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Physicians for
Human Rights

Perilous Medicine: The Legacy of Oppression and Conflict on Health in Kosovo

June 2009

A Report by Physicians for Human Rights

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Table of Contents

Physicians For Human Rights	4
Acknowledgments	5
Map	6
I. Executive Summary	7
II. Introduction	12
III. Methods	12
IV. Background	15
V. Attacks on physicians, patients and medical facilities, 1998-June 1999	22
A. Overview	
B. Killings/disappearances of physicians	
C. Unlawful Detentions, torture, and sham trials of physicians	
D. Harassment, intimidation and forced flight of physicians	
E. Discrimination against and attacks on Albanian patients	
F. Impact of the assaults on the larger Kosovar Albanian community	
G. Destruction of Health Facilities, Illegal Searches and the Seizure of Medical Supplies	
H. Expulsion of physicians and patients from Pristina Hospital.	
VI. The Albanian and Serbian medical communities in the immediate post-war period	35
and plans for a new health system, 1999-2001.	
A. Kosovo after the war	
B. Serbian physicians and patients in Kosovo after the war.	
C. The Kosovar Albanian medical community after the war	
D. Planning for a new health system.	
E. Human resources and financing in health reconstruction.	
F. Implementation, 2000-2008.	
G. The parallel health system for Serbians.	
VII. Legal analysis	52
A. Attacks on Kosovar Albanian medical personnel and patients	
1. International humanitarian law	
2. International human rights law	
B. Human resources for health in post-conflict health reconstruction	
1. The Right to health	
2. Standards for health services	
3. Process requirements: participation and accountability	
VIII. Conclusions and Recommendations	60
Glossary	62

Physicians For Human Rights (PHR)

PHR was founded in 1986 on the idea that health professionals, with their specialized skills, ethical commitments, and credible voices, are uniquely positioned to investigate the health consequences of human rights violations and work to stop them.

PHR mobilizes health professionals to advance health, dignity, and justice and promotes the right to health for all. PHR members have worked to stop torture, disappearances, political killings, and denial of the right to health by governments and opposition groups. Using evidence-based methods, PHR investigates and exposes violations, including deaths, injuries and trauma inflicted on civilians in armed conflict; suffering and deprivation, including denial of access to health care caused by political differences as well as ethnic and racial discrimination; mental and physical anguish inflicted on women by abuse; loss of life or limb from landmines and other indiscriminate weapons; harsh methods of incarceration and interrogation and torture in prisons and detention centers; and poor health stemming from vast inequalities in societies.

PHR is a non-profit, non-sectarian organization funded through private foundations and by individual donors. Membership is open to all, not only health professionals. PHR is a 1997 co-recipient of the Nobel Peace Prize.

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This report is dedicated to all the health professionals in Kosovo who lost their lives because they were practicing medicine.

Kosovo



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I. Executive Summary

War inflicts enormous suffering on populations and often destroys the health system that had served people in the past. The need to rebuild is often a need to transform. The transformation process must rely on doctors and nurses who shared the traumatic experiences of their compatriots. Meeting the challenge of nurturing and engaging these precious human resources for health can determine whether the new system offers equitable and high quality care consistent with the right of people to the highest attainable standard of health. In Kosovo, during the period of systematic oppression of the 1990s and the war from 1998-1999, members of the medical community experienced particularly heavy repression and brutality. They were largely excluded from Serbia's health care system during the 1990's. As violence in Kosovo escalated in 1998, moreover, many were subjected to arrest, detention, torture, and prosecution by Serbian forces. These health care professionals were accused of providing health care to wounded combatants, although such action is protected under international law and mandated by tenets of medical ethics.

This report tells the story of the impact of these experiences on the medical community, and how in post-war Kosovo, both international planners and later the Kosovo Ministry of Health adopted a strategy on human resources for health that largely ignored the searing experience of Kosovo's own doctors and nurses and the extensive skills they could contribute. That failing contributed to a system that today, ten years after the war, relies on a demoralized medical community and delivers care inequitably across the population. The report calls on the political leadership in Kosovo to take the needed steps to end these and related barriers to fulfillment of the right to the highest attainable standard of health.

In 1989, the regime of Slobodan Milosevic removed regional autonomy from the then Serbian-province of Kosovo, disenfranchising its Albanian-majority population and denying them the right to go to schools taught in the Albanian language, to practice journalism, and to work in the government service, which in the communist model controlled most aspects of education, law, business, industry, and finance. A key consequence of these measures was to force almost 2000 Kosovar Albanian physicians and other health staff from employment in the state health system. Without access to providers they could trust, the Albanian majority, who had long suffered discrimination in the Serb dominated clinics and hospitals, declined to seek services in this new and harsher environment. In the decade of the 1990s, only emergencies and need for tertiary care drove Kosovar Albanians to enter these facilities.

What emerged as a substitute for non-emergency health care in the 1990's was a "parallel" health sector established by Albanian doctors who set up their own private clinics that depended entirely on patient fees, and the remarkable Mother Teresa society charity clinics that at their peak served 350,000 people, many of them very poor. The physicians tried to maintain medical education of students, creating a parallel training program--even in the absence of school classrooms, laboratories, equipment, and access to hospital clinical rotations. Yet such concerted and often heroic efforts could not substitute for a coherent health program for the entire population and over these years the health status of the population, already low, declined still further. On all available indicators, the health of Kosovar Albanians was far worse than that of others in Serbia. Child mortality rates and maternal mortality ratios were the highest in Europe.

This decade of discrimination was followed by two years (1998-1999) of violence perpetrated by Serbian police and paramilitary forces and directed at the Kosovar Albanian civilian population as part of its campaign against the Kosovo Liberation Army (KLA). PHR's investigation found that physicians and other professionals who sought to provide care consistent with ethical obligations to Kosovar Albanians civilians and wounded members of the KLA became particular targets. At least four ethnic Albanian physicians were murdered, killed, or made to "disappear" while in custody. Dozens of others doctors were subjected to arbitrary arrest, torture in detention, and prosecution for allegedly providing medical care to the KLA. These actions were an affront to the requirements of the Geneva Conventions which permit health workers to provide care to all people, including wounded combatants, without regard to political affiliation or combatant status, and assure that they be protected from harm as they carry out these obligations. Other physicians were intimidated by being brought in for questioning and many medical offices were searched and ransacked. These assaults forced many physicians into hiding and others to flee Kosovo altogether.

PHR learned that many Kosovar Albanian patients who sought care within the state-controlled, Serbian-run health system during this period were themselves subject to abuse and mistreatment. These instances of abuse included patients beaten and interrogated; patients chained to beds or radiators on a 24-hour basis; patients burned with

cigarettes; and patients held under constant supervision by armed Serbian police guards. PHR also documented reports of patients who were afraid to access medical care in the same time period, though these reports likely represent but a small sample of such cases. These acts also violated the Geneva Conventions and human rights law.

In response to NATO military intervention in March 1999, Serb forces drove almost a million people out of Kosovo to squalid camps in Macedonia and Albania; those who remained within Kosovo were at risk of shelling, destruction of villages, and wanton attacks. When the bombing campaign ended in June, 1999, a NATO military force arrived to provide security and the province was put under UN administration. As Kosovar Albanian refugees poured back into Kosovo, some Kosovar Albanians launched violent reprisals against Serbians and others thought to have been supportive of them, such as the Roma. As a result of security concerns and restrictions on freedom of movement, health care services were brought to enclaves where the Serbians lived rather than having Serbians travel elsewhere to obtain them.

Serbian physicians were subject to the same sense of intimidation as other Serbians. Though PHR found no evidence that the returning Albanian medical community engaged in physical abuse or intimidation of Serbian physicians, PHR was told by many Kosovar Albanian physicians that they were filled with memories of years of exclusion and abuse meted out against them by their Serbian colleagues and that they did not welcome these Serbian colleagues back to their positions. Within weeks after the Kosovar Albanian return, the Serbian doctors left the clinics, hospitals, and the medical school.

Serbian health professionals who remain in Kosovo today work exclusively for the Serbian population in enclaves or in Mitrovica, the northern city which remains divided between Kosovar Albanians and Serbians. The city has a hospital on the northern, Serbian side that is inaccessible to Kosovar Albanian doctors and patients. This hospital is supported, as are all Serbian health facilities throughout Kosovo, by the government of Serbia in Belgrade. The failure of the international community to end this segregated system, and Serbia's direct support of it, continues to undermine stability and fan ethnic divides.

In 1999 Kosovar Albanians returned to a country where many towns and villages were destroyed, medical services were absent or severely limited, transportation and communication linkages were extensively disrupted and the economy was in ruins. International NGOs transferred operations from refugee camps in Macedonia and Albania to Kosovo to provide emergency medical services and international donors began providing funds for hospitals and other facilities. At the same time, the UN, which was responsible for administering Kosovo, was committed to rebuilding the health system based on human rights principles including equity, comprehensiveness, quality, affordability, and non-discrimination.

The effort was flawed from the beginning. International planners, and later its Ministry of Health, were hampered by the problems of management capacity, the lack of political commitment by the new government, corruption, and the lack of economic development that deprived the country of resources, and finally, inadequate attention paid to human resources for health. The impact of the latter cannot be underestimated. Planners and later, implementing officials did not sufficiently address several critical issues: the underlying dynamics in the health profession and in the overall political culture that had been deeply marred and damaged during the years of Serbian dominance, the Albanian retreat into parallel practice, and then the fierce and vicious brief war that forced the international community to intervene.

The dynamic created severe human resources challenges to reconstruction of the health system. Skilled Kosovar Albanian health providers in the generation that had been trained before 1990 who would be central to reconstruction had been outside the state system for a decade and had been traumatized by the experience of persecution, violence and displacement. Yet having resisted the Serbian assault on their autonomy and dignity, they were leaders of the society, and it was this leadership role that the Serbian authorities had attempted to undermine in their efforts to crush Kosovar nationalism throughout this period and during the 1998—99 war. The Kosovar Albanian health providers were hopeful and resilient, and eager to return to work, though also preoccupied with taking control of all health institutions, including the tertiary medical facility in Pristina and the medical school, from which they had been excluded. However, they had neither training nor experience in health systems or management, and were not successful in organizing a medical association to express collectively their views and needs. Integrating them would nonetheless be critical. Another key potential resource was the physicians and nurses

trained in the parallel system who lacked the intensive clinical training that is crucial to the development of diagnostic and therapeutic reasoning and skills for appropriate medical intervention.

