Balkans briefing number 5. Seeking refuge (Macedonia, 9–25 June 1999): the changing needs of humanitarian aid in the face of the peace

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Ekipi Britanik

- *"Do te evakuoje refugjatet Kosovare.*
- *Asnjeri nuk do te evakuohet kunder deshires se tyre.*
- *Bashkesia familjare duhet te ruhet, familjet gjate evakuimeve humanitare nuk do te ndahen.*
- *Prioritet do te kene familjet te cilat kane probleme shendetsore.*
- *Familjet: me femije te vegjel, me nje prind, antar te moshuar ose me probleme serioze shendetsore kane prioritet.*
- *Familjet, qe qendrojne "kohe te gjate" ketu do te kene prioritet per evakuim.*
- *Ne Jemi ketu per te ndihmuar."*

(British Team Skopje 1999-Humanitarian Evacuation:

- "We will evacuate refugees from Kosovo.
- No one will be forced to leave against their will.
- Family unity must be preserved. Families will not be separated for humanitarian evacuation.
- Refugees in the most difficult situation because of family situation or health problems will go first.
- Vulnerable families with small children, single parents, elderly persons or family members with serious medical problems are a priority.

Country	Departures 20 Jun 99	Total departures to date	Scheduled departures 21 Jun 99	Scheduled departures 21 – 27 Jun	Quotas
Andorra					6-10 cases
Argentina					500
Australia		3,470			4,000
Austria		5,079			5,000
Belgium		1,223			1,200
Brazil					100
Canada	46	5,317			5,000
Chile					500
Croatia		370			5,000
Czech Republic		824			100's
Denmark		2,823			3,000
Estoria					15
Finland		958			1,000
France		5,796	204	612	not available
Germany		14,689			15,000
Greece					5,000
Iceland		70			100
Ireland		1,033			1,000
Israel		206			not available
Italy		6,199			10,000
Lithuania					100
Luxemburg		101			not available
Malta		105			100
Moldova					75
Netherlands		4,067			4,000
New Zealand					1,000
Norway		6,075			6,000
Poland		1,049			1,000
Portugal		1,271			2,000
Romania		41			5,000
Slovakia		90			500
Slovenia		860			1,600
Spain		1,426			1,800
Sweden		3,675		163	5,000
Switzerland		1,687			2,500
Turkey		8,105		736	20,000
United Kingdom		4,191		157	1000's
USA		7,126		832	20,000
Uruguai					not available
TOTAL	**46**	**87,926**	**204**	**2,500**	

Figure 1 UNHCR/IOM Humanitarian Evacuation Programme (HEP) 21 June 1999.

Figure 2 Last sight of Macedonia for Kosovar refugees being evacutated from Skopje airport.

Figure 3 The world's media descend on the peace talks at the Kosovo-Macedonia border.

Stenkovec 1 (Brazda)	21,400
Stenkovec 11	20,600
Bojane	3,800
Neprosteno	8,300
Radusa	2,500
Senokos	6,800
Cegrane	41,000
Total	**104,000**

Figure 4 Refugees in camps in Macedonia (former republic of Yugoslavia) in early June 1999.

Figure 5 Refugees in camp in Macedonia.

- Consideration will also be given to long-stay cases.
- We are here to help you.")

Such was the British delegation interpretation of the United Nations High Commission on Refugees mission statement for Kosovo on the ground. Beginning in early April 1999 the largest displacement of civilians in Europe since the second world war had led to hundreds of thousands of Kosovans being relocated to refugee camps and supportive families in the community particularly in Albania and Macedonia. The countries of the European Union, the United States of America and other members of the UN family became actively engaged in the humanitarian relief effort. By the beginning of June tens of thousands of men, women and children had been evacuated and transported around the globe (figs 1 and 2).

