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# Winter 2010

# International Update Newsletter

## Healthcare Training in Afghanistan: the challenges and opportunities

John Parks, medical student, Washington, DC

In July of 2008, I left the familiarity of medical school in Washington, DC and moved to Kabul, Afghanistan. There, I worked alongside Drs. Tim Fader (on the picture in the center) and Gary Goforth, who were responsible for the first Family Medicine residency in the country's history. My role was twofold: teaching the residents evidence-based medicine (EMB) and research methods, as well as conducting research projects with the attending physicians.

The Afghan residents were a remarkable group of men and women who had harrowing personal experiences from years of war. Working with them made me realize what I had simply taken for granted in my education. The Afghan medical curriculum does not provide strong instruction in the critical thinking skills necessary to interpret research or apply it to practical use. Over a ten month period, the residents and I worked hand-in-hand creating individual research projects. I found the residents hungry to learn this skill. It is this capacity for analyzing and problem solving that is essential for improving healthcare, which will produce interrelated effects on economic and educational development. The attendees and I were able to pursue a number of



projects during my tenure. The most interesting project, and the one that cemented my desire to become a Family Physician, involved assessing the residency graduates in practice.

After the defeat of Taliban in 2001, a new health care system was created for  
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## Save the Date!

### 2010 AAFP Family Medicine Global Health Workshop

- ✓ Learn the latest in global family medicine development;
- ✓ Develop lasting approaches to sustainability issues;
- ✓ Network with leading international developers;
- ✓ Share your experiences and learn from other.

September 9-11, 2010  
Coral Gables Hyatt Regency in Miami  
(Coral Gables), Florida

Visit [www.aafp.org/intl/workshop](http://www.aafp.org/intl/workshop) for details



American Academy of Family Physicians  
Center for International Health Initiatives  
Winter 2010

## Lessons of Global Proportions

Martha C. Carlough, MD, Assistant Professor, Department of Family Medicine, UNC Chapel Hill School of Medicine

After a two hour ride, we have arrived at our home for the next few days – a village on a hillside in rural Honduras where a cement block primary school has been turned into a makeshift child health screening site. I gingerly unfold myself from the cramped but privileged spot behind the water bottles in the back of the truck. I am met by one of our 4<sup>th</sup> year medical students who arrived yesterday and has been out and about visiting homes and drumming up business. She is weeping and angry, demanding that I do something to fix the situation she has gotten herself into. Last night she made friends with a family from another village and convinced them to come to the clinic. She ate their tortillas, slept on a mat in their home, and walked down the hill with them this morning. Her understanding was that the health screening was free – a chance to see a doctor, get a toothbrush and worm medicine, and even a blood check for anemia. However, the local health committee’s belief is everyone should pay something--that nothing in life is free. Many children need to be screened and resources are scarce.



The simple answer is to secretly pay the fee, but, to this student, it is an issue of trust, integrity, and compassion for the woman who left her field for the day and carried two of her children to stand in this line. Together we negotiate with the committee and I watch the medical student regain a sense of self and attitude of advocacy for a patient caught in a system which should serve rather than create barriers. I get a glimpse of how she will have the strength to do that again one day, when she is in practice and her middle-aged patient with diabetes is laid off, loses his insurance, and can't fill his insulin prescription.

Postpartum hemorrhage now has a face. The woman who arrived at our doorstep tonight rode three hours in the back of a truck. She is pale but conscious, with a retained placenta, and her baby in her arms. The resident and student on call for the night wake me up when she arrives. The Honduran physician who lives and works here is already there and placing an IV. We give the woman oxytocin, gently deliver the placenta and massage her uterus until the bleeding slows.

