Kosovo: the challenge to public health

For many, 1999 will be remembered for the Kosovo crisis and the ensuing international humanitarian response. By May of this year, 90% of the region’s 1.6 million ethnic Albanians had been displaced, mostly to overcrowded refugee camps in bordering countries. Thousands more have been transferred to other countries in Europe and North America. Such rapid population movements are an enormous risk to public health. What are the major public health challenges in this crisis and what will be the impact of transferring large numbers of refugees to countries beyond Kosovo?

The first threats to health in Kosovo started in 1989 when autonomy was withdrawn and ethnic Albanians boycotted the Yugoslavian public health system. Alternative arrangements for primary and secondary care were established with some success, but the rise in ethnic tension in 1996 lead again to a deterioration in health care. WHO data immediately before the current crisis suggested that immunisation rates have fallen markedly. Despite this, Kosovar refugees were relatively fit compared with many other refugee populations. Sporadic cases of gastrointestinal infection and severe respiratory tract infections have occurred, especially in old people and the very young. In the first two months since the start of the war, there have been no reported outbreaks of infectious diseases, although the population is particularly at risk from hepatitis A, typhoid, cholera and polio. High consultation rates have been reported for chronic diseases such as asthma, hypertension and diabetes. Mental illness has been a particular problem arising from violence and rape.

One of the first challenges for the authorities was to develop a public health infrastructure in new camps; providing clean water, sanitation, nutrition and medical services. Normally, this provision is lead by host countries and coordinated by the United Nations High Commissioner for Refugees (UNHCR). Through this mechanism, the work of government and voluntary aid agencies (such as Oxfam, Save the Children and Merlin) is locally coordinated. This has been the case for Kosovar refugees despite political concerns of de-stabilising the region. For example, the WHO has been able to plan a waste disposal programme for hospital wastes and a communicable disease monitoring unit has been established in Macedonia to provide early warning of outbreaks among refugees. Nato troops have also been available for logistical support. This degree of organisation contrasts with many other humanitarian emergencies. In the crises of Ruanda (1996) and Sudan (1986) for example, aid workers faced severely malnourished populations with high levels of communicable diseases. This was made worse by politically unstable neighbouring countries making it harder for UN and other aid agencies to develop a systematic response.

Britain, along with other Western countries, is in the process of accepting large numbers of Kosovar refugees. What will be the public health implications for these refugees and their host countries? On arrival, refugees are managed in “reception centres” coordinated by the UK Refugee Council. District directors of public health are charged to coordinate the NHS response with their local chief environmental health officers and emergency planning officers. Some guidance has been prepared for NHS staff for districts who are receiving refugees and further advice has been published by the Medical Foundation for Victims of Torture. However, most of our knowledge about refugee health is limited to issues in camps and little is known about managing the public health of large numbers of refugees in other settings. We will therefore require greater coordination and sharing of skills and expertise, particularly with aid agencies and across all countries accepting refugees.

Finally, one further question begs an answer. While health care for Kosovar refugees will be an immediate challenge for aid agencies and public health practitioners in Kosovo and other countries, should we not also tackle our passive attitudes about the health of other threatened populations. According to the World Bank for example, 1.3 billion people live in poverty and UNICEF estimate that half a million children die each year as a result of unrepayable debt owed to governments in the West. The needs of such people for help and assistance are very often no less than those facing refugee populations and are equally deserving of being tackled.

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7 Centres for Disease Control. Famine-affected refugee and displaced populations: recommendations for public health issues. AMIWR 1992;41:1-76.