The public health aspects of this mobilisation have been described from a British perspective in previous articles in this series.[1–4] By the time the emergency was over, more than 4000 people would have travelled to the United Kingdom, the overwhelming majority to the two northern regions, in and around Liverpool, Manchester and Leeds-Bradford. Initially, the refugees were in large family groups, sometimes of 10 or 15 people, with a range of ages, both sexes and with a smallish number experiencing serious health problems. Their main problems were psychological, to do with their recent, often extremely stressful, experiences and physical and emotional exhaustion. They were met by a remarkable local response of overwhelming hospitality in the main, and the inter-agency arrangements of social work, health, housing and social security worked extremely well. Because of the large numbers coming to the north an early decision was made to have a local public health presence from the north-west region on the ground at the Macedonian end.[2] In early June, at the time of the handover of personnel, the situation in the Balkans changed dramatically with the signing of the peace agreement with concomitant implications for the direction of the humanitarian effort (fig 3).

A change of emphasis from families to those at medical risk

On 27 May the United Nations War Crimes Tribunal indicted Slobodan Milosevic for crimes against humanity. Five days later peace negotiators considered a letter from Milosevic that was said to accept the basic principles of a deal. On 10 June the peace agreement was signed.

At this time over 100 000 refugees were living in seven camps in the area of Macedonia just inside the border from Kosovo (figs 4, 5, 6).

Once the peace had been agreed, almost immediately national delegations began to develop plans to withdraw and to close down their operations (figs 7 and 8).

The problem with this development related to the situation in which many people and families in the camps, and in the wider community, with serious health problems still found themselves. Reports were coming in of the degraded state of the health care system in Kosovo itself and, despite the best efforts of the international non-governmental agencies that were providing clinical care in the camps, they could not begin to provide the kind of specialist interventions that many people needed as a

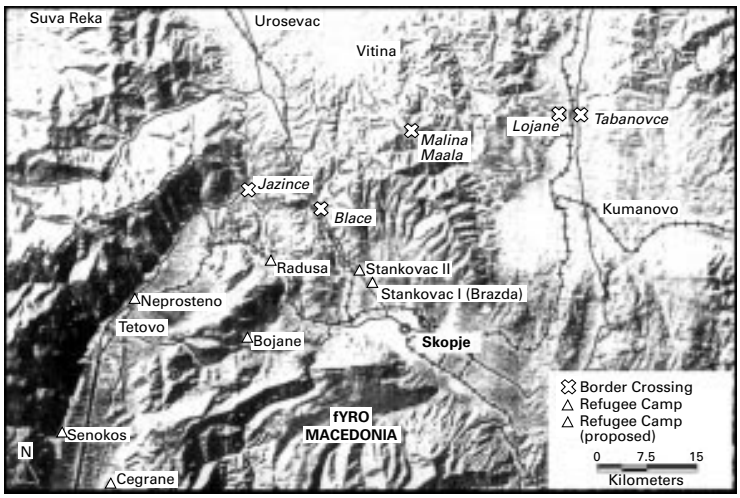

Figure 6 Refugee centres and sites in northern Macedonia (former republic of Yugoslavia) June 1999.

Country	End Date	Remarks
Australia	20/06/99	
Austria	08/06/99	
Belgium	04/05/99	
Canada		Quota full. Only accepting family reunions
Croatia	17.06.99	
Czech Rep	18.05.99.	
Denmark	15.06.99.	
Finland		Still considering medical cases.
France	07/07/99	(Approximately.)
Germany	16/06/99	
Iceland	19/05/99	
Ireland	17/06/99	
Israel	26/05/99	
Italy		Taking medical cases.
Luxembourg	15/06/99	
Malta	26/05/99	
Netherlands	31/05/99	
New Zealand		Taking family reunions.
Norway	31/05/99	
Poland	05/05/99	
Portugal		Last flights being organised.
Romania		No longer selecting.
Slovakia		No longer selecting.
Slovenia		No longer selecting.
Spain		Still selecting 400 persons.
Sweden		Considering medical cases.
Switzerland		Considering medical cases.
Turkey		Considering medical case.
UK	25/06/99	But still taking medical cases.
USA		Resettlement programme.

