

Consultation Report on  
Pediatric Clinic, Vucitrn, Kosovo  
For  
Kinderberg, Germany

March 1999

Masahiro Morikawa, MD, MPH  
Director, International Health Program  
Department of Family Medicine  
Case Western Reserve University  
10900 Euclid Avenue  
Cleveland, OH 44106  
Phone: (216) 844-3207  
Fax: (216) 844-3799

## 1. Logistics

### 1-1) Clinic Settings:

Under the agreement among Mother Theresa Society (MTS), Health Center in Vucitrn and Kinderberg, MTS relocated their pediatric clinic in new location in order to respond the increasing needs to provide pediatric care in Vucitrn, Kosovo. The clinic was planned since November and was finally opened on 2/15/99.

### 1-2) Location:

Vucitrn locates 20 km north of Pristina, the capital of Kosovo. According to one of our staff physicians who has been practicing almost twenty years in the area, there are about 40,000 people living in the township and the surrounding Vucitrn County has another 40,000 population.

The clinic is opened on the first floor of three stories building. Landlord and their family who evacuated from surrounding villages were occupying the second and the third floor at the time of my stay.

It takes about 30 minutes by car to drive up to the village. The road along the way is paved and well maintained. There are several security police (MUP Police, Serbian) checkpoints along the way. There are usually several points (one or two in the morning, few more in the evening.) Serbian police usually checked only passport for foreign expats, but scrutinize the registration card and driver's license for Albanians.

### 1-3) Facilities:

There are three examination rooms, one triage room, one charting room with a drug cabinet, and a procedure room. Each examination room has examination bed, stool, cabinet, sink, heater, and emergency light. The triage room has a table for weighing scale and desk. The charting room is furnished with tailor-made cabinet, bookshelf, heater and several stools. The procedure section has an examination bed and a table. Water supply is limited due to the unreliable city water system. Big cistern installment was underway when I left. That water cistern will guarantee sufficient supply of water to the clinic.

The clinic opens at eight and stops taking patient at three p.m. Expatriate physician is supposed to drive back to Pristina before dark. For this reason, we had to leave clinic by 4:30 p.m. every day.

The clinic was closed on Thursdays so that each member of our four local physicians could work 24 hours per week under the original agreement.

#### 1-4) Staffs:

Thirteen local staffs were hired; Four physicians (two pediatricians, two general practitioners), four nurses, one administrator, one coordinator, one housekeeper, one custodian and one translator. The MTS was responsible for the recruitment process.

#### 1-5) Patient visits:

Since the clinic was opened, there were 90 to 100 patients in a day. From the beginning of this month (March), the number of patients was fairly stable between 70 to 80 patients a day. The clinic usually got busy around 10:00am and continued to be busy until 2:00pm then slowed down towards the end (we closed at 3:00pm). Patients seen in the clinic are age below fifteen.

Patients came into waiting area first. Then a triage nurse took the name of the patient on a notebook. At triage room, the nurse will take basic information before she admitted the patient into the examination room. The basic information included anthropometric measurements (weight, height, and head circumference) if patients were less than three years old, family tree (siblings, parents), past medical and surgical history, current medication and allergy. Albanian staffs use Metric system.

#### 1-6) Breakdown of patients:

Please refer appendix for number of patients seen in our clinic. In March, number of patients was stable between 70 to 90 per day. The patient visit tended to slow down on Sundays. The lowest number of patients was observed on 3/7, Sunday, the census dropped significantly after 1:00 p.m. when four MUP police was staying close to the entrance of our clinic.

## 2. Patient care

#### 2-1) What we've been seeing in the clinic?

Fortunately there were no serious cases that required immediate transfer to tertiary care hospital in Pristina or Mitrovica.