Planners from the World Health Organization and elsewhere did embark on what became a successful nurse training program. But they did not address the human resources challenges directly. Doctors trained in the parallel system were allowed into residencies for which they were not prepared. Medical education was neglected and even information systems sufficient to match needs with training were never put into place. And most importantly, the generation that had persevered through the prior difficult decade was not integrated into the new system. With salaries in the public sector very low and dependent on annual appropriations, and with widespread skepticism about the quality of services available under the family medicine initiative, the most skilled physicians retreated into the private sector. The new health system also did not manage to integrate the competing demands for an affordable package of care accessible to all and referral and financing mechanisms that would assure the availability of skills and resources to meet population needs. As a result, the many poor people of Kosovo do not have access to their most highly trained specialty physicians.

At the same time, with little input from the Kosovar Albanian medical community or the larger society, planners created a new model of medical care for Kosovo whereby a new group of family practitioners would be trained to act as the principal point of entry and referral for health services. The new model required changes in health-seeking behavior of Kosovar Albanians that were not thoroughly considered. The new model also lacked a health financing mechanism that would assure adequate salaries for these family practitioners, who now number 500. Affordability of drugs was not addressed. Further, this new medical specialty and training program in family medicine, created by the planners, was located outside Kosovo's only medical school, thus undermining its legitimacy among the community of experienced senior physicians—a constraint that remains to this day.

Many of these problems might have been avoided at the start had UN agencies and others responsible for developing the new health system created an effective mechanism for ensuring the full participation of the medical community – as well as the community at large. When responsibility for the health system was turned over to Kosovo's Ministry of Health, the lack of management and administrative capacity, extremely poor drug procurement practices, and lack of political support continued to impede sound planning and implementation.

In the past nine years there have been some significant achievements toward achieving the right to health in Kosovo, including creation of a more decentralized system, reductions in maternal and child mortality, expanded vaccination programs, and the establishment of nurse training programs. Freedom of movement has improved for all minorities in the past four years and discrimination against minorities who seek access to care in the state system – including Roma, Ashkali, Egyptians, Turks and Bosniaks – has waned. Poverty, more than ethnicity, is now the major impediment to health services for these minorities.

Yet the health system in Kosovo remains weak and in many ways dysfunctional. The financing system still relies on budget allocations and out-of-pocket expenditures and there is no robust system of private or public health insurance. Salaries for health care providers in the public sector remain very low; the facilities are poorly equipped and supplied; and morale is poor. As a result, there has been a flight to the private sector and disengagement from the overall process of health system reform and improvement. Family practice physicians have been trained but slots in areas of greatest need remain unfilled. The most vulnerable--the very poor and the stigmatized--suffer the most, particularly in lack of access to drugs. There is no functioning health information system; processes for oversight and quality assurance are weak; and complaints are increasing that the procedures for allocating training slots and positions of authority are corrupt and politicized.

In sum, there has been only marginal progress toward fulfillment of the right to the highest attainable standard of health, as provided in Article 12 of the International Covenant on Economic, Social and Cultural Rights. The analysis presented here suggests that these failures cannot be explained by lack of resources or poor management alone, as serious as these concerns are.

The Serb population in Kosovo continues to receive its health care in separate enclave-based facilities, from Serbian practitioners. This Serbian network of care functions autonomously from that of the Kosovar Albanians and is financed entirely from Serbia. There is little contact between these two groups of practitioners and tension stems in part from specific issues, such as the fact that Serbian medical personnel receive far higher salaries than Kosovar

Albanians, and that Serbia has attempted to evade Kosovo's efforts to regulate imported drugs. Kosovar Albanians view Serbia's investment in its Kosovo-based Serbian population as an investment in future leverage for the partition, or even annexation in its entirety, of the country that Kosovar Albanians consider their rightfully independent homeland.

Recommendations

To members of the international community:

- In war and in peace, all governments must uphold and respect the principles of medical neutrality, which protect health workers in fulfilling their duty to provide medical care to individuals irrespective of political beliefs, allegiance or acts; they must not take any adverse action, including legal action, against health providers on the ground that they have provided medical care to alleged terrorists or other enemies of the state.
- Attacks on health workers during armed conflicts should be considered major violations of the Geneva Conventions and, in appropriate cases, war crimes.
- Human rights institutions and the organized medical community should insist on the protection of health professionals and the people they serve; they must not take any adverse action, including legal action, against health providers on the ground that they have provided medical care to alleged terrorists or other enemies of the state.

To the Kosovo medical community. The medical community should:

- Develop an independent voice and provide leadership through a medical association in order to support the development of professional bodies and institutions for credentialing, peer review, medical education at the graduate and post-graduate level, quality assurance, ethics standards and review, and other dimensions of professional medical practice and training.
- Assure that strict principles of non-discrimination on the basis of ethnicity, religion, and national origin are formulated and adhered to in all deliberations relating to medical practice and appointment to positions in medical facilities and institutions

To the Faculty of Medicine. The Faculty of Medicine should:

- Fully integrate family medicine into medical education.
- Introduce human rights training into the curriculum.
- Establish policies that prevent favoritism in admission and placement decisions.

To the Government of Kosovo. The Government should:

- Undertake a health financing study toward integrating private providers into a fully integrated system of care to assure equitable access to health care for all members of society
- Establish a body outside the Ministry of Health to set standards for licensing health professionals. Licensing should be based on independent examinations.
- Support dismantling of parallel structures and assure non-discrimination against Serbian health care providers and patients within an ethnically integrated health system.

To the Kosovo Ministry of Health. The Ministry should:

- In conjunction with a new financing mechanism for health, develop a plan for use of human resources for health plan to integrate private providers into a new public financing system that leads to available, acceptable, accessible, and quality care for all Kosovars.

Encourage full integration of family medicine into medical education.

- Develop mechanisms for ensuring transparency and accountability in all health systems operations, including those relating to pharmaceuticals, medical supplies, equipment, and health care facilities.
- Reform drug procurement and distribution practices to assure that all Kosovars have access to essential medicines.

To the Government of Serbia. The Government of Serbia should:

- End support of parallel health structures in Kosovo for Serbian ethnic populations;

- End interference in the efforts of Kosovo’s government to integrate all medical services and activities within its borders.

To the international community. The international community and donors should:

- Provide the resources and experts needed to implement these recommendations.
- Support the availability of prescription drugs to the population.
- Engage in political initiatives and support to end the use of parallel structures in health care delivery and medical training, and provide necessary guarantees against discrimination and marginalization of health providers and patients of any ethnic, religious and national group as all Kosovars integrate into a single health care system in Kosovo.¹

¹ The mechanisms to accomplish this are beyond the scope of this report.

II. Introduction

A key need in reconstructing Kosovo after a period of discrimination, exclusion, violence and war, culminating in the NATO bombing campaign in the spring of 1999, was to develop an entirely new health system to replace the collapsed medical enterprise that had existed before the war. One legacy of this centralized, communist-era system, dominated by the Serbians, was that the Kosovar Albanian population had the worst health status in Europe. Since 1999, international and local efforts to transform the health system in Kosovo have been substantial. These efforts have been extensively studied, in terms of planning strategy, service design, and implementation problems. Little critical attention, however, has been given to the point that the potential success of this transformation also depended, in part, on the integration into the new system of a key human resource for health; the Kosovar Albanian physicians. This was hardly a technical matter or minor concern, since these physicians had been excluded from the state health system by the government of Yugoslavia since the early 1990s. During the escalating conflict in 1998-1999, they had then been subjected to unlawful arrest, detention, prosecution and torture by Serb security forces for having complied with ethical obligations to provide care to those in need. The end of the war in 1999 also left the Kosovar Serb physicians in an uncertain position, although they had a potentially significant role to play in the new system as well.

The experience of war, persecution, brutality, and displacement left the Kosovar Albanian medical community traumatized and demoralized. Yet the physicians were committed to play a central role in a new health system grounded in human rights and were eager to participate in the planning process. The UN agencies and others responsible for developing the new health system, however, did not succeed in enlisting the Kosovar physicians in the design and planning process that could address both their needs and their place in the new system. A consequence of this failure, along with lack of a health financing system, management deficiencies and absence of transparency and accountability, is that the new health system did not integrate these physicians into a new system that could assure the availability of skills and resources to meet population needs. The failure has contributed to a fragmented and inequitable health system in Kosovo today: one which is of markedly uneven quality, and lacking in accountability. All of which is in violation of the right of Kosovars to the highest attainable standard of health. Access to the most experienced providers, as well as medication, often requires private payment that is beyond the means of the majority of Kosovars, a large percentage of whom are unemployed.

This report tells the story of how the high hopes and major investments in health renewal took a path that led to these unsatisfactory outcomes, by tracing the experiences of the Kosovar physicians, a critical human resource component in any health system, throughout this period of war and reconstruction. It begins with a detailed account of the arrest, detention, torture and prosecution of Kosovar Albanian doctors and patients in 1998 and 1999 and the subsequent retaliation against Serbs in the post-war environment. This account is based on investigations conducted by Physicians for Human Rights, in collaboration with Dr. Luan Jaha, in 1998 and 1999. It includes findings from human rights and ethics training sessions with the Kosovar medical community conducted by Physicians for Human Rights both pre- and post-war. The report then turns to plans for health transformation and its implementation, looking at the process from a human rights standpoint and focusing on human resources for health. It concludes with an assessment of the outcomes of the health planning and implementation process based on a return visit to Kosovo in 2008.

III. Methods

Physicians for Human Rights began its investigations in 1998 to gain an understanding of human rights abuses committed against Kosovar Albanian health professionals and patients in Kosovo. In the spring of 1998, PHR sent its first investigative team to the Albanian towns of Kukes, Bajram Curri and Tropoje, located on Albania's western border with Kosovo to conduct witness interviews and record observations in connection with the destruction and ethnic cleansing of villages in the Decane and Djakovica areas of Kosovo. These results were reported contemporaneously.² This preliminary visit became the basis of a larger study, which had two phases, conducted over the next two years, during which PHR investigators made 14 trips to Kosovo. The first phase investigated

² Physicians for Human Rights, "Medical Group Recounts Individual Testimony of Human Rights Abuses in Kosovo," June 24, 1998.

attacks on Kosovar Albanian health professionals and patients from 1998 through June, 1999. The second phase, beginning in the immediate post-war period, examined human rights violations committed against Serbian physicians and patients after Serbian forces left Kosovo, as well as efforts by Kosovar Albanian physicians to re-establish themselves in the health system. During both of these phases, PHR conducted training and discussion among health professions in Kosovo about human rights and medical ethics.

In its 1998 and 1999 investigations, PHR teams engaged in qualitative interviews with (1) key stakeholders in the Kosovo medical community, including physicians, lawyers, and representatives of all major NGOs operating in Kosovo; and (2) witnesses to human rights abuses and their consequences, including physicians, family members of victims, and patients. In the post-war period, PHR conducted interviews with 38 physicians, policy-makers, academic leaders, citizens, students, international organizations, and NGOs. Finally, in 2008, PHR returned to assess efforts to create health services in Kosovo consistent with human rights obligations.