During two weeks of didactic classes about global health in Chapel Hill, before our trip to Honduras, we discussed statistics and priorities for health and large scale evidence-based solutions. Maternal mortality is the health indicator with the greatest discrepancy between wealthy and poor countries. It is a marker for both health care access and quality. One in four women who die during pregnancy or childbirth does so from postpartum hemorrhage. The average time it takes to bleed to death, leaving babies and families behind, is less than two hours. Active management of the third stage of labor, including a dose of utero-tonic medication reduces this risk by two thirds. Nonetheless, many women die in their homes after an unattended birth with no chance to receive even this low-risk, low-cost intervention. Others die on the way to a health post or district hospital after hours of delay trying to gather money and a means of transport. As we debrief what happened with the woman tonight and how this near fatality could have been prevented, we are confirmed in the need to be “upstream Samaritans” – working on prevention, on access to health care for all, and the promotion of safe affordable solutions that save lives.

A week later, after a busy day at the Shoulder to Shoulder Clinic in Santa Lucia, most of us are crashed on bunk beds drifting off to sleep in sweltering heat under inefficient ceiling fans. Eighteen medical students, six residents, and another six faculty physicians sharing joint living space for a couple of weeks provide ample opportunity for understanding Myers-Briggs personality typing. As conversations dwindle, the students leaving for a village visit in the morning are organizing their belongings in mostly fruitless efforts to create external order in this unordered space. Being a team is challenging.

*continued on p. 3...*

## Ask the expert: Interview with Dr. Cindy Haq



Cindy Haq, MD, Professor of Family Medicine and Population Health Sciences, Director of UW-Madison Center for Global Health

Q.: How can a FM residency program prepare you for international service?  
 CH: I feel strongly that being a family doctor has been the best possible preparation for my career in global health. First of all, there is no other specialty that prepares you to take care of children, adults, pregnant women, the elderly, conduct procedures, and deliver palliative care. Family medicine is the only specialty that gives you that very broad skill set. As a family doctor, I

was able to walk into the Kasangati Health Center in rural Uganda with the basic skills to care for any patient who presented. Although I did not have tropical medicine skills; I learned to develop these over time. Yet I had basic clinical skills to care for patients of all ages, and an appreciation for the patient in the context of their family and community. And that was, in fact, very, very important.

Some residencies now are developing global health tracks or pathways to provide additional training in global health preparation. Our program here at the University of Wisconsin in Madison has developed a global health pathway where our residents are able to build in a longitudinal self-directed study attending seminars and courses offered by our Center for Global Health. and

integrating these with clinical, community and public health experience abroad.

If you can find a program with a global health track, that is great. If you can't, there are now enough resources available through the internet that you can do your own self-study. It is great if you have a faculty mentor or advisor who can help you prepare, someone who has done some international health work, who knows the realities of what the challenges are- those challenges are very real-and what precautions you should take to prepare yourself and your family. You need to be prepared so that you can travel safely and return healthy. Your faculty mentor can also help you use your international experience to develop a scholarly product. If you can develop a presentation or a paper, this can end up becoming an important stepping stone for your career in global health. The first time I went to Uganda opened the door for me to work in Pakistan, which opened the door for me to work in the World Health Organization, and then in other countries. So, if you think of each experience as opening the door to additional possibilities, then you begin to build a skill set that helps you reach beyond your work in the US. At the minimum, you need to find a residency program that will be supportive of your interests and that is willing to provide guidance, advising, and even course work or programs that will help you prepare at a deeper level.

*This issue starts the new section: Ask the Expert. Readers are encouraged to send their questions to [aivanov@aafp.org](mailto:aivanov@aafp.org). The above response was part of Dr. Haq's interview taken in February 2009 during the Global Health webinar sponsored by the AAFP Division of Medical Education. For more information: <http://fmignet.aafp.org>*

### Lessons of Global Proportions

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There are natural leaders emerging here that are not necessarily going to get an award at medical school graduation in two months time. They are the ones who know how to make people laugh and keep walking when we are exhausted and irritable. They can get their classmates to finish cleaning up the kitchen when they'd rather be lying in the hammock reading "Politics and Poverty," because the cooks need some to rest too. Some of us are not as easy going as we thought we were, and others have a lot to say but no words to fit the experience. Working together towards common goals takes energy and grace. Integrating what we each bring—from our families of origin, lived experience, intellect and personalities — with how we can work together to make a healthier world is hard work. This crash course in community-building will pay off during nights on call in the emergency room in residency and discussions between specialists and generalists on hospital staff committees.

