ACCESS TO HEALTH CARE IN KOSOVO'S MINORITY AREAS

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1. INTRODUCTION

The following survey of the accessibility of health care – or lack of it – in minority areas in Kosovo has been produced as a “living” document, which will be updated on a regular basis. It is designed to show the state of access to health care in villages with minority populations, presented according to municipality. The survey, prepared on the basis of information gathered by WHO’s Health Advisers, will be used to prepare proposals relating to WHO activities in Kosovo. It is also a working document that can be used to support advocacy or to provide background information for meetings dealing with related issues.

The survey is an assessment of the current situation in specific locations. It aims to map out problems that exist today and to present them in a way that the document is useful for discussions at municipal level and as a basis for further development of proposals. It is a tool to be used to improve access to medical services in minority areas, or to improve the quality of existing services.

WHO Kosovo sees the development of health initiatives as a bridge to peace. The organisation is committed to improving the access to and quality of health care for minorities of all ethnicities. To this end it is increasingly involved in advocacy and in co-ordination of activities with the Department of Health and Social Welfare, municipal authorities, UN agencies, KFOR and NGOs working in the sector.

This document is meant to be practical and useful. We will use the comments of the readers to improve the document. WHO is grateful to all.

2. BACKGROUND

All ethnic groups in Kosovo find themselves in a minority situation in different locations in the province, including K-Albanians who otherwise form the overwhelming majority. The goal of the Kosovar health policy\(^1\) is that all health facilities should be open to all patients, but current political reality is that much still has to be done before this can be achieved. In some areas a form of “parallel” structure has been accepted as a pragmatic interim solution to meet the immediate needs of minority populations, although this conflicts with the policy of the Joint Interim Administration.

The well-being and health of all ethnic groups in Kosovo diminished extensively during the disruption of more than 10 years of ethnic confrontation. Active conflict ended with the suspension of the NATO bombing in mid-1999, and the simultaneous withdrawal of Serbian regular forces from the territory. However there is a heritage of distrust and antagonism which is easily exploited by more radical elements and which makes it far harder to achieve the ambition of universal, integrated health care. Many health care facilities were destroyed or badly damaged during the violence of 1999. Kosovo’s ethnic Albanian majority emerged from its long period of repression after the bombing and was able to re-integrate the health system that had previously been monopolised by K-Serbs. Subsequently K-Serbian health workers abandoned all the main facilities except in North Mitrovica for reasons of personal

\(^1\) Health Policy for Kosovo. Department of Health and Social Welfare, Pristina, February 2001
safety. Minority communities (Serbs, Roma, Ashkalis, Gorani, Bosniaks and others) are now dispersed throughout the province, isolated in enclaves, without any real freedom of movement or easy access to secondary and tertiary health care. In addition there are several villages in the northern part of the province where K-Albanians are also in a minority situation and live in enclaves. Several mountain villages are also isolated, with difficult access to health care. The level of primary health care varies widely according to the location.

The "parallel" system of health care

In the late 1980s and 1990s two parallel health care systems developed in Kosovo. Serbs controlled the public health care system, with 90 per cent or more Serbian staff. K-Albanians, who were largely deprived of access to the public system, built up a duplicate system, based on a combination of private initiative and charitable organisation (mainly the Mother Theresa compounds). They also established a parallel higher education system for medical students, but qualifications were not recognised or certified.

When K-Serb health workers abandoned hospitals for security reasons they retrenched in the smaller health facilities in enclaves. They also took over the regional hospital in northern Mitrovica. This is the only civilian secondary level facility providing physical security for this minority, although, because of a lack of secure transport, this access is severely limited for those who live in enclaves outside the region. One consequence of this is that K-Albanians in Mitrovica find themselves without an accessible hospital.

Serbian authorities in Belgrade subsidised K-Serbian health workers who remained in Kosovo, leading to a situation of over-staffing for a sharply reduced minority population. There was little investment in the health care system in the province in the past 10 years and today there is a lack of funding to develop new programmes in non-conformist minority areas, such as primary health, secure transport, ante natal care, immunisation, community-based mental health and health promotion. Minority health care managers who do not recognise the interim UN administration, receive limited support from the administration.