Phase One: Prior to the Mass Expulsion, October 1998 – January 1999

PHR's first investigative team consisted of six physicians, two public health specialists, two lawyers, a consultant, and an international affairs graduate student. From their base in Pristina, members of the team traveled throughout the province. Access to witnesses was limited by an after-dark curfew, police and KLA checkpoints, landmines, and numerous security problems. The team interviewed 105 individuals, and sought to collect evidence regarding (1) alleged ethical and human rights abuses against ethnic Albanian physicians and patients; and (2) health-related consequences, if any, of those abuses. The team also conducted in-depth investigations of a small number of cases involving deaths, detention and torture of physicians. PHR chose these cases based on the severity and prevalence of the alleged abuse, whether the type of abuse had been previously documented, the opportunity for corroboration, and the availability and accessibility of witnesses. Where the presiding judge gave permission, members of the PHR team attended judicial proceedings brought against physicians; the team also sought, and occasionally gained, permission to visit one prisoner held in detention.

The PHR team developed a case summary form to standardize case definitions and allow for cumulative reporting. The form also identified 18 categories of abuse that were subjects of the investigation: extra-judicial execution; disappearance; torture; arbitrary detention; threats of physical violence; arbitrary charging with a crime; "trumped-up" conviction or otherwise being left in judicial limbo; inadequate access to lawyers; requirement to appear in police stations for "informative" and threatening talks; being forced to go into hiding or to flee from one's hometown into KLA-controlled areas or across borders; fear of practicing medicine (for example, treating a wounded civilian from a KLA-controlled area); being fired or otherwise suffering professional penalties, intrusion or interference with patient care; physical abuse as a patient; fear of obtaining medical care; lack of any available medical care; search of a health facility; and confiscation or destruction of property.

Investigators used interpreters for respondents who did not speak English. Statements from informants were assessed for clarity, consistency, absence of exaggerated claims, and reliability. Multiple witnesses to the same event were interviewed separately. Human rights and ethical violations were considered documented when PHR had at least one reliable firsthand witness to the abuse. In all cases where the victim was alive, the principal source of the information was the victim.

Cases were identified from a variety of sources. The methods used do not permit a determination of the total number or percentage of Kosovar Albanian physicians and other health professionals subject to arrest, detention, torture and prosecution, nor the extent to which health professionals subjected to these practices were intimidated by knowledge of them. A population based study conducted by PHR among Kosovar Albanian refugees in Macedonia and Albania in April, 1999, addresses the question of prevalence.

Phase 2: The NATO bombing campaign, March–June 1999

PHR sent three teams of investigators and trainers to Kosovo in the period just before the NATO bombing campaign began. During the first three weeks in March 1999, in trips to Pristina, Peja, and Prizren, two physicians trained

ethnic Albanian and Serbian physicians in human rights and humanitarian law.³ The training sessions drew almost 100 people. The last training team left Kosovo on March 19, 1999, five days before bombing by NATO began on March 24, 1999.⁴

Phase 3: The Immediate Post-Conflict Period, June 1999 – September 2000

In July 1999 PHR sent a team comprised of a social worker and a public health professional, and in August, 1999, a physician, to Kosovo, to explore the health situation post-war. In the fall of 1999 PHR sent another two-person team, a physician and lawyer, to meet with Kosovar Albanian physicians in Pristina and Peja, to conduct human rights and medical ethics training, and to discuss the physicians' perceptions of the future of health in Kosovo. In March 2000, PHR sent a team of three people to conduct additional training for physicians in Peja, Gjakova, Prizren, Ferizaj, Gjilan, and Pristina.⁵ Finally, in September 2000, PHR sent a physician to Kosovo for an additional assessment of the challenges in health reconstruction.

Phase 4: Immediately post-independence

In August, 2008, PHR sent a lawyer and physician to conduct interviews with about 35 physicians, policy-makers, international organizations, members of minority groups, and others, to assess the extent to which health reconstruction in Kosovo took into account the experiences of the prior conflict and established a new system based on human rights.

A Note on Names Used in This Report

The names of physicians and others who PHR interviewed are used when they gave permission to use them. Some of the individuals interviewed in 1998 and 1999 requested anonymity and that request was respected. In those cases, fictitious initials are used.

³ Unsuccessful attempts were made to include Serbian physicians in the training sessions with Albanians. PHR therefore held one separate session for Serbian physicians.

⁴ In early April, 1999, PHR sent a team of two physicians to investigate the conditions of refugees at the border between Kosovo and Macedonia, including allegations of human rights abuses occurring there; the findings were reported contemporaneously. In mid-April, PHR commenced a population-based study among displaced Kosovar Albanians in Macedonia and Albania to determine the extent of war crimes committed within Kosovo prior to commencement of the bombing campaign. The results of this study were published in a report and peer reviewed journal. Physicians for Human Rights. War Crimes in Kosovo: A Population-based assessment (1999); Iacopino, V et al, A Population Based Assessment of Human Rights Abuses Committed Against Ethnic Albanian Refugees from Kosovo. American Journal of Public Health 2001:91;1-6.

⁵ Again, PHR was unable to include Serb physicians in the training with Albanians, so several separate sessions for Serbs were held.

IV. Background

The conflict between Serbians and Albanians over Kosovo goes back many centuries. Since the earliest days of the Austro-Hungarian Empire, Serbs and Albanians have claimed ancient ties to the province. Both groups consider it central to their cultural identity and political aspirations, and have proved willing to fight for control of the region. Violent conflict between these groups has marked the region's history, although Albanians and Serbs have also fought as allies on occasion.

The more contemporary origins of the war of 1998-99 lie in the collapse of communist Yugoslavia. The Socialist Federal Republic of Yugoslavia, created by Marshal Josip Broz Tito in 1945, was a fragile entity with striking political divisions from its inception. The original federal constitution divided Yugoslavia into six federal units—Bosnia, Croatia, Macedonia, Montenegro, Serbia and Slovenia. Kosovo was formally re-annexed to Serbia at that time and declared one of two autonomous provinces within it. Within this political framework, Tito proclaimed that all ethnicities were to enjoy equal rights.⁶

Despite the official policy of ethnic equality, ethnic Albanians in Kosovo were treated with hostility by the government of Serbia. Most key jobs in the immediate post World War II era, especially in the police and security forces, went to Serbs. Serb authorities also pressured hundreds of thousands of Kosovar Albanians to emigrate to Turkey in an effort to change the ethnic balance of Kosovo in favor of ethnic Serbs.⁷ Serbs held far more public jobs and governmental positions in Kosovo than their proportion in the population.

During the liberalization period in Yugoslavia in the late 1960s and early 1970s, Kosovar Albanians demanded new rights including the elevation of Kosovo to republic status. And indeed, a new Yugoslav constitution in 1974 granted Kosovo a wide range of powers that significantly increased its self-sufficiency. It was represented in the federal presidency alongside the six republics, and allowed to establish its own central bank, police force, and regional parliaments and governments. Ethnic Albanians, who made up approximately 74% of Kosovo's population at this time, quickly assumed most positions of power in the province. Serbia's governing class strongly opposed Kosovo's new status within the Yugoslav federation. Serb criticism was relatively muted in the 1970s, and waves of arrests and subversion trials of Albanian nationalists kept the lid on Albanian nationalist sentiment in Kosovo. With Tito's death in 1980, however, Yugoslavia began slowly to unravel. In Kosovo the first sign of this came in March and April 1981, when the province was rocked by demonstrations. Protests over poor living conditions at Pristina University turned quickly to demands that Kosovo be given full legal status as a republic. Demonstrations quickly spread throughout the province. Serb authorities responded by declaring a state of emergency and sent in tanks and special police to end the unrest. Hundreds of Albanians were killed, and many more were arrested and sentenced to long terms in prison.⁸ Serbs in Kosovo complained about their mistreatment at the hands of ethnic Albanians and accused ethnic Albanians of trying to create an "ethnically pure" province.⁹

At the same time as Serbian nationalism was growing, pressure increased in Serbian political circles to rein in what was viewed as growing "Albanian secessionism." In September 1986, the Serbian Academy of Sciences issued a highly inflammatory document outlining Serbian national aspirations. Known as the Memorandum, it condemned the 1974 Constitution for "breaking up" Serbia, claimed that Serbs in Kosovo were being subjected to actions that amounted to "genocide," attacked Serbian politicians for doing nothing in the face of these crimes, and called on Serbia to return the province to its rightful place within the Serb Republic. Although then-President of Serbia Ivan Stambolic condemned the Memorandum, other Serbian communists—most notably Slobodan Milosevic, then head of the Serbian Communist Party—set out to capitalize on this rising tide of Serbian nationalism.

Several years earlier, Slobodan Milosevic had helped to pioneer the strategy of inciting and mobilizing Serbian nationalist sentiment. At his direction, the Serbian state media had launched a campaign of misinformation about

⁶ See, e.g., Noel Malcolm, *Kosovo: A Short History*, New York University Press, 1999; Miranda Vickers, *Between Serb and Albanian: A History of Kosovo*, 1998; Tim Judah, *Kosovo: War and Revenge*. 2000.

⁷ Vickers, *Between Serb and Albanian: A History of Kosovo*, p.149; and Malcolm, *Kosovo: A Short History* p.320.

⁸ Human Rights Watch, *Humanitarian Law Violations in Kosovo*. 1998.

⁹ Judah, *Kosovo, War and Revenge* pp. 47-48.

abuses against Serbs in Kosovo, including fabricated stories about the rape of Serbian woman, and promoted negative images of Albanians. During massive rallies of Serbs throughout Yugoslavia, Milosevic evoked images of past Serb glory and called for the end to Kosovo's autonomy. On November 17, 1988, Milosevic secured the dismissal of Kosovo's Albanian communist leadership and installed his supporters. The move sparked strikes by Albanian miners and demonstrations by tens of thousands of ethnic Albanians over the next six months. On February 20, 1989, the Serbian government declared martial law and deployed the army to deal with the unrest in the province.

The Revocation of Kosovo's autonomy and its aftermath

In March 1989, the Serbian government announced a new constitution that returned all authority over the province to Belgrade. The ethnic Albanian dominated Kosovo Assembly, surrounded by tanks and police, accepted the new constitution. Five days later the constitution was ratified by the Serbian parliament. Over the next two years, the Serbian parliament passed several hundred new laws and decrees to consolidate Serbia's authority over Kosovo and to deny ethnic Albanian property rights and key rights of citizenship, including restricted Albanian roles in Kosovo's police, courts, civil defense, health system, education, and social and economic life.