Figure 7 Health Evacuation Programme Countries with programme end date (situation analysis 21 June 1999).

General Criteria

- Patients irrespective of age, sex, citizenship, ethnicity, religion, political background should have an equal chance being incorporated into the program. The classification/discrimination has to be based on pure and clear medical consideration only.
- Proper diagnostic and/or treatment procedures for the given health problem of the patient are not available in the country from which she/he has been selected for PME.
- There is a clear and high likelihood that the present condition of the patient would have a good overall prognosis and a significant improvement in quality of life could be achieved, if a specific medical service only available in a third country would be provided.
- The condition that indicates the evacuation is life threatening or function compromising. In other words: evacuation will protect life and/or function. (See below in details!)
- The patient's medical condition can be stabilized for the transportation abroad.
- The patient's current medical condition won't create surplus risk for escort people and for those who are travelling together with him/her.

Classification of patients

Priority one (P1) – Expedient movement: Life threatening conditions with an immediate need for hospitalization on arrival.
Examples:
- Congenital heart disease close to decompensation
- Continuous fever with unknown origin
- Chronic or acute renal failure with need for haemodialysis
- Unstable angina pectoris
- Diagnosed malignant tumors of different origin, but without evidence of metastases
- Recurrent gastroenteric bleading, etc.

Priority two (P2) – Accelerated movement: Conditions with need for urgent follow up treatment or with need for urgent assessment and treatment for reconstructing function.
Examples:
- Known malignancies with completed initial treatment, without evidence of metastases and with need of follow up treatment (radio- or chemotherapy)
- Congenital heart disease
- Haematologic diseases
- Disease of the endocrine system with clear manifestation (including IDDM with major complications)
- Inborn enzymopathies
- Congenital malformations (e.g. Luxatio coxae cong.)
- (War) injuries with need for reconstructive surgery
- Osteomyelitis
- Active TB cases with complication but not in contagious phase (have received the initial therapy)(?!) etc.

Question: Psychiatric cases

Priority three (P3) – Low priority movement: non urgent need for assessment and for therapy not available locally.
Examples:
- Effort Angina pectoris
- Need for prothesis
- Insulin dependent diabetes mellitis with minor complications
- Disabled, mentally retarded children needing special care

No priority (P4) – Medical cases with no: no special consideration is needed, normally scheduled travel.
Examples:
- Known chronic diseases under regular treatment (e.g. non-insulin dependent diabetes mellitis, chronic hepatopathies, chronic lung diseases etc.)
- Age related health problems, geriatric diseases etc.

Figure 8 General criteria and classification of patients selected for Priority Medical Evacuation (PME).

matter of some urgency. On the ground outside the camps, Macedonian hospitals and primary care centres were struggling under the huge additional burden imposed by the swollen refugee population. Underlying the dilemma, despite the best efforts of the World Health Organisation in setting up a disease surveillance system,[3] was the dearth of information about the extent of the problem. At the daily meetings of the local UNHCR office attention switched to two things:

- how to get some decent intelligence on health needs in the camps and beyond, and
- how to maintain the engagement of country delegations in evacuating people in medical need for a while longer.

People with serious health problems had no prospect of having their needs met in the camps or locally in Macedonia, and if they were to return home there was scant prospect of their needs being met even in the teaching hospital in Pristina for the foreseeable future.

Under this pressure and working together with the country delegations and non-governmental organisations, the United Nations agency IOM (International Organisation Migration), and the sole public health doctor from the UK, a clear set of criteria for classifying patients for Priority Medical Evacuation was agreed, and during a hectic weekend casenotes and other recorded information were sifted and appraised using the classification, producing at the end of the exercise a single page summary with additional analysis by camp, location and severity as the basis for further mobilisation and evacuation (figs 9 and 10).

