

CONSULTATION REPORT  
ON  
PEDIATRIC PRIMARY CARE TRAINING  
IN KOSOVA

FOR  
KINDERBERG U.S.A.  
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## SUMMARY:

Kinderberg International e.V. has been conducting pediatric primary care training in Vushtrii and Prizren, Kosova since February 1999 immediately before the NATO airstrikes. The evaluation of the program has never been conducted and there was no feedback from the trainees of our program to reflect their voice to improve our program.

The members of medical advisory board for Kinderberg USA held a meeting in the middle of July and agreed to look into the impacts of our training program in several different ways. That includes other than statistics of how much investments and how many patients seen in our clinic and how many residents were trained, we will look into the qualitative aspects of the program. In depth interview and focus group discussions will be employed to see the effects of program from participants perspective and would like to identify the lessons learned from the interventions over two years period.

Unfortunately, it became clearer that health care system in Kosova is still serious confusion and suffering from lack of leadership compared to two years ago when WHO/UNMIK started to implement their health plans. I had an opportunity to observe two ends of the health pyramid; the primary care level in family medicine training and the tertiary care level at the ER/trauma training at the Prishtina medical center. It is clear that these two tiers are not well coordinated even though they are reciprocal relationship that primary care and tertiary care are both strengthened at the same time. Each training program is led by independent initiative and poorly coordinated. The issue is who will coordinate and who really the main architect of the health system in Kosova; some say it's UNMIK, and others say it's the ministry of health. Since the last election at the end of November, the formation of new administration will be expected to alleviate this confusion.

In this trip, many people voiced their frustration against UNMIK or "internationals" for their responsibility in bringing in beaurocracy and "parallel system" to Kosova. The parallel system was the term coined for the parallel Serbian-Albanian system, now it means local (Albanian)-international (UN) dichotomy. I heard lots of complaints that internationals not listen to locals enough to reflect their ideas and opinions for program planning.

I also heard the term, "Kosovalization" of health system for the first time from Albanian health official working for WHO. It seems there are more concerns now compared to two years ago how the Kosovars take over the health care system from now.

In WHO-led family medicine training program, the Kosovar trainers often used the term; "I've never seen that fact in literatures". But in fact, they don't perform in depth journal search in any topic, the phrase was simply adopted directly from foreign trainers. They

adopted the style very well in such a short period of time, but now on, they have to fill in the contents by themselves. And it seems the essence of training will be absorbed slowly.

Many physicians practicing medicine on the floor still ask for “panacea” of advanced medical technologies that supposed to “improve” their medicine instantaneously. It is hard to convince them that there is no magic bullet to improve their practice of medicine in short period of time. Many administrators including UN officials have this “illusions” for technologies as well.

Overall, in spite of all of these training initiatives in different levels, the essence of practice based training was not initiated yet in any levels. The core of clinical training program is to improve their ability to solve problems at the bedside. Many physicians are still start their studies from medical philosophy and fail to deal with emergencies. Many physicians are interested in developing “protocols” for treatment. Their interests to develop a standard based on discussions are welcomed, however, if the protocols will be adapted as another “magic bullet” and if it will prevent them reassess patients as needed, then these protocols are more harm than good. We should discuss the pitfall of protocols that we often take out the patients from protocols in necessary.

#### RECOMMENDATIONS FOR PROJECTS BY KINDERBERG:

1. NEED ASSESSMENT SHOULD BE PERFORMED BY EXPERIENCED PERSONNEL WITH SUFFICIENT KNOWLEDGE.

There were concerns raised among former workers that there were several occasions they felt that we managed project on ad-hoc basis rather than on long term objectives.

2. OBJECTIVE OF THE PROGRAM SHOULD BE WRITTEN AT THE BEGIINING SO THAT IT IS CLEAR TO EVERY PARTICIPANT.

There were concerns that we should have written out our objectives and goals so that every participant both international and local staff can share the clear goal.