There is perhaps a glamorous side to global health in medical education today — opportunities to travel, to try new ideas in new environments, and to feel good about ourselves and what we can offer a world in enormous need. Global education endeavors are costly in terms of time, money, or energy. Investments need to be critically assessed, and those in leadership are responsible to do so. But it is important to keep in mind that some hard-to-measure outcomes are the very ones that bring hope to the future of family medicine.

## Notes from Nicaragua: Challenges to decreasing health disparities with community based primary health care

Laura Chanchien Parajon, MD, MPH

In poor countries around the world such as Nicaragua, over 7 million children die every year of completely preventable and treatable illnesses such as diarrhea and pneumonia (1). In Nicaragua, the poorest

people have the least access to health care and poor children are three times more likely to die than those who are not (2). As physicians working in rural Nicaragua, our challenge is to decrease these health disparities through empowering and effective health programs.

In the last eight years, my husband and I have been implementing the model of community based primary health care (CBPHC) to serve remote communities in rural Nicaragua. We have trained and supervised over 40 community health workers (CHW) to

provide health promotion, disease prevention and curative care services to increase access beyond the limited existing government health services. CHWs are volunteers who decrease child mortality through evidence based interventions such as case management of pneumonia, promotion of exclusive breastfeeding, and neonatal home visitation (3).

Our organization partners with communities in an empowering process to carry out an annual census to identify their own priority health issues and develop their own action plans. The census promotes equity by reaching all people in a community including the disabled, the chronically ill, and pregnant women and children often missed by non-community based health services.

Through CBPHC, we have seen child and maternal mortality decrease in a way that is empowering to communities. It has been rewarding as a physician to see CHWs treat children like Anita in their own communities;

and as a mother, to see that life for another mother is made just a little bit easier when health care is more accessible.

*(Note: Laura Chanchien Parajon is a family physician and her husband, David Parajon, is an internist and preventive medicine specialist. They are co-directors of AMOS Health and Hope, a 501c3 non-profit community health organization ([amoshealthandhope.org](http://amoshealthandhope.org)) based in Nicaragua)*

For the full list of references, please contact Alex Ivanov at [aivanov@aafp.org](mailto:aivanov@aafp.org)

***You walked two hours  
down steep mountain footpaths,  
with Anita in your fragile arms,  
feeling hotter than the sun,  
and breathing so hard,  
you wanted to breathe for her.  
And as the doctor in me,  
begins to treat your baby,  
the mother in me is heartbroken  
by how hard your life is,  
living on a dollar a day,  
in a tin house with dirt floors,  
and all you have to go through,  
just to keep your baby alive.***



Dr. Laura training CHWs and health committee members to do participatory community assessment and planning through a methodology called photovoice in the rural mountain community of El Roblar.

## Healthcare Training in Afghanistan: the challenges and opportunities

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Afghanistan. Family Medicine as a specialty did not exist in the country at this time. The residency program I worked with, which was the first, was created in 2005. Our team wanted to advocate that Family Medicine doctors would be a valuable asset to the country and data was needed to support this. To do so, we traveled to one of the most remote villages I have ever visited to observe two of the first graduates at work.

The information we gathered illustrated the incalculable value of broad-based Family Medicine training for Afghanistan. I returned to medical school with a global vision for Family Medicine because I have seen how the holistic training can be beneficial to a multitude of settings.

