

# Balkans briefing number 7. Pristina Hospital: under new management

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This is the seventh paper in a series on the consequences for public health of the conflict in the Balkans. It describes the state of the hospital services in Pristina after the cease fire in June 1999 and the subsequent reconstruction programme.

When UN Kosovo Force (KFOR) troops entered Pristina after the ceasefire in June 1999, they found the large hospital in Pristina to be in a very poor state of repair: dilapidated, damaged, dirty and potentially dangerous. Nevertheless, ethnic Albanian staff—doctors, nurses, allied professionals and support staff who had been ousted by the Serbs in 1990—had quickly moved in and were keen to provide the former wide range of clinical services as soon as possible.

A small multidisciplinary team of NHS professionals was sent to Pristina, arriving some 10 days after the withdrawal of Serbian forces. Our brief was to review the state of hospital services in Pristina, and to report on the opportunities for the UK NHS to contribute to the reconstruction and relaunching of sustainable hospital services.

We were asked to make our review focused and rapid. We were clear that the management and operation of the hospital would remain under local control, and that we should direct our efforts to supplementing their work, and not to supplanting it.

## INITIAL APPRAISAL

On arrival, the hospital presented an extensive complex of mostly dilapidated buildings. Although these were fitted out with much high technology equipment, they were being used mainly for straightforward procedures. The informal economy had already taken hold, and the departing Serbian Army (and some health professionals) had taken opportunities for gratuitous acts of theft and vandalism within the hospital. Damaged and missing materials ranged from small items such as cleaning and sterilising equipment through to hospital boilers. Caches of looted medical equipment and drugs were found, and on one occasion, a Kalashnikov assault rifle and several hand grenades.

Large numbers of ethnic Albanians had returned to the hospital, hoping to regain work that they had been excluded from in 1990. However, there were no means of establishing identity, nor whether they were professionally qualified as doctors or nurses. The main utility services were in very poor condition, and the general standard

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of the hospital's infrastructure was appalling, with no evidence of any effective maintenance, refurbishment or service modernisation since 1990. Some crates of new equipment lay around, but with instructions in Swedish, German or English, Kosovar staff were unable to assemble or operate it.

Although KFOR troops (mainly British) were present in numbers in Pristina, providing a reassuring level of security around the hospital and main streets by day, the threat of violence was never far away, and its occurrence was all too frequent. There was regular evidence of house burning. Sporadic gunfire could be heard most nights, and the sad consequences could be seen the following morning in the hospital's wards and mortuary. One night there was sustained gunfire for several hours quite close to where we were staying, and the overall situation would have to be described as tense.

Our first tasks were to complete a comprehensive stocktake of the services and staff in the hospital, and to detail the immediate requirements for its safe operation. The most pressing of these included removing large quantities of clinical and other waste left scattered about the site, cleaning up the kitchens and improving food storage areas that presented a significant health hazard, and restoring the mortuary to an operable condition by arranging the removal of a number of bodies in very poor condition to allow cleaning, restoration of refrigeration and reopening. Many of these problems had been made worse by what appeared to be acts of deliberate sabotage by the departing Serbs, including the destruction of mortuary refrigerators and kitchen hot water supplies. The clinical waste scattered around the site had also attracted roaming packs of dogs, threatening staff and patients.

## HOSPITAL SERVICES

Pristina University Hospital had been a very large institution in 1989, comprising 2400 beds in a series of almost completely separate clinics. The hospital had evidently thrived up until this time, operating along the lines expected of such a hospital in the Eastern European system. We found, however, considerable evidence that staffing and activity patterns underwent a very significant change in 1990, shortly after the Serbian incursion into Kosovo. Many ethnic Albanian staff were dismissed, and the number of patients from the ethnic Albanian population declined steeply. As the local population comprises over 90% ethnic Albanians, this had profound consequences for the overall workload of the hospital. As admissions declined to a fraction of their former

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number, the fabric of the hospital and the condition of equipment were allowed to deteriorate badly.

During the war, very few patients seem to have been admitted to the hospital, and the majority of clinical staff seemed to have left: we found evidence that the Serbian Army had occupied the buildings. After cessation of the bombing, senior clinical staff—mostly ethnic Serbs—had not returned to the hospital. Coinciding with our arrival, however, a comparatively small number of staff (mainly untrained nursing assistants and junior doctors, who may have had fewer options to leave) began to return to the hospital and demand back their jobs from the 1990-1999 period. However, after the exit of the Serbian Army, substantial numbers of ethnic Albanian staff had rapidly reoccupied the hospital. Many of these had not worked during the preceding nine years or more, certainly not as hospital clinicians. Some ethnic Albanians had been training as doctors during this period, but had done so in a parallel “underground” medical faculty, without ready access to patients and unable to undertake procedures under supervision. The experience, qualifications and skills of these clinicians were therefore difficult to validate.