3. PROJECT PLANNING, MONITORING AND EVALUATION SHOULD REFLECT THE VOICNE OF PARTICIPANTS.

There were few concerns that sometime local voices were not well listened. That was a hard situation at the beginning since pediatric training program was started in the climate of impending war.

4. KINDERBERG USA SHOULD CONTINUE TO FOCUS ON PROVIDING INTERACTIVE TRAINING PROGRAM AT THE BEDSIDE.

There is always a request and expectations by local counterpart that they would like to have this and that “measure-them-all” multiple analyzer. However, considering our

capacity and expertise of Kinderberg USA, it is clear that we can continue to offer interactive training experiences but not supplying fancy expensive machines.

5. OUR PROGRAM SHOULD DEVELOP MONITORING SYSTEM TO REFLECT VOICES AND CONCERNS OF LOCAL PARTICIPANTS AND FEEDBACK FROM EXPATRIATES.

There were several discussions that local pediatricians had difficulty to work with few expatriate physicians. However, since there were no official mechanism to express their opinions. It turned out that people just turned their mouths and shut off their mind. It seems unfruitful experience for both sides.

6. LOCAL PARTICIPANTS AS WELL AS EXPATRIATE STAFFS SHOULD UNDERSTAND THAT THE PURPOSE OF EVALUATION AND TIMELY FEEDBACK IS TO IMPROVE OUR PROFESSIONAL PERFORMANCE NOT CRITICIZING ONE ANOTHER.

Pediatricians at the Prizren hospital had several occasions that they had to face expatriate physicians to express their concerns and ended up in bitter confrontation. We all have to share common goal of learning and improve our skills and agree to develop the attitudes to use evaluations to improve our performance.

CHRONOLOGICAL SUMMARY:

11/23/01 Friday:

I. Interview with former medical translator and local project coordinator:

1) What was your experience with Kinderberg?

“I learned a great deal from my work with Kinderberg, internet skills at their offices, patient management styles through different expatriate physicians and came to understand that the patients conditions would change rapidly.”

2) What are the mistakes do you think we made?

“They (Kinderberg) didn’t ask locals to set goals, objectives. Attending physicians at the pediatric floor are not really sharing their knowledge.”

“It’s better to make contract for those going overseas that they will stay at least two years at the hospital after they return and do some lectures for the rest of the staffs.”

II. Interview with former driver

“I lost everything in 5 minutes at the war. I believe the problem now is people depend on foreigners too much. Under the communist regime, people work from 9 to 5 and at 5 o’clock they can lock the door, but now people have to understand that they have to get their work done. I thank Kinderberg provided me a job in my hard time immediately after the war.”

11/24/01 Sat:

I. Head nurse Vushtrii

“I don’t want to be a beggar anymore. But we can’t decide anything and young people go to drugs and prostitution. I am really depressed when I think about the future of Kosova.”

“Kinderberg supported me when time was hard. I hope they would come back again and doing something for drugs and prostitution.”

II. One of the nurses at Vushtrii

“I thank Kinderberg, I learned a lot from them.”

11/25 Sun:

I. Dr. Vjosa Dobruna

“Human rights issues are skewed and bent in a strange way to protect only Serbs under current management. UN doesn’t like us to talk about human rights.”

When I asked her how we can change the style of medical teaching from knowledge base to problem-solving skill.

“I believe the change should come from two directions, from top, the administration, and from the bottom, model clinics by NGOs.”

She still wants Kinderberg to take leadership to invest private sector, network group of pediatricians who are willing to participate to change to create model clinic for residents and students education.

I got an impression that there are tremendous animosity and frustrations for this new “parallel” system, locals vs. internationals for UNMIK. They feel that they are not treated right and properly consulted for the decision making process. It seems like there is a tremendous communication gap between locals and internationals. This frustration will

lead aggression or general apathy and low morale for the participation for civil society building.

II. Former English translator for the program:

“One of the mistakes was that locals were not in decision making process and nothing was really participatory way. For example, some expatriate physicians told pediatricians (on the floor) to do this or to do that. What locals did, instead of opposing this opinion, was to shut their minds completely and leave no room for discussion or communication. They didn’t care about that person anymore.”

