsible institutions should assess their policies on regular basis in order to improve the standards of training in keeping with rapidly changing medical information due to ongoing research globally.

Medical students should have sufficient time to rotate through paediatrics. They should be actively involved in their own learning under the supervision of a trained paediatrician. All efforts should be made to cover the required paediatric curriculum by regular assessments.

It should be made mandatory for the postgraduate paediatric trainees to keep up to date with basic and advanced paediatric resuscitation skills.

In order to achieve this, they should have sufficient time spent in dealing with paediatric emergencies in emergency departments and intensive care units.

In order to improve generic skills, emphasis should be put on the importance of communication in achieving continuity of care and better patient care by organising various training days and workshops.

c) Duties of Licensing and registration bodies:

Only adequately trained professionals should be licensed to treat children. If a paediatric trained professional is not available to be appointed in remote health facilities, arrangement should be made to train those before starting their employments. A minimum requirement should be an advanced training in paediatric life support. Regular validation and appraisal should be mandatory for the professionals to keep their licence active. There should be initiatives to conduct national audits to set and improve these standards of care.

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PREVIOUS RELATED STUDY

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AUTHORSHIP AND CONTRIBUTION DECLARATION

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