The revocation of Kosovo's autonomy ignited national sentiment among the province's Albanian community. On July 2, 1990, the ethnic Albanian members of Kosovo's politically gutted assembly voted to declare Kosovo a republic— independent from Serbia but still part of Yugoslavia. Three days later, the Serbian parliament voted to dissolve the Kosovar parliament for this "illegal act." On September 7, 1990, the Kosovar Albanian deputies met secretly in Kacanik and adopted a constitution for the new republic. They also elected a new "shadow" legislature and government. In response, on September 28, the Serbian government promulgated the new Serbian constitution that formally revoked Kosovo's autonomous status. One year later, as war was raging in Croatia, Kosovar Albanians took the final step. On September 22, 1991, the deputies voted for the Resolution on Independence and the Sovereignty of Kosovo. Kosovar Albanians then held an unofficial referendum and overwhelmingly endorsed independence from Yugoslavia. The Yugoslav and Serbian governments refused to recognize the results.

During the 1990's, Kosovo was a place of political contrasts. On the one hand, Albanians held elections consistent with its declared republic status without significant interference and developed "parallel" institutions for education, health and other functions outside the Serbian government system. On the other hand, the Serb military and police presence, justified by the need to fight "Albanian secessionists," grew and committed ongoing human rights abuses in the province. Police harassment, arbitrary detention, and torture were common. Ethnic Albanians were arrested, detained, prosecuted, and imprisoned solely on the basis of their ethnicity, political beliefs or membership in organizations or institutions that were banned by or looked upon with disfavor by the Serbian government. Hundreds of thousands of ethnic Albanians were fired from government institutions and state-run enterprises under a series of discriminatory laws. Ethnic Albanian teachers and administrators were fired, students were expelled from schools and universities, and student leaders were arrested and imprisoned. Serbian authorities also began a targeted campaign of threats and brutality intended to force Albanians to leave the province.¹⁰ United Nations General Assembly Resolution 49/204, adopted in December 1994, summarizes the violations:¹¹

¹⁰ Amnesty International and Human Rights Watch extensively documented human rights abuses in Kosovo following the Serbian government's revocation of its autonomy. See Human Rights Watch, "Human Rights Abuses of Non-Serbs in Kosovo, Sandzak and Vojvodina," A Human Rights Watch Report, vol. 6, no. 6, October 1994; Human Rights Watch, "Open Wounds: Human Rights Abuses in Kosovo (New York: Human Rights Watch, 1994); Human Rights Watch, "Abuses Continue in the Former Yugoslavia: Serbia, Montenegro & Bosnia-Herzegovina," A Human Rights Watch Report, vol. 5, no. 11, July 1993; Helsinki Watch (now Human Rights Watch), "Human Rights Abuses in Kosovo," A Human Rights Watch Report, vol. 8, no. 63, October 1992; Human Rights Watch in a Dissolving Yugoslavia," January 1991; Yugoslavia: Crisis in Kosovo," March 1990. For a bibliography of Amnesty International's reports, see Amnesty International Report: EUR 70/32/98, *A Human Rights Crisis in Kosovo Province*, (June 1998). See also Amnesty International Report EUR 70/34/98, June 1998, "A Human Rights Crisis in Kosovo Province, Document Series A: Events to June 1998, #3: Deaths in Custody, Torture and Ill-Treatment." Amnesty International Report EUR 70/57/98, August 25, 1998, "A Human Rights Crisis in Kosovo Province, Document Series B: Tragic Events Continue, #2: 'Disappeared' and 'Missing' Persons."

¹¹ United Nations General Assembly Resolution 49/204, December 23, 1994.

- (a) Police brutality against ethnic Albanians, the killing of ethnic Albanians resulting from such violence, arbitrary searches, seizures and arrests, forced evictions, torture and ill-treatment of detainees, and discrimination in the administration of justice;
- (b) Discriminatory and arbitrary dismissals of ethnic Albanian civil servants, notably from the ranks of the police and the judiciary, mass dismissals of ethnic Albanians, confiscation and expropriation of their properties, discrimination against Albanian pupils and teachers, the closing of Albanian-language secondary schools and university, as well as the closing of all Albanian cultural and scientific institutions;
- (c) The harassment and persecution of ethnic Albanian political parties and associations, including the imprisonment of their leaders;
- (d) The intimidation and imprisonment of ethnic Albanian journalists and the systematic harassment and disruption of the Albanian language news media;
- (e) The dismissals from clinics and hospitals of doctors and other health professionals of Albanian origin;
- (f) The elimination in practice of the Albanian language, particularly in public administration and services;
- (g) The serious and massive occurrence of discriminatory and repressive practices aimed at ethnic Albanians in Kosovo, as a whole, resulting in widespread involuntary migration.

The development of a parallel health care system in the 1990s

Prior to 1989, Kosovo's health care system, like those throughout Eastern Europe, was state-run and highly centralized under the authority of the Yugoslav Federal Ministry of Health and Serbia's Ministry of Health.¹² At its center were a medical school and tertiary care hospital in Pristina, which also referred cases to Belgrade, Zagreb, and Nis. In addition to district hospitals, at the municipal level the system included *dom zdravlja* (outpatient primary-secondary care known as "health houses"), and *ambulantas* (primary health care centers). According to the World Health Organization, as of 1997, there were five hospitals, 28 *dom zdravlja*, and 316 state *ambulantas* in Kosovo.¹³

Kosovo's health care system was financed by the state through a health insurance system and all providers, including physicians, were salaried employees of the government. Prior to 1990, though Serbians tended to dominate the hospital hierarchies and the local branches of the Yugoslav Ministry of Health, facility staff were ethnically integrated. Albanian medical students in Kosovo could study in their own language unless an Albanian-speaking professor was unavailable. Clinical work was conducted in the language of the doctor and patient. Most Serbian doctors did not speak Albanian.

The revocation of Kosovo's autonomy in 1989 had profound consequences for Albanian health care providers and patients. Within a year, approximately 2,000 ethnic Albanian physicians and health care providers were summarily dismissed from management and senior medical positions in Kosovo's clinics and hospitals.¹⁴ By late 1998, though 60% of staff was ethnic Albanian (mostly employed in small regional facilities) fewer than 10% of doctors in the state-run health system were Albanian. Albanian medical and surgical specialists who continued to be employed in the Serbian-run state hospitals were relegated to second-class status.

Albanian physicians responded by creating a parallel health care systems in Kosovo based in private fee-for-service practices. As the fees charged for service were out of reach for many Kosovar Albanians, the Mother Teresa Society, an Albanian non-governmental organization (NGO), established a network of about 100 *ambulantas* throughout Kosovo to provide primary care and maternity services that served 350,000 people. Mother Teresa *ambulantas* were supplied by donations from the diaspora and by international NGOs such as Médecins sans Frontières (MSF), Caritas, Medi Swiss, and Equilibre. Later, other charitable organizations set up free services including the Kosovo Red Cross, United Nations Children's Fund (UNICEF), Médecins du Monde, and Pharmaciens sans Frontières.

¹² World Health Organization. Overview of Health Services and Health Indicators of the Population of Kosovo: Health Care Facilities in Kosovo 1997-1998. May 5, 1999.

¹³ *Id.*

¹⁴ C. Hamilton, and N Man, Report of the Children and Armed Conflict Unit, The Impact of Armed Conflict on Children in Kosovo. Law Department, University of Essex 1998.

The exclusion of most ethnic Albanians from the state-run health system had several important consequences for the Kosovar Albanian medical community. Senior Albanian doctors found their opportunities for ongoing professional education severely curtailed. Students seeking a medical education could access a parallel system medical school, but it was able to provide only limited opportunities for clinical instruction. By the end of the 1990s, the Kosovar Albanian medical community was composed of three distinct groups: young doctors with clinical training from the parallel system; physicians who were well-trained period before the 1990s in Kosovo or elsewhere in the former Yugoslavia and ran their own private practices in clinics they had built with personal funds or who worked in the state-run Serbian hospitals; and older physicians (generally 55 to 60 years old and older), few of whom practiced, who held pro-forma academic posts in the Kosovar medical school and whose training and experience dated from the 1970s or earlier.

Aside from the few Kosovar Albanian physicians who remained employed in the state system, Mother Teresa Clinics used the state system for laboratory tests and referrals for specialist care and hospitalization. However, cooperation between the official state system and the separate Albanian health system was set against a backdrop of deep mistrust. Moreover, Cyrillic, not the native alphabet of Albanian Kosovars, was mandated for patient medical records, further impeding the continuity of care from the state-run system to the ad-hoc system relied on by Albanian Kosovars. Even immunization notices were disseminated in Cyrillic.

Kosovar Albanian patients were deeply affected by the exclusion. Because so many Albanians were excluded from jobs that entitled them to an insurance card, more than half lost health coverage. Moreover, many Albanian patients feared going to Serb facilities, as evident in the relatively high rate of at-home births during this period and the decrease in vaccinations (less than 30% coverage), which could only be legally administered through the official state system.¹⁵ More affluent Albanians were able to obtain basic health care through Albanian doctors' new fee-for-services practices. Poorer Albanians, however, had to rely on the charitable care provided by Mother Teresa Society and other charitable agencies. While filling an important need, these services were not an adequate substitute for continuous primary medicine, did not fill the void of hospital services, were sporadic, and were not coordinated to support the old local systems.¹⁶

The Armed Conflict

In view of the revocation of autonomy in 1989 and the extent of human rights violations in Kosovo in the 1990's, violence was eerily low even as war broke out in Croatia and Bosnia in 1991. Kosovars were willing to follow the passive resistance strategy of their leader, Ibrahim Rugova. But by the mid-1990's armed resistance to Serbian rule emerged and in 1996, the formerly unknown militia calling itself the *Ushtria Çlirimtare e Kosovës* or Kosovo Liberation Army (KLA) began claiming responsibility for attacks on Serb police and military. Despite these claims, the KLA remained marginal, gaining little support among the Kosovar Albanian population and their elected shadow government. By 1998, however, a number of factors helped it grow in size and influence. Ibrahim Rugova's pacifist policies had failed to achieve results. Moreover, the 1995 Dayton agreement that ended the war in former Yugoslavia did not give Kosovo any attention. Finally, anarchy in Albania in the spring of 1997 created a huge source of weapons for the KLA from looted military depots. The flood of weapons enabled the KLA to step-up attacks on Serb police and civilians from its stronghold in the central region of Drenica.

