Children In Exile

BY NAZIM ILDIRIMZADE

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Because of the military conflict between Armenia and Azerbaijan over Nagorno-Karabakh, in the early 1990s, Azerbaijan became flooded with refugees and internally displaced persons (IDPs) expelled from Armenia, Nagorno-Karabakh itself, and seven areas surrounding the region. Some one million Azeris were left homeless, about one-third of them children. A total of 250,000 refugees and IDPs found shelter in Baku, the capital of the country, of whom 32,000 live in the Binagadi District. Since 2000, AIHA's Baku/Richmond partnership has worked to improve the primary medical care offered to this population in the Binagadi District, with its priority being the provision of aid to IDP/refugee children. In addition, we have begun to work in the Sabirabad region of the country, which is home to many IDP settlements. To understand the range of health problems that afflict these children, one needs to understand their specific situation and living conditions.

Exile's Effect on Children

The health status of IDP and refugee children—as well as the organization of medical care and preventive measures with respect to this population—has some specific features. Deep moral and mental stress caused by wartime horrors and exile, lack of confidence and belief in the future, and feelings of alienation associated with living in a new environment have literally obsessed these children—some of whom have been living in exile for more than 10 years—since the onset of the conflict.

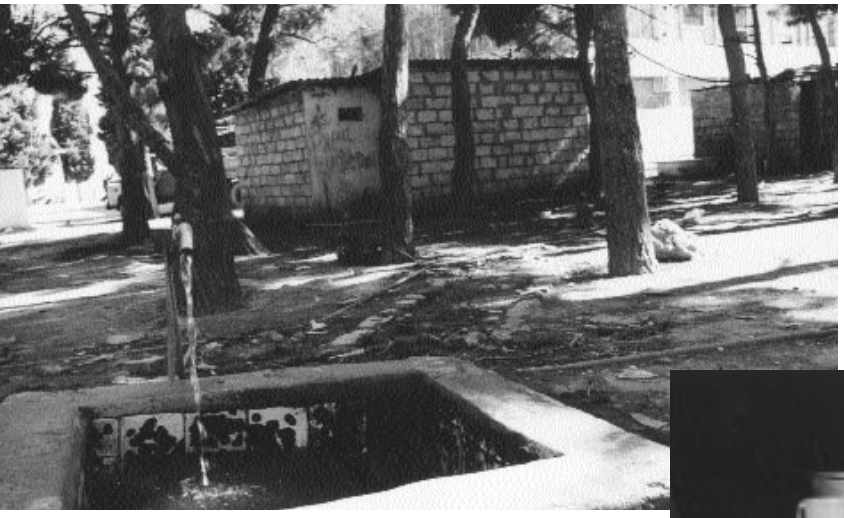
Mental stress, combined with the current living conditions of these populations, have had a profound effect on their health. Many IDPs and refugees who previously resided in mountainous and piedmont areas were forced to settle in valleys and flatlands where the stifling heat and a different climate have had a destructive impact on the children's developing organs. In Baku, poor environmental conditions typical of an industrial city of three million—such as contaminated water, air, and food—have also negatively affected the refugee children's health. The temporary locations most IDPs/refugees call home, such as unfinished buildings, former university dorms, sanatoriums, and schools, are not suited for residence and provide little more than

Photo: Suzanne E. Grinnan.

One of the settlements that houses the 25,000 IDPs who make their home in Baku, Azerbaijan.

rudimentary shelter. Furthermore, poor social and domestic conditions, bad financial situations, and overcrowding have adversely affected the mental and somatic conditions of refugee children for years. The same can be said of the Sabirabad region, where poor soil conditions yield few crops, basic sanitary infrastructures are nonexistent, and desalination ditches provide fetid swimming pools for children and breeding grounds for malaria-bearing mosquitoes.

To complicate the matter further, during their period of



Photos: Suzanne E. Grinnan.

Housing conditions for IDPs in Baku contribute to their poor health conditions. Buildings not designed for habitation now house hundreds of people who set up make-shift kitchens in the hallways and share a common water source and outhouse in the yard.

exile, all medical information or documentation related to the diseases suffered by these children, immunizations received, living conditions, and hereditary health history was lost. Those medical institutions that had been servicing the local populations in the areas affected by the conflict have now ceased their operations and their staff have been scattered across the country. As a result, the medical professionals currently treating these populations have to restore, bit by bit, a picture of a child's life in exile.

An inability to adapt to new environmental conditions, lack of anamnesis, a poor epidemiological situation, and adverse social and domestic conditions that result in weakened immunity, mental oppression, and a lag in physical development are the key factors for determining the specific features of the occurrence of certain diseases—primarily infectious and chronic ones—among these children. For example, the incidence rate of active tuberculosis among IDP/refugee children is four to five times as high as that among the native children of Baku. Children's Polyclinic #20 in the Binagadi District, which serves a total of 3,500 IDP/refugee children, has registered seven children with active tuberculosis. In contrast, only 12 cases of active tuberculosis have been registered among the 30,000 native children in the city.