For questions or further discussion, please contact: [johnticeparks@gmail.com](mailto:johnticeparks@gmail.com)

## Physicians with Heart: 2009 Mission to the Republic of Georgia

Rich Bruehlman, MD, Co-chair of the PWH FM Symposium Planning Committee

Alex Ivanov, AAFP International Activities Manager



In late October, a 24-member delegation traveled from the USA to Tbilisi, Georgia as members of "Physicians with Heart", a collaborative effort between the AAFP Foundation and Heart to Heart International, an international relief organization founded by family physician Gary Morsch. Most of the delegation began their journey to Tbilisi aboard the C-17 cargo jet that carried \$7.2 million of donated pharmaceuticals and medical equipment from Andrews AFB in Washington, D.C. to Tbilisi via Ramstein AFB in West Germany. The US Department of State (DOS) arranged for and covered the cost of the C-17, while in Georgia multiple non-governmental organizations (NGOs) assisted the delegation and distributed the supplies.



Pharmaceuticals and medical equipment on board the C-17 cargo jet in the Tbilisi airport. Dr. Ostergaard (in the middle) with representatives of the US DOS and the Hellenic Care and A Call to Serve International NGOs.

The purpose of the mission to Georgia was 3-fold: deliver essential medications to clinics and hospitals, promote the development of family medicine through informal meetings and a 2-day family medicine symposium and deliver supplies to schools and orphanages (For more information about PWH Children's project: [www.aafpfoundation.org](http://www.aafpfoundation.org))

Georgia sits on the eastern edge of the Black Sea. The country is still recovering from the August 2008 war with Russia, whose troops still occupy Georgian territory in South Ossetia and Abkhazia. The war has displaced thousands of ethnic Georgians from their homes in the occupied territories.

Georgia is a very old country but a young democracy. Since the "Rose Revolution" of 2003, Georgia continues to move towards a free-market economy, even in health care. The government is encouraging individual rather than employer-purchased health insurance, except for those under 6 and "pensioners" 60 years and older. The physicians in the delegation met for an hour with the Minister of Labor, Health and Social Affairs (MLHSA) who spoke eloquently in English about the reforms.



**Total population: 4,433,000**

**Gross national income per capita (PPP international \$): 3,880**

**Life expectancy at birth m/f (years): 66/74**

**Healthy life expectancy at birth m/f (years, 2003): 62/67**

**Probability of dying under five (per 1 000 live births): 32**

**Probability of dying between 15 and 60 years m/f (per 1000 population): 255/94**

**Total expenditure on health per capita (Intl \$, 2006): 355**

**Total expenditure on health as % of GDP (2006): 8.4**

*(Source: World Health Statistics 2008)*

### Family Medicine in Georgia

Family medicine in Georgia progressed substantially since Physicians with Heart visited in 2004. Most current family physicians are former pediatricians and internists who have completed a 7-month retraining program. Over 1000 physicians have been retrained as family doctors. When the goal of 2000 is reached to provide primary care for 4.5 million citizens, the retraining programs will close and 3-year residency programs will take over. In Georgia, medical school tuition is free or subsidized but graduates must pay about \$3,500 to get residency training in family medicine.

Family doctors in Georgia are outpatient-only doctors. They make a modest living but find many challenges. A survey that found that barriers to running an effective practice included low reimbursement, poor facilities and poor systems for charting and data collection. The doctors stated that they do battle the usual chronic diseases including hypertension, diabetes, coronary atherosclerosis and stroke.

### Family Medicine Symposium

Since Georgia's independence from the Soviet Union in 1991 and the country's subsequent political elections, the country has launched a series of reforms aimed at strengthening the military, economic and healthcare infrastructures. Unlike other former Soviet