Many primary facilities in villages with a K-Albanian majority were destroyed or damaged during the violence. Most of these have been repaired and re-equipped, frequently with help from NGOs using international funding. Some health care facilities lack basic goods like bed sheets, cupboards, tables, chairs and containers for medical waste; others have been equipped with some high standard material for which maintenance is not always readily available.

The quality of health care provision

The Department of Health and Social welfare is addressing the issue of human resources and staffing levels, which affect many health facilities. But while there is an issue with over-staffing both in K-Albanian and K-Serbian health communities, there is also a shortage of staff with current training; and there is an uneven distribution of staff in and between several specialties.

The main primary health care facilities and Pristina tertiary health care are overstaffed, while some secondary health care facilities and village family medicine centres lack personnel, especially general practitioners. There is also a shortage of managerial skill because an inadequate number of K-Albanian staff has experience of this.

K-Albanians had 10 years improvised education in nursing, and medical schools without proper practical training in secondary and tertiary health care facilities. An
obvious example of the need for updating is seen in the overuse of injections, especially antibiotics. Nurses in Kosovo need to be trained to work independently.

Vulnerable communities and special needs

The needs of different risk groups in Kosovo vary, therefore each situation is set out separately according to individual villages, by municipality, in annexes to this document.

Vulnerable groups include:

1. K-Serbians living in enclaves as well as in the mountain villages in the north, have special needs and different problems. The enclaves often provide sanctuary for internally displaced Serbs (IDPs). Most young people have abandoned the villages, many left Kosovo. Family ties are less strong than among K-Albanians. Many old people are isolated and lack the support of their families.

2. K-Albanians living in, or originating from, enclaves. Those living in isolated villages were among the most deprived before the ethnic confrontation and among those who lost most during the conflict. Many of these chose to stay in urban areas as IDPs after the return from refugee camps, rather than go back to devastated villages. Many now live in urban poverty, creating a pool for prostitution, violence, crime and drug abuse. Those who went back to villages face serious environmental health problems and inadequate primary health facilities.

3. Roma and Ashkali people have specific problems. They are not accepted by K-Albanians and only tolerated (but generally disliked) by Serbs. They are poorly educated. In the territory controlled by K-Albanians, almost all their houses were destroyed. Most now live in camps in the northern part of Kosovo and in enclaves where hygiene and health conditions are poor. Those in the north have general access to primary and secondary health care, but do not take advantage of this. They are helped by international NGOs but their future is uncertain.

4. The Bosnjak and Turk minorities are generally accepted by the main ethnic groups.
THE POPULATION OF KOSOVO IS ESTIMATED TO BE AROUND 2.08 MILLION BUT PRECISE DEMOGRAPHIC DATA IS SCARCE.

The K-Albanian population represents between 90-95 per cent of the population. K-Serbs form the biggest minority, with perhaps 5 per cent. (In addition an estimated 210,000 K-Serbs are currently living across the boundary with Serbia and in Montenegro.)

Minorities in Kosovo are:
- SERBS
- ROMA
- TURKISH
- ASHKALI
- GORANI
- TORBESH
- CROATIAN
- BOSNIACS
- OTHERS (Includes Montenegrins, Macedonians, Slovenes, Hungarians)
- ALBANIANs (in Mitrovica north)

Specific problems of the different risk groups in Kosovo:
1. K-Albanian district in north Mitrovica town: urban population, security threatened by local majority ethnic group; access to health care very difficult
2. K-Albanian enclaves: villages heavily damaged, many houses still need to be reconstructed, roads in disrepair, no permanent health care services, very difficult access to secondary and tertiary care
3. K-Serbian enclaves: ageing population, prevalence of depression and chronic diseases, difficult access to secondary and tertiary health care; mental health problems including anxiety, depression and addictions as a consequence of living in a restricted area with deteriorating security; serious consequences for the health of young people
4. K-Roma camps: general access to most levels of health care but these are frequently ignored; very low educational status, disaffected from other groups
5. Remote K-Albanian mountain villages: poor access to health care, heavily damaged villages, some schools under canvas, very poor access to transport
6. Remote K-Serbian villages: variable access to health care, predominantly old people, KFOR or UNMIK police escort usually required for travel outside
7. Internally Displaced People in urban areas: lack of support; not always registered; high number of children; single families; problems with health of young people; mental health problems resulting from trauma and violence
8. People from Bosnia and Croatia: generally good access to health care but lack of future perspectives
3. METHODOLOGY

