Primary Care Training in Kosovo

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Primary care training during and after conflicts is one of the most challenging health care issues but is often neglected compared to emergency medical care. Recently, family medicine has been increasingly used as a model strategy to reconstruct primary care delivery systems in communities torn by conflicts. The lessons learned through providing primary pediatric care training in Kosovo, in two periods, both shortly before the NATO air strike and after the war in Kosovo, are shared in this paper. The training program was organized and provided in collaboration with the Kosovar nongovernmental organization, Mother Teresa Society, and Kinderberg International in support of United Nations High Commissioner for Refugees as a pilot program. This paper provides a narrative description of training experiences that focused on practical bedside training and morale support throughout these two periods. Based on our evaluation, providing morale support at the field level to encourage the health care providers’ motivation for learning and collegial support while suffering physical difficulties was beneficial. International primary care organizations should maintain collegial dialogue to support indigenization of family medicine, a process that adapts the principles of family medicine into their own needs in their communities.

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For many communities and nations after war, restoring a primary health care system becomes one of the first priorities in public health reconstruction. The effort is often neglected and forgotten, however, as the international attention dissipates. The lessons learned before and after the recent war in Kosovo may inform others working to establish or reestablish primary care training programs in other communities and nations torn by conflicts.

Polyclinic System and the Development of the “Parallel System:” Primary Care Under the Serbian Rule

Before the 1999 war, primary care in Kosovo was provided through specialists in towns and general practitioners (GPs) in villages. There was a medical facility with multiple subspecialty clinics, called the Polyclinic or Health House, in the center of each township of Kosovo. The Health House included specialty clinics for pediatrics; OB-GYN; ear, nose, and throat (ENT); internal medicine; surgery; and stomatology (dentistry). Under this system, patients would “self triage” their health problems and went directly to specialists in any of those clinics. No referral was needed to see specialists at the Health House, and there was no coordination of care among specialists.

At a village level, there were health posts, called ambulantas, where the only health care providers were GPs. GPs were medical school graduates who were assigned to an ambulanta without any specific residency training or internship. As in many countries in the world, after a few years of general practice in a village, GPs are allowed to go back to the teaching hospitals for subspecialty training through a formal residency program. Residency training for GPs (ie, general practice or family practice residencies) was nonexistent before the war.

Due to the ethnic conflict that started in 1989, the Albanians (in this article, Albanians refers to Kosovar Albanians) lost their access to social welfare, health care, and education programs. Albanian physicians were forced to leave public offices in health care facilities, creating a threat to the primary care delivery for Albanians. In 1991, they organized a nongovernmental organization (NGO) called the Mother Teresa Society (MTS) to improve the access to social welfare, including medical care through outpatient clinics. Table 1 lists key abbreviations used in this article. The MTS was supported by many foreign NGOs as well as Kosovar Albanians in foreign nations.

When Albanians were systematically removed from the structured medical education system, the existing
Albanian medical community produced a “parallel system” to educate the next generation of Albanian medical practitioners. Albanian faculty members in the medical school provided lectures and examinations to their medical students in off-campus sites, often in their own homes. Between 1989 and 1999, it is estimated that 500–800 medical students graduated from this system and worked as GPs in MTS clinics throughout Kosovo.

The health care needs of Albanians significantly increased when the conflict in Kosovo escalated in early 1998. Due to the fighting in the villages between the Serbian military forces and Kosovo Liberation Army (KLA), the Albanian villagers had to escape into the mountains for fear of rape, torture, and executions. During this period, the influx of internally displaced persons (IDPs) to the cities increased significantly. City residents hosted their IDP relatives and friends in their homes. The shortage of food, water, shelter, and the crowded living conditions made young children and the elderly vulnerable to various health problems.

One of the epicenters of the internal migration was the Vushtrri Township, located in the north of the capital town of Pristina. In February 1999, Kinderberg International, in collaboration with MTS, started a primary care clinic for the IDPs in Vushtrri. A survey of the patients at this clinic showed that the average household size expanded more than twofold by accommodating the IDPs, many of whom were children.

Recruitment of Foreign Physicians

Groups of foreign expatriate physicians from Germany and the United States were recruited by Kinderberg International, seeking physicians with previous experiences in training and patient care in crisis situations. The assignment was at least 1 month long. I was one of these physicians. Our role was to provide practical bedside training for GPs and to provide free primary care for IDP children. Table 2 summarizes the chronological events of this period. The clinic was operated 6 days per week between 8 am and 4 pm and, on average, 120–130 patients visited our clinic each day. There were three examination rooms and a precepting room. Four Albanian GPs and five nurses recruited by MTS worked with the foreign expatriate physicians.