In cross-sectional survey on 3/18/99, about 60% of visits in both IDPs and non-IDPs were related to upper respiratory complaints (including viral URI, pharyngitis, otitis media, and laryngitis). Other forty percent includes various common primary pediatric problems including UTI, enuresis, skin rash, GI symptoms, and muscular pain. The magnitude of psychological problems among IDPs was difficult to estimate since office encounter usually focused on biomedical problems. Therefore, somatization of many psychological stresses might be overlooked.

There was a significant concern that our clinic didn't provide care for the seriously ill population. According to IMC (International Medical Corp) official, in their mobile clinic, also 60% of patients were URIs (personal communication). Other mobile medical teams saw adult patients. Many of the adult patients had elevated blood pressure due to mental/psychological stress.

2-2) Characteristics of IDPs:

In terms of complaints and disease distribution, there were no difference between IDPs and non-IDPs in our clinic. According to our one-week chart review, there was no significant difference between IDPs and non-IDPs in terms of anthropometric measurements less than three years old. (A statistical analysis of anthropometric indices will be provided upon request.) IDP affected the non-IDDP household as well since a non-IDP household shared their food and house to accommodate their IDP relatives.

2-3) Record Keeping:

There was no patient record in MTS before we opened our clinic. The physicians did not use SOAP system (please refer Kosovo Primary Care Handbook) nor they recorded any findings through physical examination. In government health center in Vucitrn, there were no patients' charts. Through my daily review of their note, their description was Subjective, Diagnosis, and Prescription.

2-4) Prescription:

Paracetamol (acetaminophen), vitamins, antibiotics (particularly amoxicillin) were the most commonly prescribed drugs in our clinic.

*Paracetamol*: the most common drugs used for pain and fever. Liver toxicity was not the major concern since there were no significant malnutrition.

*Vitamins*: Indication for prescription was not clear. One clinician told me that the medication was for placebo effect. When patients wanted something for their visits, vitamins were commonly picked up. It sounded like there was a problem of "medicalization" in this community similar to the Western world.

Most Commonly Prescribed Medication in March

| Ranking | Medication                  |
|---------|-----------------------------|
| 1       | Paracetamol (Acetaminophen) |
| 2       | Amoxicillin                 |
| 3       | Multivitamin tablets        |
| 4       | Ibuprofen                   |
| 5       | Aspirin                     |

*Antibiotics:* The threshold for antibiotics use was obviously much lower than that of US. I found that there were numerous clinical subclassifications for URIs (laryngitis, pharyngitis, sinusitis, bronchiolitis, and bronchitis) and antibiotics were commonly used regardless of patients' age.

Another reason for frequent antibiotics use was associated with concerns for RF. The actual prevalence of ARF was unknown (diagnosis based on strict application of Jones criteria). Most of the ARF cases were based on "clinical" diagnosis and only satisfy one major criterion for Jones criteria. (Jones criteria should satisfy two majors or one major + two minor criteria).

#### 2-5) Patient-physician relationship:

In my observation, patient-physician relationship was more "teacher-student model" rather than "advisor-advisee model" which is more prevalent style in the US. Physicians rarely explore the reason for visit or pay much attention to psychosocial issues in patient encounter. The explanation and patient education were fairly limited compared to the office visit in the US. As I mentioned before, the clinical encounter is predominantly explained by biomedical axis.

#### 2-6) Medicalization:

There were increasing number of multiple visit patients in our clinic. The chart review of these multiple office visits revealed that in many instances physician provided another prescription or medication rather than provide education or counseling in their subsequent visits. Obviously, patient's expectation and physician's explanation will find an easy compromise when physician prescribes another pill. (Arthur Kleinman's explanatory model and negotiation of explanatory model).

### 3. Education/Partnership

#### 3-1) Focus:

One of the primary goals of this project was to provide high-quality postgraduate training to physicians working in our clinic. I tried to establish collegial relationship with these doctors. During my stay, I provided, morning seminars, one-to-one precepting for GPs and interacted with other medical staffs.