“I want Kinderberg to continue the training by directly hiring local administrator in Prizren to manage the training instead of hiring somebody from Germany. That must be cheap.”

11/26 Mon:

I. Dr. Safet Beqiri, MD, PhD, Director, Pristina Medical Center

They are currently trying to implement emergency medicine training as three years curriculum. Also Dr. Safet hopes he would build trauma center at the Pristina medical center. Currently they have 14 beds ICU for all sorts of conditions whatever requires ventilators. There are no recovery rooms at the floor, so whatever complicated post op patients will be admitted to ICU. This will limit the use of ICU for trauma and more complicated cases.

He also hopes to develop traumatology department and surgical intensive care unit. There are 40,000 ER visits per year and 20% admission rate. 2 or 3 multiple trauma surgical cases per day. 300 emergency operations per months. 10% approximately is trauma surgery cases. And 80% of multiple trauma patients admitted to the hospital die.

Family medicine trainees from WHO supposed to rotate for two months at the ER but somehow the WHO program is not keen to provide emergency medicine for their trainees.

II. John Kerstetter, MD, In-Country coordinator, Johns Hopkins ER program

John from Johns Hopkins has been coordinating and trying to implement ER residency program. He has been a full time personnel here at Pristina for more than a year. He asks us to provide and organize pediatric ER curriculum particularly pediatric trauma cases and toxicology cases.

He invited Kinderberg to provide 2-3 months per year core competency training for pediatric emergency medicine skills and develop core curriculum with them.

Currently he has 18 residents and he will have two residents next year. Two residents are guaranteed by ministry of health for the next year but he hopes to get 28 residents for this program. Family practitioners should be trained part of this program as well. Core competency would be pediatrics, surgery, anesthesiology, internal medicine etc for a year, with six core rotations 6 weeks each.

Next year, 30 didactic lectures on emergency medicine will be implemented into medical school curriculum. The first year residents are supposed to take PALS, ATLS AND ACLS all three of them. CARE International has been supporting for PALS AND ATLS for two years but extension of the funding support is unknown.

ALL THREE OF US AGREED THAT THE CLINICAL TRAINING SHOULD BE PRACTICAL NOT AT THE CLASS ROOM BUT AT THE BEDSIDE FOR MANAGEMENT ORIENTED WAY, NOT PHILOSOPHICAL WAY.

III. Dr. Natyre Karahoda, Professor, physiology medical school

She explained to me the involvement of medical school reform. Currently there are 60-80 medical students per class for six years training. During the parallel system only for five years. So far 600 to 700 probably 650 medical students at the medical school.

Dr. Strickler and Dr. Korish from Dartmouth medical school just visited the school and they will help supporting family medicine center at Gjilan, one of the eight regional family medicine centers in Kosova. Besides, Dartmouth has been involved in supporting medical education reform in Pristina as institutional involvement, helping out medical library, exchange program of students and faculty members. Dartmouth promised to provide support in educational level not in clinical level. For instance one month exchange of students and faculty members for next two years.

Mental health, emergency medicine, child health, OB, surgery and dentistry are six core areas for family health curriculum.

Family medicine training implemented by WHO has been led by BBI, French consulting group, British, French and Dutch have been involved. EAR European Agency for Reconstruction has been the main donor of WHO's program. There are currently 50 trainees per year for WHO. But as stated earlier, their curriculum is extremely weak on emergency medicine not focusing on stabilizing trauma or anything, just scoop and run approach.

IV. Former local project coordinator and English translator

It was tough time to motivate trainees to participate our training program two years ago in Vushtrii.

“There were several things made training difficult

1. Authorization of the training.
2. Inconsistency in payroll, somebody were paid, others didn't get paid."

"As long as the organization has some flexibility to self correct the direction in the middle of the project including local voice or transparency of decision making process, it would be easier to carry out the project."