Kosovo’s health care system is being developed on the basis of principles described in the “Health Policy for Kosovo” (February 2001)

These principles are:

- Equity and non-discrimination both in service provision and employment
- Protection of the rights of the most vulnerable groups
- Acceptability (cultural, social and professional)
- Accessibility (geographic and economic)
- Effectiveness
- Cost-efficiency
- Appropriateness
- Quality of care
- Sustainability

The goal is to ensure full health potential for all by promoting and protecting health, reducing disease and injury, and alleviating suffering. The health care system will offer all residents of Kosovo, with special emphasis on vulnerable groups, universal access to basic primary, secondary, and tertiary health services, as well as to public health protection.

The current health care system in Kosovo is still far from meeting these principles or achieving these goals and is facing at least four major challenges:

1. previous limitations of the socialistic Semashko model
2. effects of 10 years of repression with concomitant parallel service delivery
3. consequences of three intense months of war against a longer term background of violence, repression and enmity between groups
4. a complex political situation in which the UN is the internationally recognised legal authority while the longer-term political future of Kosovo remains unclear

Many people of Kosovo have limited access to health services due to geographic and economic constraints. Residents of enclaves and minority areas have even greater limitations on access because of security issues and consequent movement restrictions.

To improve equity in service provision for all people of Kosovo WHO has a special focus on access to care for people living in enclaves, minority areas and isolated circumstances. WHO supports an equitable health system.

Equity is not the same as equality. Not all groups in society need equal access to health care. For example, the elderly, children and disabled usually need more access to health care than the rest of the population. Equity means that these people get more health care. Thus, equity means unequal access for unequal needs. As movement in and around enclaves and minority areas is often heavily impaired some services need to be brought to these places. Equity in these circumstances means unequal access for unequal needs in unequal circumstances.

E.g.: the monthly visit of an internal medicine specialist to support a general practitioner in caring for patients with limited access to secondary health care.
4. GUIDE TO THE METHODOLOGY

To assess the situation with regard to access to health care in areas with vulnerable people, the access of these people must be compared with the access of other people in Kosovo or set against certain standards. As discussed above, equity means unequal access for unequal needs in unequal circumstances. In this survey, the comparison is with a minimal set of standards. The standards, described below, are set at a level that implies the best possible access attainable in the current circumstances in Kosovo. It is a set of standards that can be achieved by the (national and international) community in Kosovo. The achievement of these standards does not mean that the result is "good"; it means that the result is as good as can be expected in prevailing circumstances. The best aid to full access to health care services for the people living in enclaves and minority areas, and a more equitable access to care for all the people, would be the return of peace. This document is designed to describe the situation with regard to access to health care for vulnerable people as a result of the conflict. This document will be regularly updated and is meant to be a tool for all parties involved in improving access to health care.

The situation in each of the enclaves and areas surveyed is presented through a colour code:

**RED** means that the situation is not acceptable and that access to care is seriously impaired. The health and lives of the population are at risk

**YELLOW** means that the situation is not as good as it could be. Action should be taken to improve the situation

**WHITE** means that the situation is as good as it can get in the given circumstances

**Note:** “Good” is a relative term. It does not mean that the situation is satisfactory, but acceptable given the current situation in Kosovo. In other words conditions are similar to those encountered by the majority population allowing the specific situation in the enclaves

Given the security situation, access to health care can never be optimal for the people living in enclaves or for those who can not move freely or visit health facilities because of security risks. The benchmark has been set at a level WHO thinks can be achieved when civil authorities, health authorities, the population, agencies and NGOs and KFOR are co-operating and willing to support the development of best possible access to health care.
KEY to graphics:

**RED** Acute need for action
**YELLOW** Improvements advised
**WHITE** Acceptable in the given circumstances

In the case of individual denominators, these colours have the following meanings:

1. **Access to primary care:**

   **RED** Primary care doctor visits the enclave/village less than once per week or travelling takes more than two hours
   **YELLOW** Primary care doctor visits the enclave/village at least once per week or is within two hours of travel
   **WHITE** Primary care doctor visits the enclave/village at least twice a week or is within one hour of travel

   Access to primary care services should be at least twice a week or within one hour of travel. A primary care facility that is open all days of the week within maximum one hour of travel would be best although mobile clinics may provide a temporary solution for those places where this is not possible. Primary care services should provide a range of activities including vaccination services, antenatal care, preventive services, etc.