#### 3-2) Seminars:

Please refer the table attached to this report for topics covered during my stay. I developed handouts (protocols) in English and made it translated into Albanian by translator. I encouraged local doctors to participate discussion as well as presentation. Two GPs provided several seminars. Towards the end of my stay, two general

pediatricians got more involved in discussions and they shared with me lots of their experiences and interesting cases in our clinic.

Two general practitioners selected topics by themselves and presented. In one lecture on Vitamin D deficiency, all four of them were delighted to share their clinical experiences and showed me some clinical cases.

### 3-3) Precepting/interaction:

I precepted almost all cases with two general practitioners. Their level of care is equivalent to third or fourth year medical student in the USA. They are able to handle common pediatric problems but needs more training and guidance to see patients with multiple medical problems.

I really enjoyed interacting with physicians in our clinic. Two general practitioners graduated from their medical school within last two years. They were very motivated to learn all aspects of medical care. I spent time for one-to-one precepting with these GPs.

I tried to interact with two general pediatricians as much as I could. After the first week, as we spent more time together, they tried to show me more interesting cases they have, such as BCGoma, umbilical granuloma on infants (looked like a pyogenic granuloma), rickets.

### 3-4) Nurse education:

In the last two days of my stay, I encouraged nurses to participate patient triage process. I gave one stethoscope to each nurse. I spent one whole afternoon with two nurses in the triage room to teach them how to pick up serious clinical signs.

Lume (one of the nurses) told me that there were number of reasons they didn't use stethoscope;

1. They were not allowed to do anything with stethoscope except BP check in their health care system.
2. Patient does not want nurses to examine them.

And obviously, the nurse education will be a threat to general practitioners as well. For example, during my nurse education session at the triage room, one GP stayed with me all the time to see what I was teaching to nurses.

I stressed that nurses can not be secretaries. The nurse should tell the physician whether the patient should be seen or not, or should be seen immediately or not.

### 3-5) Triage:

Concept of triage was originally developed in war situation where overwhelming number of seriously sick patients were brought in and the health resources were fairly limited. In our clinic where patients were mostly stable the notion of triage was different. Triage meant in our clinic by the medical coordinator, Dr. Gjika, was to prioritize the patient

visit so that seriously sick patient be seen by doctors as soon as possible. And at the same time, it was an opportunity for nurses to provide basic patient education so that patients can avoid unnecessary visit.

In my observation, this notion of triage was relatively new to both nurses and physicians. There were several obstacles to implement triage into the current system. First of all, physicians did not expect nurses to do more than registration and measurement. Secondly, we had to educate all basic physical examination skills to nurses which nurses were quite unfamiliar with. In the third, patients were not used to be examined and asked questions by nurses.

Unfortunately, I did not have enough time to implement and monitor this triage system into our clinic.

#### 4. Research

One of the clinical questions we had was whether IDP status made the patient more vulnerable to any medical conditions. We decided to perform semi open-ended questions to all the IDPs came to the practice one day.

We discussed the purpose of this survey including triage nurse and translator. Albanian physicians took initiative to modify questionnaire to local context. Each interview was performed by trained triage nurse or translator. The interview was performed not to lead or bias the interviewee to certain categories. Interview was performed in triage room where each patient came in for registration. The triage room was ideal for protect privacy since the door was always closed during the interview.

The purpose of this study was:

- Identify the problems among IDPs in their priority order.
- Identify whether IDP status is risk for any medical conditions.
- Try to describe the plight of IDP in this conflict through their health status.
- Take this opportunity to train physicians and nurses for epidemiological methods so that they can prepare for future community outreach.

##### 4-1) Semi open-ended questionnaire for IDPs:

Please refer to the attached questionnaire. Results of this survey were striking. By far the biggest concern of IDP family was the overcrowding of their house. Indeed, more than 95% of the answers placed this problem as their first concern.