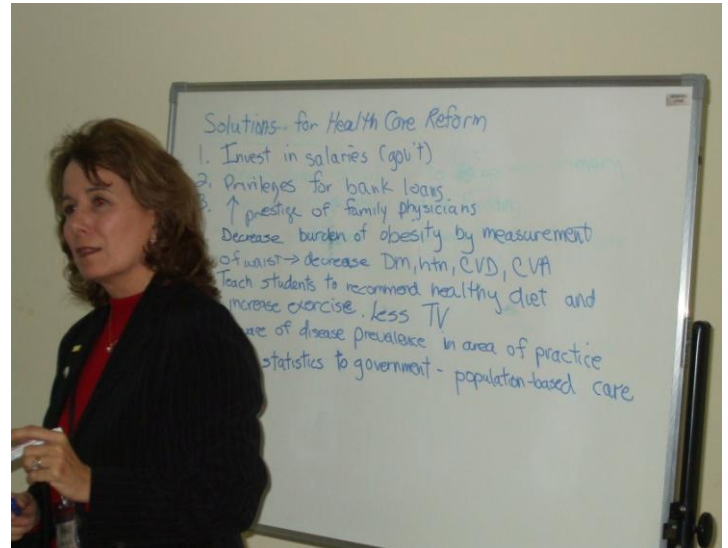
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states, progress in Georgia has been fairly steady, but was recently hampered by the Russian invasion in August 2008.

During the preparatory Needs Assessment trip made by the PWH partners in February 2009, the Georgian MLHSA, Georgian Family Medicine Association (GFMA) and other local healthcare partners indicated a need for training local family physicians in the advantages and benefits of primary health care, family practice management and healthcare administration, which have been greatly impacted by the current healthcare situation.

The Symposium program developed under the leadership of the PWH Symposium Planning Committee and in close collaboration with the GFMA and Tbilisi State Medical University (TSMU), reflected the above local needs and focused on Primary Health Care and family practice management. The 2-day Symposium was held in Tbilisi and, unfortunately, due to the still volatile situation in some parts of the country, the PWH family medicine team was advised not to hold their education activities outside the capital city. The Symposium Planning Committee ensured that health professionals from the regions be provided with travel allowance and accommodation to attend the conference.

The Symposium was a true collaboration of local and international partners. It featured plenary sessions and workshops presented by the PWH medical team and Georgian counterparts: MLHSA, TSMU, GFMA and Kipshidze Central University Hospital. The USAID provided financial assistance while on-site logistical support was generously provided by World Learning and ACTS International, USAID grantees in Georgia.



Jane Weida, MD, co-chair of the Symposium Planning Committee, talks about Challenges and Solutions of Primary Care in the US.

About 160 local physicians, residents and physicians-in-training, TSMU faculty and governmental officials attended the Symposium and had an opportunity to share their views and concerns about the Georgian healthcare system, family medicine development in Georgia and worldwide, primary care role and value of family medicine. The family practice management sessions held on Day 2 covered such topics as collaboration between PHC facilities and hospitals, introduction of the Evidence Based Medicine, basics of the Patient-Centered Medical Home, types of medical practices, high performing clinical team creation and the impact of patient satisfaction on health care outcomes.

#### NGO Profile: **Genesis World Mission**

Tracy Haworth, RN, International Director  
([www.genesisworldmission.org](http://www.genesisworldmission.org))

Genesis World Mission (GWM) is a faith based organization that provides sustainable human health services to economically disadvantaged individuals through local and international partnerships. GWM strongly believes in partnerships that foster innovative sustainable health care solutions for the underserved. GWM empowers people, organizations and communities - helping them access health care, to make healthy choices for themselves and their families.

In 2001, Dr. Karl Watts, current recipient of the Physician of the year, co-founded GWM with an initial focus on addressing the unmet health needs of people in the developing world. However, it wasn't long before Watts expanded his vision to include the less fortunate people in his

own community. When the local medical community came together to tackle the issue of a closing free clinic, Dr. Watts offered Genesis World Mission to open and operate the Garden City Community Clinic (GCCC). The GCCC now provides medical services three days a week and on-site dental services are offered two days per week. Mental health care, counseling and patient education are also provided free of charge to eligible patients. The clinic accepts only lower-income, uninsured patients and relies on about 200 volunteer health care workers to provide the direct care.

Watts has continued to fulfill his medical mission work in other developing nations, and has been involved in outreaches in Kenya, India, Haiti, Honduras, Guatemala and the Philippines. Watts and International Director, Tracy Haworth was instrumental in mobilizing resources to establish a medical facility in Kenya and is serving on the average 1,037 patients a month. The current focus of GWM is the

duplication of similar smaller clinics in remote areas of coastal Kenya.