2. **Quality of primary care services:**

   **RED** More than two conditions not met
   **YELLOW** At least three conditions met
   **WHITE** All four conditions met. In the case of a mobile clinic condition d. will be converted to total time spent in the village/enclave in relation to the number of inhabitants

   Conditions:
   a. At least 80 per cent of ‘core’ drugs available. See list in Annex 1.
   b. Basic equipment in place. See list in Annex 2.
   c. Facility is cleaned and heated adequately.
   d. Adequate number of health staff (1 doctor per 2,000 inhabitants and 1 nurse per 1,000 inhabitants)

3. **Vaccination programme:**

   **RED** Vaccination coverage less than 80 per cent
   **YELLOW** Vaccination coverage probably higher than 80 per cent, but no proof
   **WHITE** Vaccination coverage at least 80 per cent

   Vaccination programmes, organised through a campaign approach or through continuous vaccination services, should reach a coverage of at least 80 per cent. Good co-operation between the Institute of Public Health, health workers is necessary as well as the possibility of transport and a functioning cold chain. In some places the vaccination programme may be well organised, but due to lack of proper registration no certainty of a good coverage.
4. Access to antenatal care:

**RED** Antenatal care services not available and safe travel to secondary and tertiary care services less than once per week

**YELLOW** Antenatal care services not available and safe travel to secondary and tertiary care services at least once per week

**WHITE** Antenatal care services available at least once per month in the village/enclave

Access to antenatal care services can be provided through visits of secondary care services outside the enclave, but would normally be provided by primary care providers within the enclave/minority area.

5. Access to secondary and tertiary health care:

**RED** Less than once per week safe travel to secondary and/or tertiary care facilities possible for whatever reasons (security, lack of confidence, lack of transport, etc.)

**YELLOW** At least once a week safe travel to secondary and/or tertiary health services is possible

**WHITE** At least twice a week safe travel to secondary and/or tertiary health services is possible

In many places buses or other means of transport are regularly provided by UNHCR and KFOR to enable the population improved movement. To guarantee minimal access to secondary and tertiary health facilities the population needs to have at least twice per week the possibility to travel to cities were these services are provided. In the case of limited transport, a number of seats should be reserved (or priority should be given to patients seeking health). Although oral health services are part of primary care services, access to oral health services can be guaranteed though access to secondary care.

6. Emergency transport to health service including maternity services:

**RED** Emergency transport can not be organised at all times or will take more than 4 hours

**YELLOW** Emergency transport can be organised at any time but can take more than 2 hours

**WHITE** Emergency transport at any time can be organised within two hours

Emergency transport of patients is all transport to health facilities that can not wait till the next organised transport. A minimal standard is that such emergency transport can be organised at any time during the day within two hours. This requires good communication between health providers within the enclave/village and KFOR/UNMIK Police for the security of the transport. A primary care worker that can be consulted prior to the request for emergency transport who can also take care for first aid would make the system work well. The better the health services within the enclave are the less need for emergency transport.
Annex 1

Availability of pharmaceuticals

1. Paracetamol Oral
2. Anti-inflammatory (diclofenac, indomethacin, ibuprofen) Oral
3. ORS Oral
4. Salbutamol Oral
5. Amoxicillin or Ampicillin Oral
6. Adrenaline Injection
7. Diazepam Oral
8. Hydrochlorothiazide or Furosemide, Moduretic Oral
9. Digoxin Oral
10. Cimetidine or Ranitidine Oral
11. Tolbutamid or Glibenclamide Oral
12. B-blocker (propanolol, atenolol, Metoprolol) Oral
13. Hyrocortisone Injection
14. Desinfectant External
15. Bandages and gauzes External

80% or more (12 or more items) available?

Annex 2

Equipment for ambulantas (future family medicine centres and punctas)

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