Primary Care Training at the Height of Internal Conflict in February 1999

In organizing clinical training in conflicts, several medical issues must be kept in mind. First, limited access of patients to the clinic due to security or political reasons gives us a skewed picture of an area’s real patient population. Our practice, for example, was strictly restricted by the Ministry of Health to children under the age of 15, for fear that the older age groups might include those who were affiliated with the KLA. Second, transportation was fairly limited due to security concerns, and sicker patients often could not come to the clinic. Third, as the conflict continued, the management of chronic conditions became essential because many patient visits were related to exacerbation of chronic conditions simply due to lack of medications or lost follow-up with other physicians. At the height of the war, at least 28% of deaths were attributed to chronic conditions, rather than to war-related acute trauma.

As soon as our group began working in the area to assist and train local Albanian physicians, we found three major areas of problems. First, these physicians were trained in the parallel education system described earlier, and there were serious deficiencies in their practical skills. The GPs with whom we were working had no experience using an otoscope to examine children’s ears. None of them had done any laceration repairs nor had applied any splints for fractures. Second, during their medical education in Kosovo, students learned by imitation rather than by understanding clinical judgment and learning how to make diagnoses. During their training, students did not have any opportunities to discuss findings with preceptors. Rather, senior physicians’ decisions and diagnoses were accepted as fact and used as a gold standard. Afraid to be mistaken, students blindly accepted their teachers’ judgments. Third, communication and interaction between patients and physicians were nonexistent. The importance of communication and care was evident, considering the fact that approximately 15% of patients in our clinic were suffering from war-related psychological stress symptoms. However, rather than spending their time counseling patients, discussing stress, or explaining the etiology of symptoms to their patients, our Albanian colleagues prescribed treatments or medications, which seemed to fuel the expectation of the “magic bullet” for all ailments. Lack of public education and the high
level of expectation for magic bullets seemed pervasive in the community.

Based on these observations, we decided to focus our training efforts on two major areas. The first was to improve clinical problem-solving skills to help the physicians make more-appropriate diagnoses. To facilitate discussions on making diagnoses, we tried to develop a nonjudgmental and collegial atmosphere for our case discussions by focusing more on the process of making diagnoses rather than just having a diagnosis. We presented our way of practicing as only one example they could consider and not as the only approach. This advisor-advisee relationship rather than student-teacher relationship helped us create a less threatening environment for asking questions and opened a path to more-active discussions.

The advisor-advisee relationship also helped us nurture the habit of looking up resources together to verify information. With frequent power outages, the use of computers was fairly limited. We therefore would look up information in whatever textbooks were available. The Albanians and the expatriate physicians worked together to compile the bedside discussions and seminars into the Kosovo Primary Care Handbook. The handbook covered a wide range of topics from sore throats and enuresis to basic war surgery.

The second focus of our training was to facilitate communications with patients. The Albanian model for health was exclusively biomedical or disease oriented rather than dealing with patients’ illness in a psychosocial and cultural, as well as biomedical, way. This medicalization was the result of expectations of both patients and physicians that all illness be treated with medication. Under this circumstance, we helped the GPs play a more catalytic role by learning to change their community through communication. For example, the most common complaints in the clinic were respiratory symptoms related to upper respiratory infection (URI), probably due to the crowded housing and high prevalence of exposure to cigarette smoking in the house. We conducted a case-control study and identified that patients who lived with smokers were at higher risk for developing a URI. Together with our Albanian counterparts, we were able to incorporate these results into patient education.11

The clinic operated for more than a month. It closed 2 days before the NATO air strike due to concerns about safety of the staff.

Introduction of Family Medicine Under UNMIK
WHO and UNMIK launched a health care reform in September 1999 after the war. One of the key plans for rebuilding the country’s health care infrastructure was to decentralize the old polyclinic system by establishing a primary care system based on the concept of family medicine. The concept was used to create a new health pyramid structure that differentiates primary, secondary, and tertiary care. With a goal of increasing the catchment of 80%–90% of common problems by primary care providers, this approach was supported by WHO and the World Bank as cost-effective and efficient.

In this new model, therefore, training GPs to function as family physicians in communities was one of their top priorities. Following the reform plan, major NGOs, which had provided emergency relief activities during the war, partnered with WHO and shifted their
projects quickly to primary care training programs. NGOs and WHO developed a 6-month curriculum that included six modules: orientation to family medicine, child health, reproductive health, management of common acute and chronic illnesses, mental health, and community medicine.  

Training Program After the War  
The GPs and nurses, who safely returned to Kosovo from the refugee camp in Macedonia, along with the expatriate physicians, reopened the Vushtrri clinic in September 1999. We resumed our training program in November 1999, 6 months after the war. Even though reconstruction of a primary care delivery system was an urgent agenda, it was difficult to conduct any training programs when the entire community was devastated. Winter was approaching, yet almost half of the houses in the villages had no roofs or windows. Additionally, there was a chronic shortage of fuels and gasoline. None of the houses had tap water. The shopping areas in many towns were completely destroyed. Our patients were waiting in silence in sub-zero temperatures. It was too cold for the patients to undress for an examination. Our bedside training and seminars were mostly conducted under torch and candlelight.