"It seemed like the project was carried out ad hoc and availability basis without any vision or objectives. If it did, the decision and thought process of the project and program was not clear from the field level."

"In country administrator changed so often every three months and it was hard to keep up with these people."

"The Vushtrii project spent too much money for physical structure putting together clinic facilities rather than training or salaries."

"It should be written out the object of the program at the beginning. Even in the emergency cases. Ministry of health, or health house and Kinderberg should have exchanged the agreement and made it official to participants as well."

#### V. Former medical project coordinator

"Communication between the headquarter (HQ) and field office was not good in terms of decision making process. Sometime, HQ asked the field office to write some proposals in few days depending on the availability of funding."

"As soon as HQ had somebody work fulltime for the organization, we have to concern about overhead cost and start to seek funding to support overhead cost."

"The organization was built by single handedly by a charismatic person, however the project requires more than charisma when it should be carried out professionally. In this respect, the project needed transparent occasional feedback and evaluation, open discussion of direction of the project."

11/27/01 Tue:

#### I. Dr. Rushit at Mitrovica, WHO family medicine training center

Visited one of the seven regional family medicine training centers organized by WHO. Dr. Rushit and four others are in charge of providing training for 17 family physicians, they call the 2<sup>nd</sup> cohort on Monday and Tuesday from 9 to 2:30 for didactic sessions.

There are tremendous uncertainties among trainers and trainees about the future of family medicine. Some of the concerns from trainers are;

“It is sometimes extremely challenging to teach trainees older than the trainers. Some of these elder participants are very resistant to change. ” Then we discussed the importance of persistence of our effort as a trainer.

They do not have any systems to improve their teaching skills systematic way. I suggested creating a group to discuss cases and teaching methods to improve their performance. However, they are extremely busy at the moment and they are not sure whether they can do that or not. Besides, it seems difficult to motivate them to be a better performer if there is no rewards for a family medicine trainers.

I also told Rushit that their training should be collaborated with ER medicine. They all agreed that their ER component is very weak.

Trainers concerned about the paucity of clinical training by foreign preceptors at the training sites. They can provide lectures and seminars at Pristina, however their interactions at the scene has been fairly limited. Trainers seem they adapted dynamic Western approach of teaching using overhead projectors and with concise bullets points, however, they don't have that much interaction with participants and their method seems still very vertical. Part of the reason would be their lack of confidence. Participants tend to ask many questions and their comments during the session, sometimes discussions ended in “I have never seen any literature on that”, probably the comment they acquired from their foreign preceptors. They have to learn the meaning of learning as well as styles of teaching.

Trainees of the training program also have concerns for their training and future income.

11/28 Wed:

I. Dr. Gazim, attending pediatrician, Prizren Hospital

He has been in Tirana, Albania pursuing his master's degree in pediatric science. He went there for two months and now back in the hospital. He is interested in going USA for three months for training. I encouraged him to learn how to teach and how to facilitate discussions with other colleagues. He is still interested in pursuing development of protocols with his colleagues and residents.

II. Ms. Hamada, In-country coordinator, Asia Medical Doctors Association (AMDA)

Ms. Hamada, the country director of AMDA had difficulty providing field mentor for WHO's family medicine training. After major big NGO left two years ago, each eight family medicine training center has individual NGO support to obtain field mentor for their trainees. The field mentors supposed to supervise teaching done by trainers of

family medicine and discuss cases at the clinic when trainers have problems. AMDA has a contract to recruit mentor for Mitrovica and Ferizi family medicine centers.

11/29/01 Thu:

I. Dr. Alush, vice president, prizren hospital

He agreed to send Dr. Gazim for three months and I explained him about the concept and contents of the training based on our written agreement. I specifically asked him about the contract to let whoever doctors been in abroad to share their knowledge and skills with other colleagues. I suggested modifying my drafted contract. He appreciated my effort to make the draft.

He also showed tremendous interest to learn laparoscopic surgery going to be implemented pretty soon at the hospital. Jacova hosp, pristine hosp are already started and he doesn't want to be left behind. He will go to visit Tirana next week for their facility but he is eager to go to visit US specifically for the training.

