

## Purpose of the visit:

1. Observe daily practice and assess their training needs at the KBI clinics and Baby Care Stations
2. Make milestone measurements implemented at the Baby Care Station in all project sites
3. Discuss with midwives and refine 'mother's assessment scale
4. Implement 'unlisted diagnoses' supplementing to HMIS datasheet

## Summary:

This is my very first visit to our project sites outside Kabul in five years. It took me three years since the beginning of our medical projects in the Northern provinces to have first-hand exposure of the programs. There are numerous areas in which our staff needs immediate intervention for strengthening and support. We have been discussing variables of collected data and contemplating training program in Stuttgart without much information about field reality: the focus of their practice: to focus on the needs of midwives, physicians, nurses and others who are actually working in the field sites.

The local people's appreciations and expectations have evolved around our projects in Badakhshan. The positive acceptance also raises a concern for the future direction of our program. When we first negotiated with the health Minister of Afghanistan for BCS/PCC 5 years ago, the purpose of the program was to regain people's trust to the public health system which was fallen apart during the war. We have been working closely with local and central Ministries of Public Health since then. The problem is the recovery and rehabilitation of public health care system is taking longer than we hoped for. As people's expectation to the provincial hospital and the public health system in general has plummeted, PCC/BCS are attracting more patients. This might potentially create a 'dual system' in Badakhshan, the KBI facilities vs. the provincial hospital (the public health system). We will have to develop a strategy to integrate the services of two players to complement each other at some point in the future.

Observing daily practice and discussing directly with healthcare providers in the field gave me an opportunity to have tremendous insights and hints for how to assist them. It reassured me the importance of field visits and working at the frontline of care as I do in Cleveland. I am very grateful for the support from remarkably talented and passionate staffs at the Kinderberg HQ office in Stuttgart.

## Findings and recommendations:

### Malnutrition, BCS

1. Provide the same scale for all BCS, clinics and mobile teams immediately.

The quality of scales at each facility was inconsistent. Hanging scales should be max 25 Kg (100 gm increment) with both pants and cot attachments. Regular scales are for < 6 months old children.

2. Conduct hands-on workshops for all BCS facilities on weighing children and assessing milestones.

At the Baby Care Stations, children are measured 2 times per week and kept there until they gain 85%tile weight. However, the staff does not monitor the weight gain as they do not have knowledge about how much weight the patient should gain in a few days. It was obvious that they needed basic training for feeding and monitoring weight gain. Though breastfeeding is quintessential, we have to reiterate the importance of healthy growth in all dimensions even after weaned off from the breast, both anthropometric and neurodevelopmental milestones in our feeding center.

The neurodevelopment milestones were received without major problems at the focus group discussions with 4 midwives held on December 12th in Kabul. The new head of the MCH Department seemed very comfortable to instruct these scales to others. We have to follow closely the quality of data they would send to us. Again, these milestones are to detect at-risk children. Once they detect any abnormal milestones, midwives and physicians have to monitor patients closely.

3. Develop a system to capture 'early warning signs' of potentially severely ill children.

I saw a 75% tile child with good appetite with poor weight gain at the BCS. Her older sister was obviously stunted. Acute-on-chronic malnutrition is pervasive in Afghanistan and that is one of the reasons we developed 6-month follow-up SF program. It would be very useful and appropriate to implement a 'warning sign' system in BCS to closely monitoring patients. The examples of these signs are 1) Poor weight gain in 2 consecutive measurements, 2) Fever at BCS, and 3) loss of appetite. When any of these signs are detected, physicians have to examine the patient and the patient needs to be observed closely.

4. Monitor and refine 'mother assessment scale'

We spent one whole day to conduct a focus group session with midwives in Kabul to discuss how to capture and assess mother's well-being. They all prefer 5-point Likert scale than the dichotomous scale. The three variables to address mother's wellness were identified: 1) have you been ill in the past month? 2) Do you feel you are blessed? And 3) assessment of affect by interviewing midwives. There was a difficulty in translating the nuance of 'affect' or a sense of 'blessed', but we will examine the data for the next two months to see whether we can capture some differences among mothers at BCS/SF program.