##### 4-2) URI risk factor survey:

Try to further characterize the IDP status as a risk factor for health problems, we decided to perform the next stage survey. In two consecutive days, we interviewed 144 patients or

their parents for IDP status and their housing conditions. Please see attached questionnaire.

Findings: (Preliminary analysis of the data. The final analysis with multiple logistic regression will be performed by SPSS (Statistical Package for Social Science shortly.))

1. IDPs were more likely to end up in crowded living conditions for longer terms compared to non-IDP population. (OR = 7.54, 95%CI (3.15-18.40))
2. “Overcrowding” in household was not significant predictor for upper respiratory infections in this study. Non-IDPs and patients from less crowded household had similar number of URIs in this study.
3. Smoking in the household might be a risk factor for URIs but not statistically significant.

There are several reasons we discontinue the study after two days even though there were not enough samples to satisfy statistical power.

1. It was busy clinic and it was too much work besides patient care and bedside discussion.
2. Duplicating survey form could cause financial burden to the clinic.
3. The training purpose was partially satisfied through developing and modifying questionnaire with local staffs.

Potential explanation for these unclear association between crowding and URIs might be:

1. Case definition was unclear.

There might be a significant amount of misclassification in the study. Musculoskeletal pain can be a prodrome for viral URI.

2. Case-control status was unclear.

URIs are fairly common diseases with relatively short duration. A case can be a control and vice versa in the next week of survey.

3. Overcrowding might not be a single risk factor for URI.  
As we see, other risk factors can be stronger risk factors.

## 5. Conclusion and recommendation:

1. Pediatric clinic in Vucitrn, Kosovo was providing primary pediatric care + urgent care.  
The clinic covered wide range of common pediatric problems. The patient number and severity was stable. The wide variety of health problems in this community could not be solved entirely by urgent care style. Primary care approach could not provide timely care for acute medical problems. This population needed the combination of both primary care and urgent care. Unfortunately, the notion of primary care

pediatrics was new to the local physicians. Nonetheless, we were providing primary care to our population including growth monitoring and anticipatory guidance.

2. There was a serious concern that our service could not reach to seriously ill patients. Outreach program and surveillance system in the community should be established to make our efforts more meaningful.

Despite the situation of surrounding villages, we didn't deal with any psychiatric, nutritional or medical emergencies.

- The sick patients could not come to our clinic. The accessibility of the clinic for villages in mountainside was unknown. Or the patient and the family might do self-triage and go directly to the bigger hospitals when they were really sick.

Even mobile medical teams (MSF, MDM, and IMC) did not see many seriously sick patients in their clinics. Therefore, accessibility can not explain the whole picture of this phenomenon.

- Too early to see any significant pathology. As the UNICEF nutritional survey showed, there was no acute malnutrition in the sample in December. The nutritional effect will take for a while to cause significant damage to the body. We are seeing relatively fresh IDPs, that means that they might be healthier compared to refugees fled to Albania or other countries.
  - The population in Vucitrn area was not seriously ill compared to many other areas.
3. Education/training can be best facilitated through collegial dialogue and discussions in daily bases. This process will take for a long time until they eventually change their behavior. They were delighted to share their knowledge and skills with us, foreign physicians through seminars and discussions. It is important to provide them any opportunities to share their skills.
  4. The level of care we provided in the village surpassed the local level both in terms of facility equipment and quality. So-called "second opinion" cases had increased steadily throughout my stay. Sustainability of this clinic with 100% local infrastructure was opened to discussion.

I was my great honor and pleasure to work with people in Vucitrn, Kosovo. I would like to appreciate Kinderberg for providing me this opportunity. I would like to see you all in the near future again.