A Strategic Approach

Given all these peculiarities, local medical institutions pursue a specific strategy to address the needs of the IDP/refugee children, focusing on prevention, identification, and treatment of various infectious diseases. For example, in 1996, Azerbaijan was threatened by a diphtheria epidemic. The disease was predominantly striking IDP/refugee children who were the most vulnerable population group, so a massive, multi-stage effort to immunize the population was carried out by local medical professionals in conjunction with UNICEF to help eliminate this threat.

As another component of the strategy, given the low living standards of the IDP/refugee population, the President of Azerbaijan has decreed that all medical services provided to them should be free of charge. And, as a preemptive measure, comprehensive medical examinations are performed on a regular basis in densely populated areas by field examination teams. These teams are comprised of pediatricians, laboratory assistants, radiologists, surgeons, neurologists, otorhinolaryngologists, and other specialists. The main purpose of these examinations is to identify pulmonary tuberculosis, cardiovascular pathologies, infectious parasitic diseases, and various somatic illnesses in a timely manner. In parallel, health education efforts are also made.

Within the framework of the partnership, community representatives were identified and ongoing health education is being conducted among them. Nurses are heavily involved in this work. A nurse leader from the health district administration oversees a cadre of other nurses leaders who work in each medical facility throughout the district and report to her. These nurses talk about

disease prevention, treatment, and personal hygiene with the community representatives. Topics commonly discussed include breastfeeding, preventing diarrhea among children, nutrition, respratory illness, the importance of seeing a doctor in the case of some specific diseases, and vaccination schedules.

In addition to nurses, area physicians also participate in our health education efforts. In many cases, these nurses and doctors are themselves IDPs, so they live within the community they serve. This provides an extremely effective way to obtain information and provide care. It is one thing when a person goes into a community for one or two hours and tries to assess the situation, but is another when the person lives in the community and has constant access to those he or she serves. It is also beneficial to have medical personnel who reside within more remote IDP settlements, if only because it precludes having to send providers to the patients, or patients to the cities, for routine care. In these locations, vaccination schedules and routine exams follow the same pattern as those conducted in Baku.

Somatic and Other Diagnoses

To get a sense of the scope of the health status of IDP children, one can look at the data from a field examination conducted November-December 2000 in the Binagadi District, during which a total of 1,024 refugee children were screened for tuberculosis using the Mantoux test. Based on the results of that test, 115 children were referred for preventive treatment, while 102 were revaccinated. At the same time, 109 patients were diagnosed with health problems that had not been previously identified. Of this number, 96 presented with somatic disease(s), 11 needed surgical care, one was diagnosed with an endocrine pathology, and one had cancer. Ninety children were subjected to follow-up monitoring and six were hospitalized.

The profiles below help to further illustrate how life in exile affects the health of these children.

- Eight-year-old Togrul and his 9-year-old brother Tural fled with their parents from the Fizuli area of Azerbaijan and now live in extremely adverse conditions in a former sanatorium. Chronic malnutrition, low-quality food, and a lack of elementary domestic conveniences have resulted in chronic diseases for both. Tural, who has recently recovered from angina, now suffers from chronic tonsillitis, rheumatism, myocarditis, and chorea minor. Apart from carrying a hepatitis virus, Togrul also suffers from cardiomyopathy and chronic gastritis. These children have been repeatedly referred for treatment to the United Municipal Hospital #6 in the Binagadi District and are in the care of staff at the Children's Polyclinic #20.
- Children's Polyclinic #20 constantly monitors IDP/refugee children with inborn and acquired heart diseases, which are often caused by the hardships associated with living in exile and its continued stress. For example, 3-year-old Suleiman was born in exile with aortic ostial stenosis after his parents fled from Gubadli and 1-year-old Tariel suffers a congenital ventricular septal defect that was caused by his mother's considerable stress during her pregnancy.
- Respiratory infections are a real scourge for children caught in these conditions, such as 2-year-old Chinara who was born weak, unhealthy, and often suffered from respiratory diseases, which have eventually resulted in bronchopneumonia. Apart from bronchopneumonia, she now also suffers from rachitis of the third degree, hypotrophy of the second degree, and encephalopathy with spastic syndrome.
- Niyamyaddin now lives with his parents in an unfinished multi-story building after fleeing the area of Dzhabrail. When he was 5 years old, Niyamyaddin acquired an acute respiratory disease. The next year, during a routine field examination, a neurologist diagnosed him with encephalopathy, mental retardation, and diastosis. His health is now constantly and carefully monitored by physicians.

A Targeted Response

Wartime horrors never leave without a trace and it is especially painful to see children suffering from them. With the help of our American partners, we are working to mitigate their distress. One simple step we've taken that has had far-reaching results is—in conjunction with AIHA's Baku/Houston and Baku/Portland partnerships—providing area doctors and nurses with physician bags that contain an optimal selection of tools that allow them to do examinations previously conducted by specialists at IDP settlements. In order to be able to use that equipment effectively, those who received the bags were given training both in the United States and in Baku. The bags contain items such as digital thermometers, blood pressure cuffs, stethescopes, otoscopes, optomoscopes, reflexive hammers, and glaucometers, which are used by medical personel both in Baku and in the Sabirabad region of the country. These bags enable clinicians to provide care and diagnostic services to children and other members of the IDP communities at a level never before possible. By bringing care directly to the people who need it most, the doctors and nurses are striving to improve the health of this underserved population. ■