Staff returning to the hospital were keen to restore services as rapidly as possible despite the condition of both infrastructure and support services, and often to a model that could be regarded as 25 years out of date in Western European terms. Under the circumstances, it was not surprising that their attention was predominantly focused on clinical areas and on the need to recreate pre-1990 organisational structures. Little emphasis had been placed on the institutional environment and on hospital-wide support services. We found significant shortcomings in waste management (including the disposal of clinical waste), vermin control, food hygiene, control of infection, security of people, records and supplies, and handling of the dead. Poor management of supplies led to critical shortages in some areas despite apparent availability elsewhere; in addition, the uncoordinated and unplanned arrival of sometimes inappropriate supplies from aid agencies could be a hindrance.

Although clinical standards were high in some areas, this was not the case everywhere, and clearly depended on the presence of particular individuals. Nursing care was being provided to a model that would not be recognisable in the UK, and this had significant effects on the delivery of care. While many of those styled as nurses displayed reasonable clinical skills (especially considering the history since 1990), the majority seemed to have little appreciation of the wider basis of nursing practice, including nutrition, infection control, wound management, and the psychological and social aspects of care.

As there had been no formal training of ethnic Albanian staff in any professional discipline since 1990, we were faced with the dilemma of establishing not only who was who with no formal means of identification, but also what they may be qualified and skilled to do. This brought a new dimension to our previous understanding of accreditation and validation. In the event, we were able to identify the dean of the alternative, ethnic Albanian, medical faculty, a well known and respected professor with an international reputation. As a short-term measure, we simply worked with him to identify those who were qualified to work in the hospital, and issue them with passes that served as identification and temporary accreditation.

## HOSPITAL ACTION PLAN

It was very clear that in the short time we had it would be impossible to undertake a comprehensive management review, or indeed to propose detailed plans. In any case, our firm belief remained that a successful and sustainable reconstruction of the hospital's services would depend crucially on working with the local people who must remain responsible

for the functioning of the hospital, including clinicians and support staff. What they would need, we believed, was assistance, encouragement, advice and development; in the long run, it would have been a tragedy had the running of the hospital been taken out of their hands.

Our approach, therefore, was to identify the key areas where assistance and advice could most effectively be deployed, and the skills necessary to provide it. We could then identify UK-based staff from a range of clinical and managerial disciplines who would work for relatively brief periods in Kosovo of say three months, alongside the local hospital staff.

We identified seven priority areas for development work, on the basis principally that they were the most pressing immediate problems in the short-term, but also because they could act as exemplars for future joint working. These priorities were a mixture of clinical improvements underpinned by strengthening of hospital management, as follows.

### 1 Improving women and children's health (including neonatal services)

The objective was to make real improvements in the care of women antenatally and in labour, both improving their health and decreasing perinatal mortality and morbidity in their children. The project would also be directed to community services, improving integration with existing hospital-based obstetrics, promoting good health and healthy lifestyles, and providing reliable information on the health of mothers and children.

### 2 Provision of central patient receiving room

The aim was to coordinate all emergency and urgent adult admissions (excluding obstetrics) through a single receiving area. This would reduce the duplication and fragmentation of emergency admission facilities currently split across four or five clinics, avoid the need for seriously ill patients presenting to the “wrong” clinic to be repeatedly redirected around the site, and develop clinical expertise in the field of emergency care.

### 4 Adult critical care services

These services were also fragmented across several different clinics, and our aim was to integrate and rationalise them. Such a move would foster the continuing education of staff and the development of improved standards of care and outcomes. Its successful achievement would emphasise the need for—and benefits of—rationalisation of other services replicated needlessly across the site.

### 5 Protection of health and environmental improvement

The aim was twofold in the first instance. Firstly, we recommended putting in place the measures necessary to maintain the protection of public health on the site, sustaining and building upon the short-term measures to improve waste management, food hygiene, vermin control and other environmental protection issues. Secondly, we proposed measures to improve the awareness of health protection measures including infection control among clinical staff, and to develop expertise in these fields in the hospital.

### 5 Review of works and support services

We found that essential utilities, including power supplies, water, sewage disposal, provision of medical gases and boiler-house services, were available intermittently or not at all. When available, the standard was often very poor, hindering the care of patients and the delivery of clinical services. We proposed that a small team of works professionals should survey the hospital and make recommendations to ensure that these services quickly began to function to an adequate and consistent standard.

## 6 Developing effective facilities management

The objective was to ensure the consistent delivery of an adequate standard of non-clinical support services, including catering, domestic and laundry services, estate management, procurement, and financial accounting.