On February 28, March 1, and March 5, 1998, Serbian Special Forces launched a major assault on the Drenica Valley area. In addition to the combat against the KLA, Special Forces fired indiscriminately at Albanian women, children and other noncombatants. Helicopters and military vehicles sprayed village rooftops with gunfire before police forces entered the village on foot, firing into private homes. Several members of one family were summarily executed by the police. In total, eighty-three people lost their lives in the three attacks, including at least twenty-four women and children.¹⁷ These events in Drenica marked a turning point, radicalizing the ethnic Albanian population

¹⁵ Id.

¹⁶ WHO, Brief Description of the Health Care System in Kosovo 1997-1998. May 5, 1999.

¹⁷ Human Rights Watch, Humanitarian Law Violations in Kosovo. 1998.

and swelling the ranks of the KLA.¹⁸ The events also marked the start of the Kosovo conflict under international law. In July 1998, Justice Louise Arbour, then Chief Prosecutor of the International Criminal Tribunal for the former Yugoslavia (ICTY), officially declared that the war in Kosovo had reached the nature and scale of armed conflict within the meaning of international law. This triggered the application of the Geneva Conventions and established the ICTY's jurisdiction over war crimes committed there.

Throughout the fall and winter of 1998-1999, Serbian police, military and paramilitary forces continued to carry out indiscriminate and disproportionate attacks against civilians and civilian property. There were massacres of civilians, disappearances, extra-judicial executions and widespread destruction of civilian property. Frequently, Serbian attacks on civilians and civilian structures followed a KLA assault on a Serbian military asset.¹⁹ Hundreds of thousands of people fled or were expelled from villages. Some obtained refuge in the larger towns but many were forced deeper into the mountains of the southern and western border areas.²⁰

The possibility of wide-scale civilian deaths as winter approached triggered a strong response from the United States and other NATO countries. Under the threat of NATO bombing, in October, 1998, Milosevic reached an agreement with US Special Envoy Richard Holbrooke to draw down Serbian military and police units and to allow 2000 monitors from the Organization for Security and Cooperation in Europe (OSCE) into Kosovo. It allowed displaced Kosovar Albanians to leave the harsh conditions in the mountains and return to villages. During the months of October and November, the diffused presence of OSCE observers in distinctly marked bright orange vehicles created some stability and enhanced humanitarian access throughout Kosovo, but only during daylight hours.

Unfortunately, the agreement only restrained the violence temporarily. The KLA, which was not a party to the agreement, reclaimed positions from which it had earlier retreated and clashes between Serbian forces and the KLA intensified. In early December, Serbian forces began to violate the provisions of the agreement by moving their tanks and formal forces into the territory of Kosovo and once again on the roads and into the villages of the province. On January 15, 1999, Serb forces allegedly murdered 45 Kosovar civilians in the town of Reçak/Racak.²¹ This action galvanized world attention and once again raised the threat of bombing by NATO. Secretary of State Madeleine Albright called a conference for all parties in Rambouillet France, which started in early February and resumed in March. However, Milosevic refused to agree to the terms presented to him. With the breakdown of talks, OSCE monitors – the last major international presence – were pulled out on March 20, 1999. Two days later Ambassador Holbrooke told Milosevic that unless he relented, Serbia would be bombed. Meanwhile, Serbian forces had managed a rapid buildup of military strength of approximately 45,000 soldiers, police, and paramilitaries in Kosovo proper, many of whom were drawn from Serbia. The Serbian military also significantly reinforced its regional air defense capacity.

NATO bombing began in late March. In the two preceding months, the level of violence within Kosovo had escalated dramatically. Situation reports from the OSCE monitors and from the United Nations High Commissioner for Refugees (UNHCR) described a high level of insecurity for Kosovar civilians,²² along with burning and destruction of villages, farms and hamlets. By March, it was nearly impossible to travel on the main roads of Kosovo and see a single intact village or settlement from the road. Thousands of people had sought refuge in the larger towns or fled deeper into the mountains of the southern and western border areas.

¹⁸ International Crisis Group, Kosovo's Long, Hot Summer: Briefing on Military, Humanitarian and Political Developments in Kosovo, September 2, 1998; International Crisis Group, Intermediate Sovereignty as a Basis for Resolving the Kosovo Crisis," November 9, 1998. See Judah, Kosovo: War and Revenge.

¹⁹ OSCE Office for Democratic Institutions and Human Rights Kosovo. Kosova as Seen, as Told, Part III – The violation of human rights in Kosovo, Chapter 11. 1999.

²⁰ Human Rights Watch, Under Orders: War Crimes in Kosovo (2001); Organization for Security and Cooperation in Europe. Kosovo/Kosova: As Seen, As Told (1999).

²¹ The incident was subject to worldwide attention. However, the government of Serbia denied that any murders had taken place and alleged that the town was a base for the KLA. Subsequent human rights and criminal investigations, including forensic examinations, led the prosecutor of the ICTY to include the incident in the indictment of Slobodan Milosevic. Evidence of the manner of the killings was introduced at his trial.

²² OSCE Office for Democratic Institutions and Human Rights. Kosovo/Kosova as Seen, as Told, Part III – The violation of human rights in Kosovo, Chapter 11.

On March 24, the NATO bombing campaign began and the humanitarian situation became even graver. Within days, hundreds of thousands of Kosovar Albanians were forced out of Kosovo into neighboring Macedonia and Albania, and ten of thousands of others had fled; by the end of the war, 850,000 people had left the country. The air strikes, rather than halting the Serbian offensive, provided cover for Milosevic to drive civilians out of Kosovo. Serbian military and paramilitary groups, backed by tanks and armored personnel carriers, moved rapidly against civilian targets: people, villages, homes, livestock, farms, cultural and religious sites, schools, and medical facilities. Thousands of Kosovar Albanians were forced at gunpoint to leave their homes, fleeing to the border in trains and cars; families were often separated in the chaos.²³ Those who remained inside Kosovo were subjected to brutality from paramilitary groups and gangs. Shortages of food and medical supplies began to reach crisis proportions.²⁴ Meanwhile, inside Kosovo, Serbian forces committed widespread violations of human rights against ethnic Albanians including: killings, beatings, torture, sexual assault, separation and disappearances, shootings, looting and destruction of property, and violations of medical neutrality.²⁵

The NATO bombing campaign lasted for more than two months. On June 3, 1999, Milosevic and the Serbian parliament accepted the NATO plan for ending the war and policing the agreement. NATO suspended its bombing of Yugoslavia on June 10, the day after Belgrade agreed to a full military withdrawal from Kosovo. The Yugoslav military began its withdrawal from Kosovo on June 10, 1999. As part of the peace process, the United Nations Security Council enacted Resolution 1244, which formally authorized the deployment in Kosovo, under United Nations auspices, of an international civil and security presence: a UN Mission in Kosovo (UNMIK) for civil administration and a large international protection force (KFOR) consisting of NATO and Russian troops.²⁶ As part of the agreement the KLA was to be disarmed.²⁷

Post-Conflict.

In June, 1999, as Serb forces left Kosovo and KFOR arrived, refugees began to return. This was despite KFOR warnings that the terrain had not been cleared of landmines and cluster bombs from the recent conflict. Within three weeks of the signing of the ceasefire agreement, more than 800,000 of the original 848,000 Albanians who had departed during the war were back, the fastest refugee return in history.²⁸ But they returned to a devastated country. The city of Pristina remained intact, but houses and apartment blocks in middle-class areas of the city had been occupied by Serbian forces or looted and damaged. Many other cities and villages suffered worse damage, with extensive destruction of houses and other structures by fire, bombing, and looting. As Serbian forces left, they destroyed additional villages in their passage north towards Mitrovica.

The end of the war left Kosovo's future uncertain. It remained formally a part of Serbia, but was administered by the UN. As UNMIK came into existence in the summer of 1999, political factions within Kosovo sought to exercise their own authority. UNMIK remained in control, however, and soon established administrative agencies, including a Department of Health and Social Welfare, later to become the Ministry of Health. In January 2000, an administrative structure gave Kosovars a formal voice in governance, though decision-making power remained with UNMIK. In 2001, UNMIK established a further framework for governance in Kosovo and organized elections for a provisional government, which were held in 2001.

²³ Physicians for Human Rights, War Crimes in Kosovo; OSCE Kosovo / Kosova as Seen, as Told, Part III - The Violation of Human Rights in Kosovo, OSCE, Chapter 12.

²⁴ Physicians for Human Rights press release, Kosovar Albanian Physicians Call for Immediate NATO Ground Troops and Airdrop of Food and Medicines to Save Remaining Civilian Population in Kosovo. April 22, 1999.

²⁵ Physicians for Human Rights. War Crimes in Kosovo: A Population Based Assessment of Human Rights Violations Against Kosovar Albanians. 1999.

²⁶ United Nations Security Council, Resolution 1244, 10 June 1999.

²⁷ In September 1999 UNMIK signed a regulation turning the former rebel group into a civilian emergency service, called the Kosovo Protection Corps (KPC). The agreement provided that the KPC would consist of a maximum of 3,000 active members and 2,000 reservists, with at least 10 percent of recruits to be selected from minority groups

²⁸ Judah, Kosovo: War and Revenge, p. 286.

The end of the war did not bring an end to violence, as reprisals by some Kosovar Albanians against Serbs and others, particularly Roma thought to be collaborators, began immediately. Tens of thousands of Serbian civilians left and many who remained were at risk of violence against them and their property. Depredations included widespread looting and ransacking of Serb-owned shops and businesses.²⁹ Over the next months, Albanian attacks on Serbians, many undertaken openly and in daylight, were extensive. Despite efforts by UNMIK and KFOR to increase security, the Serbian population of Kosovo continued to experience intense insecurity and inter-ethnic violence continued. By the end of August, 1999, UNHCR reported that more than 150,000 ethnic Serbs had fled Kosovo after NATO arrived, along with significant numbers of Roma.³⁰

The city of Mitrovica proved to be a significant and enduring flashpoint. The Ibar River had divided the city, with a predominant Serbian majority living on the northern side. In late June 1999, self-organized ethnic Serb groups gradually started preventing returning Kosovar Albanian refugees from coming back to their homes in the northern part of the city,³¹ where, among other institutions, the hospital was located.

On July 23, 14 ethnic Serbs were shot to death outside the village of Gracko, in the south of Kosovo. In the first week of August, the UNHCR announced that some 4,500 ethnic Albanians had fled a campaign of intimidation in southern Serbia.³² The violence between these two ethnically divided communities, in the form of killings, harassment, intimidation, and destruction, continued into 2000 as UNMIK sought to recruit and train in adequate numbers a police force that could be deployed in the cities, along transport routes, and at key points throughout the country.