Armed with this information it began to be possible for individual delegate members to make representations at home and through the international bodies to develop a coherent and effective approach to this new phase of the emergency. The components of this were identified as being:

Total number: 781
Out of them priority one: 311
priority 2A: 326

The most frequent need for accurate diagnostic procedures and/or treatment:

Reconstructive surgery, orthopedy (most of the cases are related with war injuries: **64**

Oncology (diagnostics, surgery, chemo & radio-therapy): **73**

Haemodyalisis: **38**

Congenital malformations (orthopedy): **22**

Endocrinology (the majority of the cases are hyperthyreosis with thyreotoxic symptoms): **17**

Children heart surgery: **9**

Other heart surgery: **8**

IHD (with possible need for coronary-plastic surgery): **27**

Psychiatry & Neurology (unexpectedly high number of cases with epileptiform convulsions. Note: Postwar-psychotrauma cases are not involved!): **102**

* The majority of the cases were reported by medically active NGOs. Although the accuracy in establishing the diagnosis – mainly because of the lack of previous medical documentation and lack of current diagnostic possibilities – varies too much, and IOM has no capacity performing individual medical supervision on each reported case, the prioritization was reflecting well enough the real need.

Figure 9 Review of priority medical cases until now and still not evacuated.*

- 39 year old woman with acute thyrotoxicosis.
- Young adult man needing mandibular reconstruction following bullet wounds
- Older man with complex fracture of tibular and fibular and retained bullet.
- 44 year old man with gunshot wounds
- 5 year old child with vesico-uteric reflux
- 55 year old man with renal calculi
- 66year old woman with a large ovarian tumour
- Young woman with diagnosed but untreated ovarian cancer
- 36 year old woman with newly diagnosed breast cancer
- 12 year old girl with acute lymphoblastic leukaemia
- 54 year old man with testicular tumour
- 1 year old boy with an untreated cleft lip and palate (one of many)
- 1 year old girl with untreated spina bifida
- 6 year old boy with cystic fibrosis
- 18 year old female victim of multiple rape
- 57 year old man with post traumatic stress following brutal treatment by para-militaries
- 3 year old girl with unstable epilepsy
- 20 year old woman with pregnancy complications

Figure 10 Priority medical cases for evacuation from Macedonia, June 1999.

Figure 11 Royal Air Force Hercules ambulance plane evacuating priority one medical refugees to the United Kingdom.

- Maintaining adequate primary health care within the Macedonian camps until all the refugees are able to return home.
- Maintaining medical supplies (in particular for example insulin, antiepileptic drugs and painkillers) with robust systems to ensure that supplies reach the clinical staff who need them.
- To provide more specialist staff and services including additional support to local hospitals and continuing medical evacuation if needed.
- To ensure effective collaboration between agencies and national delegations in the process of rebuilding capacity in the Kosovan health and healthcare systems.

In the event, the willingness of some countries to continue with their medical evacuations, coupled with appropriate representations to other countries based on the epidemiological analysis of priority medical need, enabled the necessary continuing mobilisation to occur. A typical manifest of evacuees is shown in figure 10.

Three hundred and eleven Priority 1 medical cases may seem a lot to any one health care system, but a problem shared is a problem halved and when many countries agree to play their part it can become readily manageable.

Footnote—living in real time

Public health practice in a humanitarian aid situation is different from the kind of business and planning cycles that characterise large public sector organisations. It is necessary for people to think on their feet and to mobilise resources in timescales of hours and days rather than the customary weeks and years. Yet organisation, planning and continuity are also required. It is a personal view based on my Balkan experience that this kind of work requires public health expertise, systematically applied but in a light footed way. I think though that there is a corollary that entails more living in real time, more hands on in the day to day practice of public health in the UK and elsewhere. I suspect that our predecessors knew this but that it has been lost somewhere as we have developed elaborate bureaucracies, and business planning has become a kind of fetish.

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3 Brusin S. The communicable disease surveillance system in the Kosovar refugee camps in the former Yugoslav Republic of Macedonia, April-August 1999. *J Epidemiol Community Health* 2000; **54**:52–7.
4 Sram I, Ward D. Kosovo refugees in the North West Region of the United Kingdom. *J Epidemiol Community Health* 2000:**54**:314–17.