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International Organization for Migration: Experience on the Need for Medical Evacuation of Refugees during the Kosovo Crisis in 1999

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The International Organization for Migration (IOM) developed and implemented a three-month project entitled *Priority Medical Screening of Kosovar Refugees in Macedonia,* within the Humanitarian Evacuation Program (HEP) for Kosovar refugees from FR Yugoslavia, which was adopted in May 1999. The project was based on an agreement with the office of United Nations High Commission for Refugees (UNHCR) and comprised the entry of registration data of refugees with medical condition (Priority Medical Database), and classification (Priority Medical Screening) and medical evacuation of refugees (Priority Medical Evacuation) in Macedonia. To realize the Priority Medical Screening project plan, IOM developed and set up a Medical Database linked to IOM/UNHCR HEP database, recruited and trained a four-member data entry team, worked out and set up a referral system for medical cases from the refugee camps, and established and staffed medical contact office for refugees in Skopje and Tetovo. Furthermore, it organized and staffed a mobile medical screening team, developed and implemented the system and criteria for the classification of referred medical cases, continuously registered and classified the incoming medical reports, contacted regularly the national delegates and referred to them the medically prioritized cases asking for acceptance and evacuation, and co-operated and continuously exchanged the information with UNHCR Medical Co-ordination and HEP team. Within the timeframe of the project, 1,032 medical cases were successfully evacuated for medical treatment to 25 host countries throughout the world. IOM found that those refugees suffering from health problems, who at the time of the termination of the program were still in Macedonia and had not been assisted by the project, were not likely to have been priority one cases, whose health problems could be solved only in a third country. The majority of these vulnerable people needed social rather than medical care and assistance – a challenge that international aid agencies needed to address in Macedonia and will need to address elsewhere.

Key words: *Macedonia (Republic); refugees; relief work; transportation of patients; United Nations; war; Yugoslavia*

After the beginning of the North Atlantic Treaty Organization's (NATO) air strikes on Yugoslavia in March 1999, the already ongoing exodus of Albanians from Kosovo grew with rapidity that international humanitarian agencies had not forecasted or encountered before.

United Nations High Commission for Refugees (UNHCR) estimated the number of the refugees who entered Macedonia to be as high as 243,000. Due to the very fast and effective reaction of the international community and the humanitarian solidarity of the Macedonian government and local citizens, this huge number of most vulnerable people soon found a temporary shelter in the newly established refugee camps and at host families.

By April 4, 1999, the situation in Macedonia had reached the point where UNHCR recommended an international evacuation of some refugees to ease the burden on the humanitarian operations in Macedonia.

It became clear at the very beginning of the process that the local health care system did not have the needed capacities and profile for fulfilling huge demands that the refugee wave has placed on the secondary and especially tertiary level of the health care system.

Humanitarian Evacuation Program

By the April 30, 1999, the burden of the human crisis reached a level where UNHCR made a formal request to non-European nations to begin with operations to evacuate Kosovar refugees from camps in Macedonia. The Humanitarian Evacuation Program was thus launched with full capacity.

UNHCR identified individuals and family groups for whom international resettlement was a priority. The priority criteria were the following: single parent families, unaccompanied minor children, the elderly, and those with serious medical conditions requiring urgent medical or surgical intervention (the responsibility of the IOM).

The task of the medical data registration and classification of those Kosovar refugees in Macedonia

who needed humanitarian evacuation because of their medical conditions (Priority Medical Evacuation) was delegated to IOM, as a consequence of IOM's great expertise and previous successful IOM-UNHCR cooperation in this field (1,2). In such situations, the process of selecting and transporting patients was affected by bureaucratic obstacles, political priorities, and media attention, which IOM also had to deal with (3).

To evacuate medical cases from the refugee camps, IOM worked out and set up a referral system, which included establishing and staffing a medical contact office for refugees in Skopje and Tetovo; organizing and staffing a mobile medical screening team; developing and implementing the system and criteria for the classification of the referred medical cases (see below); continual registering and classifying of the incoming medical reports; and contacting the National Delegates on a regular basis and referring to them the medically prioritized cases that needed acceptance and evacuation (4,5).

General Criteria and Classification of Patients Selected for Priority Medical Evacuation

General Criteria

There were six general criteria for priority evacuation:

1) Patients, irrespective of their age, sex, citizenship, ethnicity, religion, and political background, had to have an equal chance of being incorporated into the program. The classification/discrimination had to be based purely and clearly on medical consideration only.