He also showed his interest to have pediatric anesthesiologist for even two weeks assessment and moral support. He does not believe that Prizren hospital would have pediatric surgery center in the future but he wants to implement appropriate level of pediatric surgery in the hospital. He does not know whether Dr. Agim, a pediatric surgeon will have time to go to the US for study. But he has no doubt in his mind that Dr. Agim will be the leading pediatric surgeon in Prizren.

He told me that EAR and Luxembourg government pledged financial support for their laboratories for next two years, so he is anticipating better care and equipment within next two years.

II. With Pediatric attendings, Drs. Tringa, Imran, and Jehona (neonatologist), and residents, Drs, Bajram, Fatmire, Lendita, Lilyana and Rexhep.

There are lots of complaints about the poor facilities and equipment. They believe that their laboratory is getting worse. I told them that we can not bring any big machines or equipment at all. And the possibility of us to bring in big funding is ZERO. We are happy to continue small scale interactive training program, though. I told them that I met several people in Pristina side and it seems the people know how and what should be changed. Dr. Uke and everybody else has lots of uncertainty for the future of training and their job security whether they will have more trainees or get extra training themselves somewhere. They don't know how many trainees they would have in the future. Ministry of Health will decide everything and nobody knows what their thoughts are.

Dr. Uke also mentioned about the importance of developing protocols but without any lab or equipment, it is extremely difficult to do so. I told them that protocol development should be realistic and adapted to the level of care in current Kosova. I reiterated my point in May that none of the US trained pediatricians are comfortable practicing

medicine here in Prizren with current level of equipment. So, it is challenging environment and tough situation. Nonetheless, the important part is to continue the dialogue and discussion among your colleagues. Without healthy discussions, even with fine equipment, protocol will not be developed.

1) How were their experiences with Kinderberg doctors?

They all agreed that they had good times with American doctors. They sometimes had problems with doctors from Germany.

2) How to improve your experiences with Kinderberg?

1. list of lectures
2. handouts
3. Everybody is anxious about going abroad.

I asked them the situation and condition about the training in the US. They all agreed to work hard once they get there. I asked the possibility to vote for the best resident and attending who would be selected to going abroad.

3) What are the complaints about the residency training programs so far?

1. Only through observation in other clinics.
2. short rotation
3. no evaluation or feedback for performance
4. uncertainly about the future what's available for them at the job marketwise, economic concerns as well
5. No fellowship is available for further training
6. No hands-on teaching
7. No bedside skills are taught by attending physicians.

I asked about their motivation, next time if I come back to the floor, can I count on you to be responsible for managing patients? They said, yes.

4) What are the good aspects of having foreign physicians?

Practical lectures  
Problem based learning  
Differential diagnosis

5) What would you do if you have problems with expatriate doctors?

They seem to have no official complaint mechanism so far and in the past, individual confrontation was the common way to manage the problem. Obviously, there was a feeling that Kinderberg could have responded much earlier and better if they have listened to their comments. I told them what we do in the US to deal with issues in preceptors and how we help them to improve their teaching skills. But I am not sure how

much they understand the importance of system to improve performance of the trainer. The principle of evaluation is always to help to improve the performance through feedback not just grading them.

6) What is the quality we need as preceptors for you?

1. Sufficient clinical experiences to guide them for their assessments and instruct hands-on skills.
2. Listening skills to learn from them or learn with them, not look them down.

It seems they have a bitter experience with one German doctor with quite a strong attitude. They felt that their voices were not heard enough by Kinderberg. But also they didn't have a system to manage problems.