Seminar topics during my stay

| Date        | Topics                                 | Speaker            |
|-------------|--|--------------------|
| 3/5/99      | Treatment of Burn Injury               | Mori Morikawa      |
| 3/6/99      | Growth Monitoring of infants           | Mori               |
| 3/7/99      | Pharyngitis                            | Mori               |
| 3/8/99      | ABC/Resuscitation                      | Mori               |
| 3/9/99 (AM) | Pneumonia                              | Mori               |
| 3/9/99 (PM) | UXO/Landmines                          | Mori               |
| 3/10/99     | Logistics, Patients for second opinion | Mori               |
| 3/12/99     | Enuresis                               | Mori               |
| 3/13/99     | Sepsis                                 | Dr. Rexhep Kovaci  |
| 3/14/99     | Basic epidemiology                     | Mori               |
| 3/15/99     | Vitamin D deficiency                   | Dr. Rushit Ismaili |
| 3/16/99     | Assessment of Trauma patient           | Mori               |
| 3/17/99     | Logistics, patient flow, registration  | Staff              |
| 3/19/99     | Logistics                              | Staff              |

Number of patients seen in our clinic during my stay

| Date       | Male    | Female  | Total      | % of IDPs |
|------------|---------|---------|------------|-----------|
| 3/3 (Wed)  | -       | -       | 84 (34)    | 40        |
| 3/5 (Fri)  | -       | -       | 84 (37)    | 44        |
| 3/6 (Sat)  | 38 (7)  | 38 (9)  | 76 (16)    | 21        |
| 3/7 (Sun)  | 19 (12) | 15 (7)  | 34 (19)    | 56        |
| 3/8 (Mon)  | 46 (16) | 49 (17) | 95 (33)    | 35        |
| 3/9 (Tue)  | 46(21)  | 42 (17) | 88 (38)    | 44        |
| 3/10 (Wed) | 46 (17) | 36 (11) | 82 (28)    | 34        |
| 3/12 (Fri) | 49 (25) | 47 (16) | 96 (41)    | 43        |
| 3/13 (Sat) | 31 (17) | 33 (12) | 64 (29)    | 45        |
| 3/14 (Sun) | 33 (17) | 32 (14) | 56 (31)    | 55        |
| 3/15 (Mon) | 48 (18) | 38 (23) | 86 (41)    | 48        |
| 3/16 (Tue) | 42 (17) | 38 (19) | 80 (36)    | 45        |
| 3/17 (Wed) | 41 (19) | 39 (17) | 80 (36)    | 45        |
| 3/19 (Fri) | 38 (21) | 43 (11) | 81 (32)    | 40        |
| Total      |         |         | 1086 (451) | 41.5      |

The number of IDPs is in parenthesis.

Semi Open-ended questionnaire for IDPs

Date of the Interview:

Interviewer:

Name of Interviewee:

Age:

Sex:

Reason of visit to our facility today?

The reason you left your house?

Why you come to Vucitrn? How you get to Vucitrn, by car, by bus or walk?

Where are you staying? (Parents', friend's, or relative's house?)

How long you are staying in current house?

How many people in your house now?

How many adults?

How many children?

How many children under age 5?

What is your major concern now? (housing, economics, water food, health, politics whatever for the most concerning problem)

Why it's the major concern to you?

Thank you for your cooperation. This is very helpful for us to identify the problems you are facing and will help us to better serve you as a health professionals.

URI risk factor survey

Date of Interview:

Interviewer:

1. Diagnosis
2. Sex of patient:     Male   Female
3. Age of patient
4. Significant past medical/surgical history, such as hospital admission, surgery
5. Anthropometric measures (if age <3)  
    Wt                 Ht                 Hc
6. Breastfeeding for the patient:     Yes         No
7. IDP status:     Yes         No
8. Length of IDP status (if IDP):
9. Number of people in the house
10. Number of rooms in the house where people are staying
11. Number of people in the room sleeping together
12. If you are sleeping more than five people in the room, how long you have been staying together?
13. Number of smokers in the house
14. Number of meals per day on average
15. Availability of water for bathing, shower, handwashing

No problem at anytime, available but limited, hard to get water for living, very difficult to get water