A key component of the process of replicating clinics is the use of short term medical teams. These teams give those that serve a life changing experience while educating and delivering health care to communities and building in-country relationships – which paves the way for sustainable, accessible health care. Since the inception of GWM, the experience of establishing the GCCC has served as a model for replication elsewhere, while being careful to provide personal touch that reflects the native culture and society.

The heart of Genesis International is captured in this quote: "Go to the people; live with them, learn from them, love them. Start with what they know, build with what they have. But of the best leaders, when the job is done, the task accomplished, the people will say: 'we have done it ourselves'. Lao Tzu

## A Visiting Professorship at The University of Crete, Department of Social Medicine

Andrea Manyon, MD, Professor and Chairman Family Medicine  
Upstate Medical University, Syracuse, New York

In Crete, Dr. Gabriella Aspraki, an anthropologist working with Professor Christos Lionis in the department of Family and Social Medicine at the University of Crete (UOC) first met me. Professor Lionis is only one of three academic General Practitioners (GPs) in Greece. Two medical schools (Thessaloniki and Larissa) have Family Medicine departments.

“Learners” included nine GPs employed by the Greek government in rural clinics participating in a Master’s program at the UOC. Primary care is delivered as a “hub-and-spoke” model in rural Greece, with a Health Center and 4-10 GPs in practices at the spokes. Some have computers; none have individual charts--just one large book. They see 10-16 patients per day; receive a salary ranging from 1200-1800€ per month.

Historically it was common for physicians to accept tips, in the “fakilaki” or “little envelope,” for income enhancement, more commonly practiced among specialists, to prioritize a patient’s procedure. It is illegal, oversight is limited. Salary advancement for GPs are based on length of service, advanced degrees (Masters, PhD) and research publications. These learners are ethical doctors in the masters program for advancement opportunities.

The students were inquisitive, challenging and friendly. They loved hearing contextual stories about the practice of Family Medicine in the United States; family and social issues, information access, organization and work ethic. These GPs were in their late 30’s, in working couple



Dr. Manyon (third on the right standing) with the colleagues from the department of Family and Social Medicine at the University of Crete

families. They appreciated interactive teaching, team-based homework, contextual learning, and discussing differences in health systems and cultures. Everyone expressed concern about the over-worked American doctor!

This model of General Practice is relatively new in Greece. The Greek Society of General Practitioners was founded in 1986. After 6 years of medical school and 4 years of residency, all GPs must work for 7 years in a rural practice. Most of the GPs I met never want to leave their rural practices.

Of course we shared meals. Stelios, the take-charge leader of the group led us on a circuitous, cliff-hugging drive to a restaurant/hotel complex with a night vista at the mountaintop. Dinner included Cretan rusks (hard slices of bread), local cheeses, olives, salad, and traditional macaroni and rice dishes, stuffed grape leaves (the best I’ve ever had), wild mushrooms, grilled meats and stewed goat. The meal was complemented by local wine and fresh cherries.

The most compelling learning point over dinner was HOW MUCH these doctors enjoy their work. They finish their days by 2pm., unless they are over-nighting at the Health Center. Patients ring the bell and wake the doctor. The doctors laughed and told stories about patients who complain “I’ve had a pain for three months, now it is gone, I am worried!” These GPs love their work. They seek to formulate a disease registry in their practices, without appointments open access is a given. Shunning the “little envelope,” these GPs accept watermelons, bread, eggs, chickens, and home-baked foods; receiving these gifts honor Hellenic tradition.

## 19<sup>th</sup> Wonca World Conference of Family Doctors

**Millenium Development Goals:**

**the Contribution of Family Medicine**

19<sup>th</sup> – 23<sup>rd</sup> May 2010, Cancun, Mexico

[www.wonca2010cancum.com](http://www.wonca2010cancum.com)



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