

Balkans briefing 6. Picking up the pieces: reflections on the initial stages of the reconstruction of the health care system in Kosovo, July 1999

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Kosovo came to the attention of the world's media in 1998 as details emerged of an apparently systematic attempt by the Serbian government to terrorise resident ethnic Albanians into leaving the region. This culminated in the flight of thousands of ethnic Albanians to refugee camps and other places of safety outside the region. The NATO bombardment in the spring of 1999 and the subsequent establishment of the United Nations Mission in Kosovo (UNMIK) as the civil administration encouraged many Albanians to return. Concurrently, many ethnic Serbs fled the country, frightened of reprisals.

I spent the month of July 1999 working for the WHO in Pristina, the regional capital, with a brief to develop a strategic framework for sustainable health service development in the region.

By the time that I arrived, the initial dramatic population flows had slowed and Kosovans were beginning to re-establish their lives and their society. This paper describes some of the challenges of this initial period and one of the approaches taken to meeting these. It is a personal view, based on my own recollection and the information available to me at the time.

Social and built environment

Kosovo has a population of approximately 2 million people distributed among six major population centres and many scattered rural villages. The landscape varies from remote mountainous areas to undulating lowland. Before the bombardment the economy had a mixed base of agriculture, industry and a limited amount of tourism. Much of the land is rich in mineral deposits and the industrial base included mineral extraction and processing. Housing is an unexceptional mixture of new and old, ranging from tiny traditional farm-houses to high rise apartment blocks. Bomb damage was restricted largely to strategic targets such as bridges, industrial complexes and communication centres. Many domestic, commercial and public sector premises had, however, been burned or vandalised, apparently by departing Serbs. Removable equipment and vehicles had been stolen. Many returning families found that few of their possessions remained intact.

In July 1999, fuel for industry and transport was in short supply; electricity was generally reliable in Pristina but less so elsewhere; running water was available for part but not all of each day; food supplies were limited in range

but adequate in quantity; few land line telephones were working and mobile phone systems were functional unpredictably for just a few hours daily. At the beginning of July, most shops were boarded up but the pavements were crammed with vendors selling brightly coloured plastic furniture, kitchen bowls and buckets, Coca-Cola and cigarettes. By the end of the month, a much wider range of goods was available and the majority of shops and restaurants had reopened. The speed of the transition was remarkable.

In addition to the resident population, this fragile infrastructure was also supporting a transient population of several thousand journalists and aid workers based mainly but not exclusively in Pristina. These alerted the world to the issues, provided humanitarian aid and contributed to strategic thinking. Restaurants reopened in response to their demand and householders were able to let rooms and apartments to them at high rates, often using the rent advance to replace essentials such as washing machines and televisions. On the more negative side, this created an artificial economic cushion that was unlikely to be sustained when the initial interest waned; locals had to compete with the foreigners for essential supplies, and communication networks became overloaded.

Population and health status

Fifty per cent of the population of Kosovo is under 20 years old and only 1.5% over 75.¹ The most frequently recorded causes of death before the age of 65 are heart disease, stroke, cancer, and lung disease. The infant mortality rate (23.6 per thousand) and population growth rate (1.7% per annum) are unusually high for a European population. Reliable morbidity data are sparse but reports from doctors in refugee camps have suggested a relatively high prevalence of diabetes, chronic renal disease and of untreated congenital malformations such as cleft lip and dislocated hips in children born since 1990. No reliable data on mental health were available but in July 1999 demands on the service were heavy and up to 70 new patients each day were seeking admission to the region's main treatment facility.

Health services

The health service in Kosovo was, until the advent of UNMIK, funded and managed by the Serbian Government. It was based largely

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Accepted for publication
17 February 2000

around secondary care, provided by six district hospitals including that in Pristina, which also provided tertiary care in some specialties. Other more specialised care could be accessed outside the region. Each hospital comprised a number of separate specialist “clinics”, each offering inpatient and outpatient care and each normally having its own laboratory facilities, intensive care/high dependency beds and operating theatres. There were a total of 5300 inpatient beds in the region, of which 2200 were in Pristina Hospital.

Outpatient facilities in some specialties were also available in poly-clinics known as “Health Houses”, but specialists working in these did not have access to hospital facilities.

Mental health services were based on a biological model with very little psychosocial or community-based input. Services were provided almost exclusively from one clinic in Pristina, with only 70 beds. There were no mental health services for children within the statutory sector. Care for people with learning disabilities was benevolently custodial, based in a single isolated institution with 400 beds.

Primary care was not well developed. The concept of family medicine was not widely understood and primary care staff did not have a formal “gate keeping” role for secondary care. Primary care services were provided from 300 basic facilities, known as ambulantas or health stations. Few offered care outside normal office hours. Emergency transport was available in only a few areas.

Although access to services was in theory open to all, governmental policy had prevented the employment of all but a very few ethnic Albanians in the public sector since 1990. As a result, Albanians had lost confidence in the care provided by the statutory services. In response, the Mother Theresa charity established 96 ambulantas, staffed by ethnic Albanian doctors and nurses. This “parallel system” had been the main source of health care for ethnic Albanians in Kosovo for almost 10 years. It was complemented by a parallel medical school, in which students were taught in private homes and basements and had no access to patients in a hospital setting.