Over time, KFOR and the UNMIK police established greater security, though freedom of travel remained restricted and an outbreak of inter-ethnic violence erupted again in 2004. Since then security has improved, with few incidents in the past five years. The Serbian population in Kosovo lives in the northern area that includes Mitrovica and in small village enclaves. Within Mitrovica, the stand-off continues, with the Serbian population preventing Kosovar Albanians from crossing the bridge to reach the hospital on the northern side and effectively restricting access to an area that is part of Kosovo.

The end of the war left Kosovo's final political status unresolved, essentially left for a later day. There was little progress on this key question until 2006, when UN Special Envoy Mari Ahtisaari began talks on the future status of Kosovo. In 2007 the Ahtisaari Commission set out a proposal for the "supervised" independence of Kosovo. Serbia, with Russian backing, strongly opposed any form of independence, making action by the UN Security Council impossible. Ultimately, in February, 2008, Kosovo declared its independence. This declaration was recognized by the United States and most members of the European Union. Serbia declared Kosovo's act of independence null and void. Fears that the declaration would lead Serbs to leave the enclaves en masse or for Serbia to initiate economic boycotts or even military action did not come to fruition.³³ However, Serbia continues to take steps to seek to undermine Kosovo or to seek a partition of Serb areas.³⁴

²⁹ Id...

³⁰ UNHCR press release, High Commissioner for Human Rights Calls for End to Continuing Violence in Kosovo. August 4, 1999.

³¹ International Crisis Group Balkans Report #96, Kosovo's Linchpin: Overcoming Division in Mitrovica. May 31, 2000.

³² UNHCR. Second Assessment of the Situation of Ethnic Minorities in Kosovo (period covering July through August 1999, Sept. 6, 1999).

³³ International Crisis Group. Policy Briefing No. 47. Kosovo's First Month. 18 March 2008.

³⁴ International Crisis Group. Kosovo's Fragile Transition. Europe Report No. 196. 25 September 2008

V. Attacks on physicians, patients and medical facilities, 1998-June 1999

A. Overview.

As part of its escalation of violence against civilians in early 1998, Serb forces began arresting, imprisoning, torturing and prosecuting Kosovar Albanian health professionals who lived in the communities under attack. The attacks served as a warning to health professionals not to provide medical care to KLA members, even though such care was consistent with physicians' ethical obligations, as well as threat to their own personal safety. In response, many physicians fled these areas adjacent to the attacks, which made it very difficult for Kosovar Albanians to obtain health services in areas where they needed it most. Furthermore, when injured civilians tried to flee into areas that were not under attack, they had to cross zones controlled by Serbian forces, where they were subject to harassment or arrest.

PHR documented 202 cases of gross interference by Serbian forces with the provision of medical services for Kosovar Albanians.³⁵ These cases included three extra-judicial executions, one disappearance and twelve cases of torture, all but one instance of which involved a physician. The violations including the following:³⁶

Act	Number of Cases
Health professionals forced to go into hiding or to flee from his/her hometown into KLA-controlled areas or across borders	54
Health professionals who feared deliver ethically appropriate care in a particular instance (for example, treating a wounded civilian from a KLA-controlled area)	35
Intrusion or interference with patient care	26
Health professional fired or otherwise suffering professional penalties	21
Arbitrary detention of health professional	14
Health professional arbitrarily charged with a crime and/or inadequate access to a lawyer	14
Confiscation or destruction of property belonging to health professional	13
Requirement of health professionals to appear in police stations for so-called "informative" and threatening talks	12
Torture of health professional	12
Threats of physical violence or of being hunted delivered against a health professional	10
Prosecution of health professional for an alleged offense	8
Search of a health facility	7
Extra-judicial execution of health professional	3
Disappearance of health professional	1

B. Killings/disappearances of physicians

During the period February, 1998 through February, 1999, PHR documented three extra-judicial killings of physicians and one who was disappeared. The evidence indicates that at least two were targeted because they were doctors. In all cases, the evidence indicates Serb forces were responsible. The assassination and disappearance of these physicians terrorized the Kosovar Albanian medical community and at the time served as a constant reminder of the risks entailed in carrying out their duties as physicians.

³⁵ As a qualitative study, these findings do not purport to represent the total number of incidents of interference with medical care in the period from mid-1998 to late March, 1999.

³⁶ Some of the individuals experienced multiple violations.

- Dr. Lec Ukaj (referred to by most as Dr. Lec) was a well-known ethnic Albanian general practitioner who directed the Drenas/Glogovac health facility.³⁷ On May 26, 1998, when Serb forces moved into Drenas/Glogovac, Dr. Lec and his family fled to Gradicë/Gradice. In Gradicë/Gradice, he helped the KLA establish field hospitals to care for their own combatants and for villagers fleeing the Serb assault. On September 22, a shelling attack near Gradice forced Dr. Lec and his colleagues to evacuate the field hospitals. For three days, Dr. Lec, his colleagues, villagers, and wounded patients hid in the hills, with constant shelling around them. During this time, the police searched the village for Dr. Lec. Witnesses said the police threatened people and told them that Dr. Lec treated terrorists and that he would be killed if they found him. They also destroyed his clinic. The next day, Serb forces moved further into the hills. Dr. Lec, his brother and two other male relatives ran through the forest and hills to escape the police. Dr. Lec was caught, shot and his body mutilated. The Serbian forces had asked Dr. Lec which hand he used for surgery and, after his response, cut off his right hand.

- Dr. Nuredin Zejnullahu was a prominent ethnic Albanian physician in the city of Peja.³⁸ On November 18, 1998, three armed Serb-speaking men, dressed in the signature style of the Serbian special police, arrived at his home searching for him. They grabbed his 16-year-old son in the yard, burst into the house and ordered the rest of the family to line up in the hallway. Dr. Zejnullahu descended from the top of the stairs, tore his son from the grip of the gunmen, threw them out the back door, and slammed it shut. The masked men fired their Kalashnikovs through the door. Several shots penetrated Dr. Zejnullahu's left groin and right knee. By the time he was finally transported to the Peja hospital, he was without a pulse and with no detectable blood pressure. A team of Serbian and Albanian physicians attempted to resuscitate him, but the gunfire had ruptured his femoral artery, which required the reparative skills of a vascular surgeon. His family asked Serbian authorities to transport him by helicopter to Pristina where a vascular surgeon was available, but they refused, citing night-time and security conditions. Dr. Zejnullahu died in a ground ambulance en route to Pristina.

- Dr. Xhevat Gashi was murdered in January 1999, also in the Peja/Pec area. Last seen walking to work at an emergency clinic near Peja/Pec, his body was discovered by Kosovar Serb police on the Mitrovica-Pec highway. According to OSCE, he was killed by a gunshot wound to the brain with associated burns on the skull, consistent with a close range execution-style killing. Responsibility for his death hasn't been determined.

- Dr. Hafir Shala disappeared on April 10, 1998 after being detained by Serb authorities on the Drenas/Glogovac-Prishtina/Pristina highway.³⁹ Like many health professionals in Kosovo, Dr. Shala straddled both the Serbian and Kosovar Albanian systems: he worked at a government health facility in Drenas/Glogovac during the day and as a volunteer physician at two Mother Teresa clinics at night. On April 10, 1998, Dr. Shala and two colleagues were on their way to Prishtina/Pristina to obtain medical supplies for the Mother Teresa clinics. When they stopped at a police checkpoint, three men in civilian clothes emerged from an unmarked car and ordered Dr. Shala into another vehicle. His colleagues were ushered back into their car along with a uniformed policeman who directed them to drive to the Prishtina/Pristina police station. The unmarked car carrying Dr. Shala followed behind. When the unmarked car arrived at the station, one of the two colleagues in the other car, saw the car with Dr. Shala drive around to the back of the police station. When the colleague later left the police station, having been released from custody, he heard screaming that he recognized as the voice of Dr. Shala. Dr. Shala has not been seen since. He is still missing.

C. Unlawful detentions, torture, and sham trials of physicians

Before the Serb offensive of late February/early March 1998, Albanian physicians, although subject to discrimination within the health care system, were not usually subject to questioning, arrest or detention by the police. That changed as the offensive began. Physicians began to be questioned, detained and charged with offenses

³⁷ PHR interviewed Dr. Lec Ukaj's father and two brothers in October 1998; his wife and children and his sister and her children in November 1998; a colleague from Dr. Lec Ukaj's clinic, Dr. B.C. in October 1998; and, also in October 1998, two women from his village who were questioned by police about his whereabouts while he was being hunted.

³⁸ PHR interviewed Dr. Zejnullahu's brother, two sons, two daughters, and niece in November 1998.

³⁹ PHR interviewed his wife, father, and lawyer in November 1998. PHR also interviewed a colleague who was detained with him and sources at other organizations that had investigated his case.

under anti-terrorism laws for providing medical aid to the KLA. PHR identified 13 such cases. The findings suggest that officials used mere proximity to KLA-controlled areas as a basis to make the charges.

The charges in all cases were based on two provisions of the Federal Republic of Yugoslavia criminal code. Article 125 prohibits violence against the state and Article 136 prohibits membership in or assistance to organizations engaging in hostile acts against the state. Serb authorities applied these laws to the KLA and alleged sympathizers.⁴⁰ In making such charges, authorities ignored another provision of the Serbian criminal code, which stated that a physician has an obligation to treat those in need and that failure to do so was a criminal offense.⁴¹

The arrests had a terrifying and chilling impact on physicians, many of whom became aware that even remaining in a KLA-controlled area could lead to detention and prosecution. It also made physicians fearful of even staying in areas where civilians were vulnerable to attack. Dr. B.I. stated to PHR,

Every time we go into the field to see a patient, we run a big risk from the police, who classify you as a 'terrorist' if you work with 'terrorists.' We give help to everyone, we are humanitarians. We are legal; we have books and records of treatment." As the cases described below show, arrests and detentions of physicians under this charge were also usually accompanied by beatings and other forms of torture or cruel, inhuman and degrading treatment to obtain confessions. These confessions were then presented by prosecutors in court proceedings against the physicians.⁴²

Under Serbian law, police are required to complete their investigation and present their recommended charges to the investigating judge within three days. This meant that torture, usually in the form of beatings, came immediately after detention in efforts to extract a confession. This abuse was not always limited to the three-day time frame, however. PHR received testimony indicating that some doctors were tortured throughout their period of detention.

Kosovar Albanian physicians detained by Serbian authorities reported difficulty gaining access to lawyers, particularly during, or immediately after, the three-day window for presenting charges to the investigating judge. Lawyers interviewed by PHR suspected that Serbian authorities were trying to hide detainees while the physical signs of torture were still visible. When a physician was able to speak with his lawyer, the meetings were often too brief – sometimes only two to five minutes – for use in preparing a defense. Serb authorities also monitored all visits with lawyers; a Serb official from the detaining authority was always present to observe the conversation.