2) Proper diagnostic and/or treatment procedures for the given health problem of the patient were not available in the country from which she or he had been selected for priority medical evacuation.

3) There was a clear and high likelihood that the condition of the patient would have a good overall prognosis and a significant improvement in quality of life, if a specific medical service only available in a third country would be provided.

4) The condition indicating evacuation was life-threatening or function-compromising. In other words, evacuation would have protected life and/or function (see details below).

5) The patient's medical condition could be stabilized for the transportation abroad.

6) The patient's medical condition would not create surplus risk for escort people and for those who were prioritized together with him or her.

Classification of Patients

There were four levels of priority of evacuation.

Priority one (P1). Expedient movement – life threatening conditions with an immediate need for prioritization on arrival. Examples: a) congenital heart disease close to decompenzation; b) continuous fever of unknown origin; c) chronic or acute renal failure requiring hemodialysis; d) unstable angina pectoris; e) diagnosed malignant tumors of different origin, but without evidence of metastases; and f) recurrent gastroenteric bleeding.

Priority two (P2). Accelerated movement – conditions requiring urgent follow-up treatment or urgent assessment and treatment to reconstruct a function. Examples: a) (war) injuries requiring reconstructive surgery; b) known malignancies with completed initial treatment, without evidence of metastases, and requiring follow-up treatment (radio- or chemotherapy); c) congenital heart disease; d) hematological diseases; e) diseases of the endocrine system with clear manifestation (including insulin-dependent diabetes mellitus with major complications); f) inborn enzymopathies; g) congenital malformations (e.g., congenital luxation of the hip joint); h) osteomyelitis; and i) active tuberculosis with complications but not in contagious phase (have received the initial therapy). Psychiatric cases, especially posttraumatic stress disorder, had to be evaluated individually, but were not likely to be priority cases for evacuation. Pregnancy itself was not prioritized, either.

Priority three (P3). Low priority movement – non-urgent need for assessment and therapy that were not available locally. Examples: a) effort angina pectoris; b) need for prosthesis; c) insulin-dependent diabetes mellitus with minor complications; and d) disabled, mentally retarded children needing special care.

No priority (P4). Medical cases with no priority – needing no special attention and normally scheduled travel. Examples: a) known chronic diseases under regular treatment (e.g., non-insulin dependent diabetes mellitus, chronic hepatopathies, chronic lung diseases, etc); and b) age-related health problems, geriatric diseases.

Results of Priority Medical Evacuation

A total of 3,946 cases were reported and registered in the IOM Priority Medical Database (Table 1). The number of men and women was almost the same (1,729 and 1,651, respectively); 15.5% of the reported cases were children between 0 and 10 years of

Table 1. 1999 Kosovo crisis: Kosovar refugees in Macedonia reported to priority medical database of the International Organization for Migration and their distribution according to sex and age

Parameter	Men	Women	Total (%)
Priority cases			
1	471	393	864 (46.2)
2A	600	408	1,008 (53.9)
Total	1,071	801	1,872 (100.0)
Age groups (years)			
0-1	63	39	102 (3.0)
2-5	125	83	208 (6.2)
6-10	139	77	216 (6.4)
11-20	230	171	401 (11.9)
21-40	433	563	996 (29.5)
41-60	516	499	1,015 (30.0)
61-	223	219	442 (13.1)
Total	1,729	1,651	3,380 (100.0)
Unknown sex			6
Unknown date of birth			510
Duplicate cases			50
Grand total of all cases			3,946

age, and nearly the same proportion (13.0%) was older than 60 years. The numbers of persons between 21-40 and 41-60 years of age were also practically equal: 996 and 1,015, respectively. In the age group below 20, there was a significant predominance of boys (60% vs 40% girls). Only in the 21-40 age group was there a clear female majority.

Because of the differences in the application of IOM prioritization criteria by medically active nongovernmental organizations and others who were in charge of arranging possible evacuations of these cases, not more than 47% out of the 3,946 cases were classified by IOM as P1 or P2A. The appropriateness of such classification is subsantiated by figures (Tables 1 and 2). Among 1,032 cases accepted for evacuation in donor countries, more than 90% were P1 and P2A medical evacuees. On the other hand, cases registered as P2B to P4 that were selected by country delegates for evacuation comprised not more than 4.7% (97 cases) of all of the reported low priority cases (Tables 1 and 2).