The challenges

In July 1999 the entire health care system was in a state of some disarray. Medical and surgical supplies were limited. Appropriate food for patients was difficult to obtain. Many items of basic equipment, including medical devices, autoclaves, telephones and word processors, were missing or broken. In Pristina, drug supplies were found dumped in manholes on the hospital campus, wasting resources and blocking drains. Those Serbian staff who had left their jobs had taken with them the expertise to use the equipment and systems that remained. Those who had stayed were mistrusted by and mistrusted many of their new Albanian colleagues. Returning Albanians had offered themselves enthusiastically for employment, but most had had no hospital experience for almost 10 years and many of the more recently qualified had little practical experience of

Summary of criteria for reviewing development proposals

GENERAL

- Services should be: appropriate; equitable; effective; accessible; acceptable; flexible; sustainable; and realistic.
- Services should: work with existing services to the maximum extent; maximise the use of existing resources; secure an appropriate balance between primary, secondary, tertiary and preventive care; and fit comfortably with longer term options for reform; have the confidence of local people.
- In the initial, transitional emergency situation access to basic health care must be ensured. This will require the strengthening of primary care; the provision of safe and effective hospital services for the treatment of urgent problems; and the prevention and control of communicable disease. Training programmes should only be instituted at this stage if they fill immediate gaps in provision.

PRIMARY CARE

- Primary care should be provided from a smaller number of more effective ambulantas offering a wider range of services. Each should cover a population of at least 2000 people and preferably more. Staffing should be one doctor and two nurses to 2000 population.

HOSPITAL SERVICES

- No further hospital beds should be opened. Wherever practicable, numbers should be reduced and support services rationalised.
- Investment should focus on securing the safety and accessibility of existing services, improving the quality of basic equipment (mending equipment where possible) and teaching staff how to use the equipment.
- Basic levels of cleanliness, water and sanitation must be restored as a matter of urgency
- Sustainable initiatives that improve the variety and quantity of food available to patients are welcome.

COMMUNICABLE DISEASE CONTROL

- The priorities are improvement in water supplies, hygiene, sanitation and immunisation.
- Immunisation initiatives that are not part of a defined and recognised programme should not be supported.

patient examination or care in any setting. Many people were working in the health service, but none were being paid as UNMIK had not reached a decision on appropriate rates. After the initial euphoria of the return, anxiety, uncertainty and frustration were increasing.

In the voluntary sector, there were 160 NGOs with an interest in health issues working in Kosovo of whom at least 60 worked exclusively in the health field. All were looking for needs to meet and projects to support.

The challenge in the long term was to achieve the greatest health impact, over time, from the resources available. More immediately there was a need to ensure that the energy and finances of the NGOs were deployed in ways that would contribute to, rather than complicate, the future development of an appropriate, effective, accessible, affordable and sustainable health care system. This had to be set in the context of each NGO's need to demonstrate to its sponsors and donors that it had made a real difference; of the natural inclination of staff to "get things done" quickly; of UNMIK's need to agree roles and responsibilities and to establish a functioning administration; and of the need to engage local people as fully as possible in decision making.

To guide early investment and development decisions and to give a sense of direction to staff, we drafted and consulted on a set of criteria against which proposals could be tested. Although, in the fluid administrative and political situation at the time, these could have no real mandate, we hoped that agencies and individuals would recognise and respond to the logic of a considered and coherent response.

The consultation process itself posed a significant challenge. The lack of telephones made the arrangement of meetings difficult. This was exacerbated by frequent changes in NGO personnel and by the need for staff to be out in the field. Most of the previously existing professional networks had been dislocated. Even the preparation and distribution of paper documents required ingenuity and persistence as typing and photocopying facilities were initially scarce. We established regular weekly networking meetings as a vehicle for consultation and information exchange and made personal visits to complement these when necessary. By the middle of July the revised criteria had been accepted as a guiding framework by the WHO and the majority of NGOs and major donors. They had also been tested widely with local managers and professionals. Although

this had not been an inclusive or representative process, we were reassured by the general level of support commanded by the principles. The criteria are summarised in the box.

Impact

Was the effort worth it? The criteria were generally popular with NGOs who felt that the existence of written guidance made their own decision making more efficient. The number of individual requests from NGOs and donors for advice from WHO on the overall direction they should be taking. They subsequently formed the basis of the draft Health Strategy for the region and were adapted for use as a framework for action by hospital management teams. Although anecdotally I have learned that much of the subsequent NGO activity was in line with the principles this was not universally the case. One notable exception was the decision to build as an early priority a large, new accident and emergency department in Pristina Hospital, described by the designers as "equipped to the standards of the very best in Europe".

Conclusion

Securing the effective and appropriate use of resources in a post-emergency situation such as that in Kosovo in July 1999 is a major challenge. Needs are complex, the environment is fluid (and often dangerous) and many different agendas are being pursued. Guidelines such as those we developed can be instrumental in bringing some initial coherence and stability while longer term plans are formulated. Those described here could easily be adapted for use in similar circumstances elsewhere.

Disclaimer

These are the personal views of the author, and should not be taken to represent the views of the World Health Organisation or the Department of Health.

1 WHO Regional Office for Europe. *Overview of health services and health indications of the population of Kosovo, 1997-8*. Pristina: WHO, 1999.