## 7 Introduction of effective human resources capacity

The aim was to put in place an approach to the recruitment, payment and management of staff, establishing systems that were sustainable and acceptable to local support staff. We regarded this function as particularly important in view of the major dislocations of staffing that had occurred in 1990 and at the end of the war in 1999, the resulting difficulty of establishing the tenure of any particular post, the problems of accrediting staff, and—of course—the ethnic tensions still very much in evidence.

One of our key areas, that we could begin to tackle within the hospital to only a very limited degree, was the improvement of health and the development of health protection. This raised issues that went much wider than the hospital, and there is no doubt a significant piece of work to be done for the future of Pristina and the surrounding area. Although the city itself has a fair range of urban services and utilities, it shows much evidence of lack of investment, plans and protocols directed towards the health of the population, and there is a lack of public health—as compared with epidemiological—capacity and commitment.

## CONTEXT

The work that went into the preparation of our report took place in circumstances that were unparalleled in our experience. Our arrival coincided with the return of many thousands of refugees to Pristina. From being almost devoid of civilians, the streets rapidly filled over a few days. Two contrasting themes predominated among these people: anxious inquiry after missing friends and relatives, and an unmistakable sense of oppression overcome. As the remaining ethnic Serbs also re-emerged, there was a clear potential for the fragile seeming order to break down. However, the presence, discipline and good humour of the British Army prevailed for the most part, apparently in contrast with the population's previous experience of the military. Although there were obvious exceptions, the great majority of the population seemed concerned only to re-establish as much normality as possible from the chaotic conditions prevailing—not least in the health services.

Within the hospital, one of the most challenging aspects was to deal properly and fairly with the remaining ethnic Serb staff. Many ethnic Serbs had either left or may have been the victims of reprisals, but a relatively small number remained in Pristina and needed to work. They were clearly frightened, but nevertheless on occasions displayed an insensitivity to their position and to others that seemed arrogant. Not surprisingly, there were a number of actual and potential incidents of conflict, which were made keener by the ready availability of firearms in the hospital.

There was repeated evidence of the cultural divide between the two populations, and the resulting violence. Although we were prepared for the effects of this on adults, it was more difficult to deal with the consequences for children. A stark example was the dozen abandoned babies we found in the maternity unit. They were aged up to 18 months, but spent

their whole time lying in small cots with almost no human contact or environmental stimulation. The staff believed that these babies were the result of the rape of ethnic Albanian women, abandoned by their mothers and given Serbian names by the previous staff of the unit. With the help of the Save the Children Fund we were able to move these babies into the paediatric unit, where they received more attention and development activity.

The prewar hospital had clearly been run on an intensely hierarchical and medical dominated model. Staff returning after the war seemed keen to replicate these structures. Only medical staff were allowed to use the main entrances to buildings. All planned medical and surgical activity stopped in the early afternoon, apparently to facilitate private practice outside the hospital. Training for all clinical staff, including nurses, was done on the job by doctors; although there were some areas where high standards were evident, this was very inconsistent. Patients in the hospital generally appeared to be cast in the role of supplicants, grateful for any care or sustenance that they received. To those familiar with a modern Western health service, all this was quite disconcerting.

The presence of a great many non-governmental organisations—voluntary aid agencies and the like—was unmistakable, readily identifiable from the large white four by four vehicles that seemed to be standard issue. As well as being the most common vehicle seen on the streets of Pristina, their numbers were often sufficient to cause gridlock within the hospital site. The activity of the different agencies was inevitably independent, uncoordinated, and fragmented, which added to the lack of communication evident between the different hospital departments. To restore order to the hospital, it was necessary to insist that all such organisations report to the medical director's office so that they could be accredited for access to the site.

In many ways, the hospital was a microcosm of life in the city, and perhaps the whole of Kosovo. People—both staff and patients—came from both main ethnic backgrounds, but ethnic Albanians were constantly keen to establish and reinforce their new position of ascendancy in society. Although many hospital staff simply wanted to get back to work, tensions were never far from the surface. After a week or so, incidents were mainly restricted to the hours of darkness. However, the hospital and its staff continued to have to deal with the victims of ethnic violence—Albanian or Serbian, living or dead—and large numbers of their relatives. These situations were difficult to handle, and the combination of high emotions with easy access to firearms led to continued tensions and difficult confrontations.

## CONCLUSION

Our visit to Kosovo was an experience that offered both personal and professional development to us, for which we will remain grateful. We worked long hours in sometimes difficult circumstances, and can only admire those who do so for much longer periods.

Much of our report was accepted, and UK staff are now working in Pristina Hospital, alongside the local population and hospital staff, to develop services. The health services in Pristina will face immense problems for some years to come, but it has been an unrivalled—and humbling—opportunity to work alongside such highly motivated and dedicated people helping to rebuild their lives and their society.