⁴⁰ Article 125 of the code provides:

Whoever causes an explosion, fire or take some other generally dangerous action out of hostile motives against the SFRJ, or commits an act of violence which may create a feeling of personal insecurity in citizens or a in a group of citizens, shall be punished by imprisonment for not less than five years.

Article 136 of the code provides:

(1) Whoever sets up a cabal, band, group or any other association of persons for the purpose of committing criminal acts under articles 114 to 119, paragraph 2, articles 120 to 123, articles 125 to 127 and articles 131 to 132 of this law, or whoever forms a group for the purpose of transferring or dispatching citizens of the SFRJ abroad for the sake of carrying out hostile activities against the SFRJ, shall be punished by imprisonment for not less than five years.

(2) Whoever becomes a member of an association referred to in paragraph 1 of this article, shall be punished by imprisonment for not less than one year.

(3) The member of an association referred to in paragraph 1 of this article who exposes the association before he has committed a criminal act defined in the provisions of this chapter in the association's ranks or on its account, shall be punished by imprisonment for a term not exceeding three years, but the court may also refrain from imposing a punishment on him.

⁴¹ As part of a federal system, Serbia's criminal code contained an enforceable set of laws distinct from the Federal Republic of Yugoslavia criminal code. At the time, Article 127 of the Serbian criminal code provided that a physician had a responsibility to treat those in need and that failure to do so was a criminal offense.

⁴² The torture of the doctors was consisted with practices used by Serb police more generally. See, for example, Human Rights Watch, Federal Republic of Yugoslavia: Detentions and Abuse in Kosovo. December 1998.

Access to trials by international observers, was severely restricted but PHR did gain permission to observe some of the trials, which were usually conducted in Serbian before a Serbian judge with three lay jurors in attendance. Prosecutors, defense lawyers and defendants often presented their cases without witnesses. The trials were brief, often less than 45 minutes. A transcript of the proceedings was often made, but it was based on the judge's paraphrasing of lawyers' and defendants' statements rather than a verbatim record of the proceedings. Confessions obtained through torture were often the primary form of evidence presented by the government during these trials. PHR is not aware of any investigations into physicians' claims that their confessions had been obtained by torture.

Cases in which physicians were detained and subjected to forms of torture and other forms of cruel, inhuman or degrading treatment or punishment, include the following:

- Dr. Shani Bajraktari,⁴³ an ophthalmologist, was in his hometown of Orahovac during the period July 19-24, 1998, when the KLA launched an attack. He had provided medical aid to KLA soldiers through a clinic. Because his wife has a disability, they were unable to flee and he and his family initially hid in a windowless bathroom; later they hid with their Serb neighbors, but he was eventually found. An inspector from state security interrogated Dr. Bajraktari about his relations with the KLA, including a visit to a KLA hospital in Gajrac where he had gone to care for a woman with a serious eye injury. He was not then detained further.

Dr. Bajraktari eventually returned to work but his wife's medical condition worsened and he and his family made their way to Prizren. While there he was detained again on September 28, 1998. This time he was brought to a detention center, where he was "beaten to hell" to the point of unconsciousness. As interrogations continued, Serbian authorities showed him a statement by someone else that he had worked in a KLA clinic, and beat him further until he signed a confession. When he appeared before a judge he denied the charges and was beaten again in the courtroom. He was then held for three weeks in a room 22 meters square, with 37 other detainees and no sanitation facilities; he said it was difficult to breathe because of the lack of air. He was later moved to a cell containing four people.

Dr. Bajraktari was charged under Article 125 with being a terrorist and the prosecutor asked for 15 years imprisonment. The indictment stated:

"In the time from April to the end of September 1998 in the areas of Orahovac, as a member of terrorist organization called KLA, he took part in the acts of violence to create insecurity among the citizens, by working in [State Hospital] in Orahovac. He took part in a meeting of medical workers in the elementary school and accepted the role of organizing health care and treatment for the members of KLA after they committed terrorist attacks. Working under the advice of supervisors in the so-called "KLA," he left his work place in the Orahovac clinic several times and went into the village of Drenoc led by a person named Mensur to the illegal KLA ambulanta where he delivered medical care to so-called "KLA" members wounded in armed conflicts. He also went to the village of Gajrac where he examined and treated so-called "KLA" members by undertaking surgical interventions. He took part in the supply of dressings and medicines and transport of the same to illegal clinics. In an effort to hide these activities, he explained his absence from work as taking vacations. By doing this he has committed – the act of terrorism from Article 125 of the Penal Code of Yugoslavia."

Finally, at a hearing on January 29, after four months in detention, Dr. Bajraktari's Serbian neighbors testified on his behalf. In a majority decision (3-2), Dr. Bajraktari was sentenced to 3 ½ years imprisonment. However, with the help of a bribe, he was released on bail pending a decision by the Supreme Court of the Republic of Serbia. He left detention with no identification papers, no passport, no driver's license and no job. When he sought to obtain documents, he was detained again for eight hours, but then released. He returned to Djakovica, but after the city was attacked by Serbian forces as he fled with his wife through the mountains to Albania.

After the war Dr. Bajraktari returned to Kosovo, spending the first month in Orahovac. Because the equipment in the clinic was gone, he eventually moved to Prizren, where he now practices ophthalmology.

⁴³ PHR interviewed Dr. Bajraktari's wife and other family members and his lawyer (a Serb) in November 1998 and Dr. Bajraktari himself on August 6, 1999 and again on August 10, 2008. PHR also obtained a translated copy of the indictment against him as well as a transcript of the trial.

▪ Dr. Luan Jaha operated a clinic near Rehovec/Orahovac.⁴⁴ In July 1998, Orahovac was the site of the first major Kosovo Liberation Army (KLA) offensive. During the fighting, Dr. Jaha, his wife Vlora (a pediatrician), and their two young children fled to Malishevë/Malisevo where Dr. Jaha cared for sick and wounded people in a makeshift facility. On August 17, 1998, on his way back to Rehovec/Orahovac he was spotted by a police officer who had once been his patient. Dr. Jaha was handcuffed, taken into custody, and brought to the Prizren police station. He was interrogated about his activities, accused of organizing KLA medical services and of taking Serb hostages in his *ambulanta* in Orahovac. When Dr. Jaha denied these accusations, he was beaten with rubber sticks and a plastic bag was placed over his head to suffocate him. He was then taken to a small cell with 20 to 30 other prisoners. They were given little water and food was very meager: tea and soup three times a day. A pail was used as a bathroom facility.

During each of the next three days, he was interrogated about his own activities. He was also asked the names of other physicians who were working in the area. When he denied the accusation of assisting the KLA, he was beaten with rubber sticks on his hands, legs, and feet. He developed hematomas on his feet and hands, and lost consciousness and collapsed after the plastic bag suffocation. He was also denied medical attention.

He asked to see a physician in Prizren. When this was granted, he asked the physician to provide a written certificate that he had been beaten. The physician refused. Dr. Jaha also asked for analgesics and sedatives, which were also denied. He was taken to court to hear the investigator's charge. Dr. Jaha's lawyer told the court that his client had been beaten.

Dr. Jaha reported that the sessions of torture occurred nightly outside of the cells and halls of the prison. Every night, prisoners were taken out of the cells to an area where he could hear Serbians singing patriotic songs, talking. He smelled grilled meat. He could also hear screaming and the sound he took to be the beatings of prisoners

After a month and a half, Dr. Jaha was released and all charges of terrorism against him were dropped.

• Dr. Fehmi Vula is a well-known and respected general surgeon and former president of the Kosovo Red Cross. In 1998 he was director of Djakovica Hospital. In May 1998, Serb state security police came to his office and demanded that he accompany them to search for two Serbian police officers who were missing, on the assumption that he could use his authority in the community to secure their release. They threatened to kill him if the officers did not return. Dr. Vula followed their orders and sought to track down the missing police officers. After three days of seeking but not finding them, the police told Dr. Vula he was free to leave. Before he departed the police station, however, he was arrested by municipal police. Interrogators accused him of medically aiding wounded KLA soldiers behind battlefield lines, of buying arms for the KLA, and of being a KLA organizer.

Dr. Vula was held for three days in the Djakovica jail, which was located in the basement of the police station. He described his cell as "like a WC [water closet], with no toilet and everyone having to urinate or defecate there. There was no light and no chair or bed in the basement jail, so I stood for three days." He was not beaten, though he was given no food other than a slice of bread and cheese at his interrogations. He was charged with terrorist activities

Dr. Vula was then transferred to Prizren and brought before an investigating judge, who told him that the statements he made while jailed would not be used. Dr. Vula told the judge that he had been in a KLA-controlled village but there had been no fighting at the time. He explained that a landmine explosion had killed five civilians and injured another five others. The local doctors had asked him for help. According to the police and the judge, Dr. Vula's charge became failing to report the incident to the police. The judge then issued an order holding Dr. Vula in detention for 30 days, which was later extended to 60 days, pending investigation.

After 49 days in Prizren, Dr. Vula was transferred to Pec. Upon arrival, other prisoners accompanying him were beaten, but an Albanian medical technician protected him. In Pec, Dr. Vula went before another investigating judge, who ordered Dr. Vula be kept in unlimited detention while under investigation. Six weeks later, Dr. Vula was transferred again, to Mitrovica. During the transfer, all the prisoners but Dr. Vula were beaten on the bus. Upon arrival, however, he said he was severely beaten. At Mitrovica, prisoners slept on mattresses without sheets,

⁴⁴ PHR interviewed Dr. Jaha several times, as well as his colleagues from /Rehovec/Orahovac before Dr. Jaha assisted PHR with the investigation, serving as a researcher.

the food was poor and there were no washing facilities for personal hygiene. Although prisoners were entitled to two daily walks outside, Dr. Vula was permitted only twelve walks in his three months of incarceration there. When the guards came for what was known as “control,” the prisoners were routinely forced to strip and then were beaten. The guards would then put all of the clothes into a large pile and order the prisoners to dress in three minutes or they would be beaten again. The guards warned them that anyone who reported that they had been beaten would be killed. Dr. Vula said that he lost 15 kilos (or about 33 pounds) during the time he was held in prison.

Dr. Vula’s trial, originally scheduled for October 20, 1998, was postponed to November 3, 1998, and again involved terrorism charges. The prosecutor asked the court to sentence Dr. Vula to 10 years imprisonment. At the trial, the Serb director of the Djakovica hospital and three other citizens testified on his behalf. After hearing the evidence, the court found him guilty and sentenced him to five months and released him for time served.

It appears that Dr. Vula was imprisoned not because Serb authorities actually believed he was a member of the KLA or provided assistance to wounded soldiers, but because he was a pillar of his community. He believes that he was singled out “to separate [him] from the people who most needed his professional services, and to create fear among the intellectuals [so as] not to help the common people.”