3. Updated knowledge and techniques. Some of the retired physicians were not suitable for education.
4. Short term assignments are OK but preferably longer. And also it's ideal if they can accommodate appropriate specialist for appropriate seasons. (e.g. pulmonary specialist for winter time, GI for the summer)
5. There are strong concerns that language skills should not be the base for selection for studying abroad. They were very discouraged that when they heard the rumor that the same person will be taken to abroad simply based on their proficiency in English.
6. Practical aspects of patients' management, assessment, examination, should be hands-on.
7. The physicians went aboard should share their knowledge and skills with others immediately after they come back. (I told them that I put that recommendation specifically to Dr. Alush as a requirement).
8. We discussed to develop a system to say NO to expatriate physicians. I specifically told them that they SHOULD NOT just shut their mouth if they have problems with foreign doctors. They have to develop a system to deal with a problem. And I believe that in our side, we have to have a system to deal with the same. I suggest somebody should come out every three months or so independent of the expatriates doing training and make sure everything is OK, particularly if we, Kinderberg USA does not have any in-country coordinator.

I believe that I got a lot of honest feedback from our residents and pediatricians. I told clearly to Dr. Uke and other pediatricians that Kinderberg USA does not have any big money to bring equipment or new machines. And I can not make false promise to ask any big funding. We have to be aware that funding is diminishing. Our intention is to provide interactive training at the bedside in small scale. I explained to them how Alan will invite there pediatricians to Jacobi hospital, taking extra calls and shifts. Dr. Uke said that still

they will welcome any American pediatricians for training them at the bedside. They deserve the best and we try to bring the best. We are still interested in making this pediatric department the best in Kosova.

11/30 Fri:

I. WHO family medicine training program at Pristina Medical Center

I attended trainers' training program at the medical center coordinated by a British GP, Professor Bob Hesley from UK. He has been providing training for the 2<sup>nd</sup> year family medicine trainees for a month at the time on and off. He has been the main architect of the training course led by the WHO.

The session was on chest pain and how to make a diagnosis and how to refer and how to implement the first aid.

Almost 50 of the trainees were split into three groups and discussed a case. The facilitators were not trained for problem-based learning skills to guide the discussion and it seems often the discussion ended into very scattered dialogue. At the end, one group presented their discussion and led the entire group for discussion. There seemed to be a several problems in this session.

1. The group was too big and the set up was for the didactic session not for collegial discussion among them. They face the speaker and set up chairs like a class room.
2. Bob was not a dynamic speaker and failed to coordinate or facilitate the entire discussion.
3. They didn't get any messages for the difference between regular case and emergencies.
4. They didn't discuss how to look up information or improve their skills.
5. It seems they still preoccupied with the notion of medical knowledge as a gold standard. They spent 20 minutes on the dosage of morphine and kept coming back to the dosage issues rather than discussing the diagnosis or what to do.

TRAINERS TRAINING  
PROBLEM-BASED LEARNING  
EMERGENCY MEDICINE  
FACILITATOR TRAINING

They should learn more about group work, problem-based learning, how to be an effective trainers. Also, the cases they discussed were not well designed, since their diagnosis was MI and Bob failed to explain the concept of ACS.

II. Dr. Genc Bucinca, WHO family medicine coordinator

He has been a main coordinator for this WHO led family medicine training for the last two years. The program was started as a continuing professional development (CPD). WHO is responsible for the 1<sup>st</sup> year of the training and 2<sup>nd</sup> year is done by BBI supported by European Agency for Reconstruction (EAR). There are 200 participants for the 1<sup>st</sup> year and 50 participants for the 2<sup>nd</sup> year program like Dr. Rushit. Another 50 trainers are currently working with them as trainers as well. (Fast track trainers with sufficient practice experience can be trainers after one year of training by WHO).

The first year trainees are trained through 8 regional centers. All of the regional centers are supported by NGOs (except Peja by Italian Red Cross). There is a one US NGO, called NorthWest Medical Team.

They have been trained almost 300 GPs already which is almost a half of the GPs in Kosova. Based on the application for WHO, it seems there are 560 GPs in entire Kosova.

