Assessment of international medical evacuations in Macedonia

During the months of April, May, and June, 1999, hundreds of thousands of people, mainly ethnic Albanians, fled the Yugoslavian province of Kosovo into the neighbouring republic of Macedonia. Less than half of these people ended up in refugee camps—most were hosted by families in villages populated by the same ethnic group (Macedonia being ethnically mixed). Among the refugees were many people with pre-existing medical disorders and some who had suffered illness or injury as a result of the conflict or the exodus. The provision of health care to the refugee population involved a large number of agencies including NATO forces, the Red Cross, and many non-governmental humanitarian agencies.

Médecins Sans Frontières (MSF) was one of the non-governmental organisations active in serving refugees in camps and the integrated refugee populations in Macedonia, Montenegro, and Albania. In places where MSF was involved in the provision of health services many serious problems were observed in relation to the process of screening and selection for international medical evacuation. In this report, we focus on the experience of MSF in Macedonia.

The UN High Commissioner for Refugees (UNHCR) was required by NATO governments to implement a procedure for medical evacuation to a third country. No fewer than ten governments presented to UNHCR their own criteria for medical evacuation. This was done without coordination and without consultation with health-related agencies present in Macedonia. The responsibility for screening and selection was officially delegated by UNHCR to the International Organisation of Migration (IOM). There was no effort by UNHCR or IOM to standardise criteria for medical evacuation based on potential loss of life or function.

The agreed task for MSF was to provide primary health-care services for two camps with a total of 70,000 refugees, and for refugees living among the host population. The IOM insisted that all patients to be considered for evacuation had to be referred from primary and secondary health-care facilities. This meant that irrespective of objections to the IOM’s policy, MSF was de facto included in the process of selection for medical evacuation, with major negative consequences to the programme; the volume of patients is estimated to have increased by 30–40% as a result of evacuation requests. Medical staff frequently spent 2–3 h of every 8 h shift explaining to patients why medical evacuation was not warranted for their condition. One MSF doctor commented “I have never had...
people become so sad when I told them they were well.” There were several reports of patients (with diabetes, arterial hypertension, or angina pectoris) deciding to stop taking their medications in the hope that they could worsen their condition sufficiently to warrant medical evacuation. The time consumed in dealing with evacuation seekers forced the cancellation of essential skills-building courses for national health staff. This meant lost opportunities for teaching subjects identified as of critical importance, for example, management of insulin-dependent diabetes. But most importantly, it effectively diminished the attention that could be offered to ill people not specifically seeking evacuation.

IOM staff were not regularly present in all locations where refugees were residing, in order to carry out screening (the expatriate staff for the entire screening programme consisted of two medical doctors and four clerks). IOM staff did not attend health coordination meetings and had no clear idea of what services were available in the camps such that, in early May, they were identifying insulin-dependent diabetics as “high priority”, while MSF had already undertaken care of diabetic patients, including the provision of insulin.

In some cases medical evacuation could be justified on the basis of a need for specialist medical or surgical care. After referral to IOM, delays in evacuation varied unpredictably from 2 weeks to 3 months. Neither doctors nor patients were kept informed at any part of the decision-making process and changes in priority or delisting without notification took place. The result was confusion and desperation among patients and their families. Since some people who had been screened and selected by IOM nonetheless remained in the camps, whereas others were evacuated, there were accusations of irregularities and bribery against individuals associated with the procedure. The absence of a clear policy, and the inconsistent practices that resulted, left ill people without the respect they deserved.

Between April 19, and June 13, 1999, 702 people had been medically evacuated from Macedonia. Despite requests no documentation was made available about how evacuees were prioritised in relation to their medical diagnoses and the outcomes of their subsequent medical care. There was therefore no basis for assessing the procedure of medical evacuation in health terms at the time.

The rates of medical evacuation differed substantially depending on where refugees were staying. Brazda and Stenkovic-HI camps held about 40 000 people of whom 468 were medically evacuated (or about 115 per 10 000 population). Cigrane, Radusha, Bojane, Neprostina, and Senekos camps held about 65 000 people in total of whom 201 were medically evacuated (about 31 per 10 000 population). Host families housed another 138 000 refugees of whom 33 were medically evacuated (about two per 10 000 population). At least 2000 Serbs and 12 000 members of the Roma minority were also present as refugees; two Serbs and no Romas were medically evacuated.

UNHCR did not effectively lobby the Macedonian State health-care system for access by refugees. Targeted assistance to the local health-care system could have benefited both refugee and host populations in Macedonia. It would undoubtedly have been much more cost-effective than international medical evacuation by air.

The option of international medical evacuation in an acute refugee crisis is not a simple matter. Ultimately medical evacuation should be considered as the extreme end of a range of possibilities for referral of patients whose medical problems cannot be dealt with by health-care facilities in the region, and never as a viable option for desperate people to flee a crisis. The motivation to rescue an ill person must be placed in some perspective. For practical reasons we cannot ever consider evacuating all individuals deemed very ill, because in a refugee crisis we also have the obligation to strive to deal with the host population at least as well as the refugee population.

In Macedonia there was not a clear and consistent application of medical criteria to determine which people should be evacuated for medical reasons, and which could be treated adequately in Macedonia. There was an unevenness in the rates of medical evacuation depending on refugee location, and nothing to suggest that there were important differences in health status from one group of refugees to another.

The refugees in camps were given much higher levels of service by the international community than those integrated into the host population. There is circumstantial evidence that non-medical criteria may have had some role in the actual medical evacuations that took place, which seriously tainted the perception of medical care providers as fair and impartial. Governments seemed more interested in medical evacuation as an opportunity to generate favourable media images to feed their home audiences than in responding to medical needs among refugees.

The process of international medical evacuation should be exceptional. In this and future refugee crises the agencies involved in the international response need to stipulate a clear and fair policy on medical evacuations in which the following are stated as principles (panel). In the Balkans, as in previous humanitarian crises once again took precedent over the basic needs of refugees. Currently, the primary criterion for international medical evacuations in humanitarian crises appears to be that the crisis occurs in a highly politicised Western European country. For the victims of crises in such countries as Angola, Nicaragua, Sierra Leone, or Rwanda the option of international medical evacuation is rarely, if ever, available.

In an era where donor governments are increasingly trying to insist on standards of good practice by non-governmental organisations and increased coordination, it may pay the piper to listen to his own tune and act to improve policy, criteria, and coordination of donors for the well-being of those in desperate need.

*Michelle Kelly, Richard Bedell, Austen Davis, Nathan Ford

Médecins Sans Frontières, Max Euweplein40, PO Box 10014, 100 EA Amsterdam