In this situation, we found several difficulties in developing our GP training program. The first was motivation. How could we motivate our Albanian colleagues to stay in the training program when their own day-to-day lives were not secured, and they themselves were the victims of war? Similar difficulties in motivation have been observed in other conflicts as well.  

Expatiate physicians took on a supportive role by helping the morale of our colleagues. We helped them restart their clinics, which had been devastated by the war. We continued our bedside discussions and exchanges under flashlights and candles. Second, in our discussions with Albanian GPs, we observed a fair amount of loss of self-confidence. They were concerned that they were being left behind from the progress of medicine due to the total devastation of societal infrastructures by war. Often they were frustrated and asked for quicker solutions, rather than tedious training, so that they could improve or catch their medical skills up to modern standards. We focused on positive reinforcement of their performance and reassurance in an attempt to improve their self-esteem. We patiently stayed at the clinic to continue our focus on morale support, rather than material support, through bedside dialogue. We continued our efforts to develop several treatment protocols for common conditions, eg, otitis media or fever workup.

In addition to the motivational difficulties just discussed, there were also logistical problems that discouraged the Albanian physicians from participating in the training. One was salary. Even though many Albanian physicians could resume their previous positions before the war in public office, their salary was much less than they expected, and payment was delayed for many months. Another issue was the credibility of the NGO programs. It was uncertain how many credits the training participants could transfer from NGOs to an official WHO training program that was to be started soon. Additionally, there was widespread anxiety about their job security with international NGOs. Nobody knew how long these NGOs would stay to support their training.

In October 2000, WHO finally started a 2-year formal family practice training program for the entire region in Kosovo. The first-year program was directly supported by WHO and the second year by the European Agency for Reconstruction (EAR). The current second-year residents are functioning as trainers in eight regional health centers all across Kosovo that are supported by various NGOs. Each center collaborates with an international NGO to provide clinical mentors. As of December 2001, there are approximately 300 trainees, in the first and second year of training combined. This number accounts for almost 50% of the currently practising GPs in the entire province of Kosovo.

Informal Evaluation and Discussion After the War  
What we provided throughout war and after was clinical bedside training and morale support for our Albanian colleagues. We conducted an informal evaluation of our interventions 2 years after the war, in November 2001. Four GPs and six nurses were interviewed, and group discussions were conducted. Almost unanimously, the first thing mentioned about our training was morale support. One of them mentioned, “... I really appreciated that Kinderberg stayed with us when our lives were most difficult ...” Also, one of them mentioned that “... After the war, the job opportunity was fairly limited, and there were not that many choices for a training program. For me, there was no other choice but to stay in the program since there were no other training programs available for us.”

It was interesting to see that they valued the experience of sharing hardship together, rather than the actual medical content of what we discussed or how we discussed it. These findings might be a reflection of trainees’ perceptions during wartime, when they considered the morale support a priority over technical aspects.

In technical aspects, however, our observations support the findings from another training program established during conflict in which only noncomplex tasks were retained after 2 months of intensive emergency medicine training in Rwanda. It is important when providing training in health care in conflict areas to assess and promote the coping skills of local colleagues since they are coping with their own personal losses (death of loved ones, loss of property).
“Kosovalization” of Family Practice

The family practice program established by WHO has trained a large number of GPs in a relatively short period of time. However, there are still many concerns for the future of family practice training in Kosovo.

The first is funding. The financial support from the international relief community for building Kosovo’s infrastructure is diminishing rapidly.

Second, even though many trainees in family practice have voiced their need to have bedside training, there is a serious shortage of clinical mentors in Kosovo and elsewhere in the area. Mentors with a wide range of clinical skills and experiences in humanitarian emergencies are rare.

Third, the post-training strategies are yet to be implemented. Those include board certification and the introduction of continuing medical education to maintain and strengthen acquired skills.

Now, both WHO officials and the trained GPs are discussing seriously the “Kosovalization” of family practice. Kosovalization is how the Kosovars modify and adapt the principles of family medicine gained through the training programs into their daily practice. We don’t know yet how they would use the family medicine approach to deal with some of the pervasive phenomena in this community, such as "magic bullet" seeking behavior or disease-oriented patient assessment.

Any training program brought from the outside, but particularly primary care training, requires an indigenization process because primary care is culturally constructed both from physicians and patients and is socially unique to each society, whether in peacetime or in conflict. With a strong history of the polyclinic system and subspecialization, the Kosovar version of family practice will be different from the one in the United States.

A department of family medicine was just opened in the local medical school. Albanians need continuous dialogue and support from outside to absorb family practice into their community. I believe that continued communication with our Kosovo colleagues will help them continue the development of family practice and will help us further understand family medicine.

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