And finally, the Family Medicine department is developed in medical school. He does not know who will be the chairman of the department. The foreign supporting chairman would be Dr. Bob. Dr. Genc told me there are few problems. By far the most immediate problem is the funding. Who would continue for how long? And the second problem is to Kosovalize family medicine to fit it into their soil. In his perspective, the most difficult part of Kosovalization of family medicine is implementation of the program at the ministry level.

DRAFT CONTRACT PRESENTED TO DR. ALUSH

1. The training program at the Jacobi hospital/ Columbia University in New York City, USA will be for three months.
2. The purpose of this training in the US, 1) learn the patient management in the pediatric floor in the US, 2) learn how the attending pediatricians teach their residents at the bedside and at lectures, 3) learn how they manage pediatric patients at emergency rooms.
3. The participant of the program can not treat patients in the US by him/herself. Always, you need supervision from US physicians.
4. During the training program, every participant is expected to stay all day for three months without any exceptions.
5. After they finish their training at Columbia and return to Prizren, they are expected to stay at the hospital for at least two years to transfer whatever they learned in the US to other colleagues and residents.
6. They should provide several seminars and lectures on what they learn in the US immediately after they come back.
7. They are asked to stay at designated accommodation during their training period.
8. The Prizren hospital is expected to provide on-call coverage while the trainee is in the US.
9. The contents of the training is to follow pediatric patients at the ER with American residents, participate their discussions every morning, round patients with them, help their daily work so that he/she can be familiar with patient management in the US. Also the trainee is expected to attend all the lectures and seminars for residents in the US.
10. Kinderberg USA will pay for their travel and provide accommodations during their stay in New York City.

SCHEDULE:

Date	AM	PM
11/22 Thu	Cleveland to Washington Dulles	Dulles to Vienna, Austria
11/23 Fri	Vienna to Pristina, Kosova	Met Rickie and Driton at the airport Arranged driver for next week Visited Dr.Shkendija Dobrona
11/24 Sat	Visited Vushtrii and met with Dr. Rushit and four nurses worked for Kinderberg	Discussed about our project with Dr. Rushit, Gjika and Driton
11/25 Sun	Met Dr. Vjosa Dobruna discussed about human right issues in Kosova	
11/26 Mon	Visited University Clinical center met with director, Dr. Safet Beqiri  Met Dr. John Kerstetter from Johns Hopkins and discussed with them about emergency medicine residency training	Round patients with Dr. Kerstetter to ICU and ER  Met with Dr. Natyra Karahoda at the medical school and discussed about medical education reform  Discussed with Driton, Gjika about Kinderberg project
11/27 Tue	Visited Mitrovica WHO training center for family medicine	Visited Vushitrii and met with Mr. Chaban.  Drove down to Prizren Met with Prof. Karmit Zysman
11/28 Wed	Visited Dr. Gazim at his private clinic  Visited pediatric floor at the Prizren hospital	Met with Ms. Hamada, AMDA coordinator and discussed about the WHO family medicine project in Mitrovica and Ferizai  Met with Dr. Agron and Dardane

11/29 Thu	<p>Visited pediatric floor at the Prizren hospital and met with residents and attending pediatricians.</p> <p>Met with Dr. Alush, vice-president of Prizren hospital and discussed about the exchange program</p>	Continue my discussions with pediatric attending physicians and residents.
11/30 Fri	<p>Drove from Prizren to Prishtina and visited WHO family medicine training center, Prishtina met Prof. Bob Hesley from UK.</p> <p>Facilitate discussions on chest pain case with trainers.</p>	<p>Met with Dr. Genc the coordinator for WHO family medicine training and discussed about the difficulties and problems of the current training program.</p> <p>Dinner with Dr. Gjika and Mr. Michael Weinhara and discussed the evaluation of Kinderberg project.</p>
12/1 Sat	<p>Breakfast with Professor Karmit Zysman discussed about the psychosocial program.</p> <p>Met with Ms. Hamada, AMDA to clinical mentorship program in Mitrovica</p>	Flight from Prishtina to Vienna, Austria
12/2 Sun	Flight from Vienna to Washington, DC	Flight from Washington DC to Cleveland