Because of the special conditions and classification criteria, the morbidity characteristics of evacuated refugees were necessarily different from the morbidity of the entire refugee population, but provided a clear enough picture of the most serious medical conditions of the most vulnerable population and an invaluable and unique database for planning the reconstruction and rehabilitation of the health care services in Kosovo.

Psychotrauma-related conditions were very frequent. Many refugees suffered from epileptiform convulsions but, given the circumstances, there was no possibility to confirm whether they were of organic origin or related to psychotrauma. Due to these two conditions, the group with neuropsychiatric diseases was the largest one, comprising 24% of all evacuated cases (Table 3). As mentioned earlier, the prioritization of these cases was not free of contradiction: how would patients with posttraumatic stress disorder, for example, benefit from psychotherapy in a totally alien environment and in a foreign language (6)?

Table 2. 1999 Kosovo crisis: priority medical cases of the International Organization for Migration evacuated into a third country, according to the country of destination[a]

Country of destination	Priority of medical cases (No.)						
	1	2A	2B	2C	3	4	Total
Albania	1						1
Australia	4	6	3	2			15
Austria	8	11	4				23
Belgium	1	3					4
Canada	12	10	2				24
Croatia	1						1
Czech Republic		2					2
Denmark	18	8	6	1	2		35
Finland	5	1					6
France	44	18	1				63
Germany	146	67	8	1	2		224
Ireland	4	3			1		8
Italy	11	11			1		23
Left for Kosovo	97	41	1		2		141
Malta	1		1				2
Netherlands	9	16	1		4		30
Norway	19	16	5		1		41
Portugal	2	5	2	1	1		11
Romania		1					1
Slovakia		1					1
Spain	11	11	1				23
Sweden	42	30	5	5	2		84
Switzerland	22	24	1	2			49
Turkey	3	3	1	1	1	1	10
United Kingdom	46	22	5	1	3		77
USA	63	55	9	3	3		133
Grand total	570	365	56	17	23	1	1,032

[a]Evacuation from Macedonia until August 20, 1999.

Table 3. 1999 Kosovo crisis: medical priority 1 and 2A cases evacuated from Macedonia, according to the groups of diseases

Diseases	Men	Women	Total (%)
Cardiovascular diseases	43	65	108 (11.5)
Malignancies	71	55	126 (13.5)
Congenital diseases	41	43	84 (9.0)
Pediatric heart surgery	11	16	27 (2.9)
Reconstructive and orthopedic surgery	37	52	89 (9.5)
Neuropsychiatric diseases	103	124	227 (24.3)
Other	155	119	274 (29.3)
Total	461	474	935 (100.0)

The need for pediatric heart surgeries and high number of other congenital diseases, such as congenital hip dislocation, reflected the poor or non-existing pre- and postnatal care in Kosovo, which is likely to be a focal point for the reconstruction efforts.

There were a number of cases suffering from malignant tumors who had already undergone an initial surgical treatment in Kosovo, but had no access (even before the crisis) to chemo- and/or radiotherapy.

The proportion of cardiovascular diseases, including coronary heart disease, was not as high as in other parts of the Central-Eastern European region (7). Knowing the nature of psychosomatic diseases, this proportion may increase after the evacuees return home.

Because of endemic Balkan nephropathy in this region (8), hemodialysis was a special problem not only while the patients were out of country, but also after they returned home. For 60 patients, a special IOM "quick relief operation" was launched to facilitate the reconstruction of the hemodialysis service in their country of origin.

Discussion

Humanitarian Evacuation Program demonstrated an enormous worldwide solidarity. Participation of numerous government and intergovernmental organizations and Priority Medical Evacuation provided an example of international humanitarian cooperation. The data indicated a surprisingly high ratio of congenital diseases among the refugees, which might be a consequence of either the lack of pre-natal care or environmental factors. There was also a shortage of invasive cardiology diagnostics and cardiosurgical capacities not only in Macedonia, but also on the regional level as well. The program made these needs obvious, along with the necessity for more regional cooperation in diagnostics and treatment of oncology patients. It also set the relevant priorities for planning regional health care strategy.

However, a relatively high number of psychosocial cases remain, perhaps, the most striking finding. Indeed, psychosocial trauma rates were relatively more frequent than physical disease rates, pointing to the need for a posttraumatic stress disorder care/control network, but also to the challenge of providing adequate care to refugees with posttraumatic stress disorder in an alien setting. In this humanitarian crisis, and perhaps in others, disease appears more striking in its mental rather than in its physical forms (9). International aid agencies must find better ways to address this challenge.

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