## Vaccination

The vaccinators are giving away vaccinations according to EPI. The temperature control for cold chain is essential especially for live-vaccines such as measles. The EPI schedule is different from what we do in the US and Germany (the age based approach). It is because there is a difficulty determining patients' exact age and also often there is a need for catch-up vaccination. These vaccinations are both

subcutaneous administration and intra-muscular administration. It is not clear how much training vaccinators have received before they go out and give these vaccinations.

### Unlisted diagnoses

5. Carefully monitor unlisted diagnosis which will be implemented in Logar province in 2011

Based on our discussion in September with Drs. Rab and Beshan, we revised the 'unlisted diagnoses' list. Despite the hesitance by Dr. Rab regarding how quickly we can implement this sheet in our clinic, the discussion with 5 physicians from Logar convinced me in a totally positive way. They can start filling the sheet next year (at the end of December). The quality and the contents of the data should be carefully examined for the next two month.

6. Conduct a primary care workshop focusing on clinical diagnosis at our next visit to standardize treatment and diagnoses at the KBI facilities.

The physicians I met all seem to understand difference between exact diagnoses and clinical diagnoses based on signs and symptoms with an example of UTI and pyelonephritis. There was another important finding through our discussions: The physicians at our primary care clinic order lab test or imaging studies with patients' own expenses. It is not clear how much these additional tests would add any values for the patients. When physicians find something based on these labs, or they don't understand how to interpret these results, they just simply refer patients to somewhere else without any follow-ups.

### PCC in Badakhshan and PRT hospital

PCC is providing essential medical services for villagers in Badakhshan. Those who need further care have been referred to the provincial hospital. Often, the provincial hospital refers patients directly to KBI PCC. The KBI refers patients to the German PRT in Badakhshan. However, PRT has functioned as a free standing emergency room rather than a hospital. It is designed exclusively as a forward combat support hospital based on echelon of care, where the care is focused on stabilization not on providing diagnosis and definitive treatment. They do not have inpatient capacity, certainly not for elective surgery or multiple-stage surgeries (such as burns and other reconstructive surgeries). On top of it, the medical staff turns over every 2 month which negatively affects the services in terms of the continuity of care.

7. Maintain dialogue with the provincial hospital to integrate our PCC service with effective referral and treatment.

Only option for our constructive exit strategy is to utilize our political influence to lobby the provincial government to facilitate the improvement of provincial hospital's functions. Two steps should be made:

- 1) Assess what exactly they are missing: purely logistical, material problems, moral, and/or governance issues?

- 2) Collect basic information; how many cases of surgery they conduct in a month, the surgical mortality rate, the number of monthly delivery of babies, the rate of Cesarean section, and surgical mortality in obstetrics.

If they cannot provide these numbers and simply blame the fact that they do not have X, Y, and etc, we have to intervene this hospital management very carefully and cautiously. In case we would participate in managing the hospital, we should obtain our right of staff recruitment (both hiring and firing).

#### Midwife accommodation and students

8. Have female physicians figure out our midwives' level of care and delivery management as soon as possible.

It was shocking to learn about the quality of education at the midwifery school in Badakhshan. There no teachers, no textbooks, and no references. It is unclear what kind of training they would obtain through this education. If there are no teachers or textbooks, this place or system shouldn't be called as a school. In my observation, the midwives neither use urinalysis, nor barely perform any speculum examinations at the clinics I visited. It is urgent that a qualified female physician determines the level of care that midwives are currently providing to pregnant women. I would recommend NOT introducing any advanced skills such as ultrasound before we confirm their current capabilities and practice more in detail since if they don't have any basic skills, the advanced skills would confuse them even more rather than help them. This is very similar to our discussion of 'diagnostic tools' in our clinic. Before we introduce any high-tech tools, we have to properly assess the current capacity of our medical staffs. Misuse of high tech is pervasive all over the world, and results of these misuse is much harder and costly to correct.