After his release, he returned to work at the hospital but at first the Serb director refused to pay him, claiming he had been absent. He also reported that he was routinely followed by the police during this time.

When the NATO bombing began, Dr. Vula was again targeted, and hid by burying himself in a shallow pit hole that he had dug in his back garden. After five days of hiding in this pit, he escaped. He returned to Gjakova/Djakovica after the war.

- Dr. O.G. was arrested and charged with engaging in terrorist activities. During his detention, he said, “[Serb authorities] beat me like an animal; they beat me with the butt of the gun; they were kicking me; they beat me with their fists.” He explained, “In the police station I had to sign everything they wanted to stop the torture.” Consistent with other testimony, the worst abuse Dr. O.G. reported was during the first few days of arrest in police custody before going before an investigating judge. After his release, he continued to experience intense fear and did not feel like a free man. “I’m afraid of them using violence and aggression against me again.”

He was tried before a Serbian judge on October 29, 1998, a trial PHR observed. In his statement to the court, he explained that on the dates in question, he had provided medical care to several wounded people, both civilians and individuals in uniform. He told the court that while he was aware of the danger of helping these people, he was motivated only by moral and professional concerns. He also told the court that his confession, the only evidence against him, had been obtained as a result of torture. The prosecutor asked detailed questions about Dr. O.G.’s alleged criminal activity, but elicited no evidence of terrorism or any affiliation to the KLA. He maintained that Dr. O.G. should have known he was assisting the KLA since the wounds he treated were grenade wounds. He also denied that Dr. O.G.’s confession was coerced. In his closing remarks, the prosecutor asserted that the crimes had been proven and that Dr. O.G. was a member of an illegal organization.

Dr. O.G. remained in custody until November 1998, when a verdict of “not guilty” was rendered and all charges against him were dropped. Interviewed after he had been released, Dr. O.G. thought that the fact that there were international observers at his trial helped him.

- Dr. Afrim Avdaj. Dr. Avdaj is a general surgeon who, after training in Sarajevo, was invited to come to his place of birth, Verrini, a village 6 km from Prizren, to help provide medical services to wounded KLA soldiers. He arrived on May 29, 1998. In mid-July, while at a government hospital in Prizren he learned that tanks, soldiers and armored vehicles were on the road to attack KLA positions around his village. The hospital was filled with police, but he managed to leave and drive to a friend’s house. An hour later he tried to go back to the village but was stopped and detained by the police along with many others. At the detention center, where he was held in a room with 50 others, the police came with a list of people to release; Dr. Avdaj was not among them.

He was transferred to a room designed for one person where eight people were held. There was so little air that one person became sick and Dr. Avdaj thought everyone would suffocate. The next morning Dr. Avdaj was sent to prison and beaten badly. The guards set up a line and he watched prisoners running the line while beaten with sticks,

fists, and guns; he was spared. During interrogations he saw electrical cables and was convinced that if he did not sign the demanded confession he would be subjected to electric shock. So he signed a statement that he was a terrorist and had killed a policeman.

Dr. Avdag was charged with killing the policeman. When brought before a judge three days after detention he said he had only signed the confession under threat of torture. The judge approved the indictment nonetheless and sent him back to prison, where he remained for more than five months. He was not able to obtain adequate food and water and said he was so despondent that he asked the International Committee of the Red Cross (ICRC) representatives visiting prisoners to give him poison. Finally, on December 22 Dr. Avdag had his third investigative hearing and he again denied everything. As he was approaching the six month maximum detention period without trial, the judge released him. Dr. Avdag said that despite all the torture and confessions the Serb authorities never figured out that he had been working as a doctor for the KLA and had not charged him with an offense based on that work.

He returned to his village and soon left for Sarajevo, though his family stayed in the village. In March the village was attacked again and his brother arrested and was never heard from again. He described the entire series of events as very difficult to cope with emotionally. Nevertheless, in 2000 he came back to live in Prizren, where he practices as a surgeon today.

- Dr. Zaim Gashi. Dr. Gashi was a general practitioner who during the 1990's practiced in the town of Sferke and later in a health center in Kline, serving Albanian, Roma, and Serb patients. He worked with Serb doctors as well. In 1997 he decided to specialize in emergency medicine, completed training a year later, and worked in Kpuz. In 1998 Kpuz was bombed by Serb artillery because they claimed it was close to KLA-controlled areas. Over the next few weeks Dr Gashi moved from place to place, eventually going back to his home village, which was then controlled by the KLA. He was the only doctor for 25,000 including internally displaced persons, local citizens, and KLA members. There he practiced under difficult circumstances including a lack of supplies and equipment.

On July 15, 1998 transport into the town was cut off by an attack, and for the next six weeks there were battles around Sferke, including an artillery attack on the village in the beginning of August. By early September Serb forces took the town and Dr Gashi fled to Panore with his entire makeshift clinic's medical equipment in his car. But a few weeks later Serb forces entered Panore, burning and looting it, and he and other Albanians were encircled and eventually captured. Men were moved to the primary school and held in classrooms, where they were threatened and some were beaten. Serb paramilitaries determined that he was a doctor and forced Dr. Gashi to treat one of their wounded soldiers, which he did. After a terrifying time when he thought he would be executed, he and other men were moved to Peja. There he was interrogated while beaten on the back of the head and was kicked so hard in his side that he had trouble breathing. Later he was beaten on the palms of his hand, as he continued to refuse to confess. Others, however, implicated him in providing medical care for the KLA.

After a month where he continued to be beaten, he was brought before a judge, where he again denied charges against him and was transferred – and beaten, with others, en route – to Lipjan. There he and other prisoners were severely beaten, even while they were urinating. He spent two months there and another three months in Djakovica.

Dr Gashi was not able to be in touch with his family for the first six months of his detention by the authorities. He saw a lawyer for the first time after three months imprisonment. He finally was brought to trial, along with 13 others, on February 16-18, 1999. One man who implicated him recanted, saying the information was obtained through torture. Without confessing to anything, Dr. Gashi mentioned the Hippocratic Oath to the judge, but the police said he had no obligation to provide medical care to terrorists. Dr. Gashi was convicted and sentenced to six months, but released for time served.

Dr. Gashi still has physical pain in his back and shoulders from the many severe beatings he experienced, but said his resumption of medical practice after the war enabled him to deal with the psychological impact of the torture he experienced. He completed a residency in internal medicine and in 2005 a sub-specialty in gastroenterology, which he now practices.

D. Harassment, intimidation and forced flight of physicians

Health professionals fortunate enough to escape the severest abuses were often harassed and intimidated by the police through unannounced and threatening interrogations euphemistically called “informative talks”. Serb police officers would arrive at a physician’s home or place of work and ask him or her to come to the police station. Once there, the physician would be questioned about his or her political affiliations, travel abroad and colleagues. These “informative talks” were meant to, and did, harass and intimidate ethnic Albanian physicians, their families and friends. Physicians were explicitly warned by police not to acknowledge that the informative talks had occurred.

PHR documented twelve cases in which physicians were interrogated by the police.⁴⁵ Some of these involved arrests and interrogations, followed by release. The following describes two of these cases:

- Dr. B.I. was working at a clinic in the Glogovac area in late September 1998. His clinic was crowded with hundreds of villagers who had fled the shelling by Serb forces earlier that day. Dr. B.I. and several other clinical staff members were trying to calm the frightened villagers. The Serb police, carrying Kalashnikovs and pistols, arrested Dr. B.I. and his staff, all of whom were clearly health professionals because they were wearing hospital and clinic garb. During his interrogation, the police accused Dr. B.I. of being a terrorist because he had cared for “terrorists” in his clinic that morning. When Dr. B.I. denied these charges, a police officer hit Dr. B.I. in the face with a backhanded fist. Dr. B.I. was released, but before he left the station, he heard the screams of people being beaten. He believes that these were people who had been taken from his clinic.
- In September 1998, Dr. T.S. was working in a Mother Teresa Clinic in Kamenica, near the border of Kosovo and another province of Serbia. One morning, Dr. T.S. was arrested by two state security inspectors while seeing patients. At the police station, he was interrogated about other Albanian doctors, and when he refused to answer, he was beaten on the hands with a stick and hit in the face. Later that day, he was taken to his house. Three armed police officers guarded his family while other officers searched the house for medical supplies. They confiscated all of the supplies they found, including the personal medication of Dr. T.S.’s mother and father. He was then taken back to the police station. He was ordered to admit that the medication found in his home was intended to assist the KLA and was therefore in violation of Article 136. He was also threatened with torture if he refused to provide information about the other doctors. The police wrote a summary of the interrogation, which he signed after initially refusing to do so. He was released that night and not called again. The confiscated medical supplies were never returned.

Arrests, detentions, disappearances and killings in 1998 and early 1999 had a profound impact on the medical community in Kosovo, especially in the geographical areas where fighting was taking place. Some physicians left their medical practices for a time and engaged in non-medical work or volunteered on a part-time basis with one of the Mother Teresa societies. Others stopped practicing medicine and hid in their home towns while others worked in the countryside in contested areas, unable to return to their original practice sites for fear of arrest. Still others decided they had no choice but to leave the province altogether. The resulting loss of active medical manpower in Kosovo was very substantial. PHR was able to obtain documentation that at least 68 physicians were no longer in practice in the geographic area west of Pristina toward the environs of Peja/Pec and Deçan/Decani.⁴⁶

In the final two months of 1998, PHR received 38 firsthand reports of doctors actively hiding to avoid detection by Serb authorities.⁴⁷ By February 1999, the number of firsthand reports of those hiding or fleeing more than doubled.

⁴⁵ Additional cases are reported in Physicians for Human Rights, *War Crimes in Kosovo: A Population-Based Assessment of Human Rights Violations Against Kosovar Albanians*.

⁴⁶ Individual observers maintained updated lists of names and histories of people who had withdrawn from practice based on information volunteered to them or data they could gather easily in the course of their work. These lists probably constitute an undercount, since it was not safe for the individual compilers to engage in any kind of systematic survey of their geographic area.

⁴⁷ Twenty of these cases were corroborated by a second source. In addition, PHR spoke with several other health professionals who had lists of doctors missing from their residence and regular workplace. These sources yielded 30 more names for a total of 68 doctors whose whereabouts were unknown at the end of 1998. Fifty-two of these physicians came from northwestern Kosovo around Pec and Decani.

PHR also documented 28 cases in which physicians said they were afraid that their patients might experience harm if they presented for care to Serbian-controlled health facilities

The experience of Osman Vuçitërna is illustrative of the reported pattern of flight and hiding. Dr. Vuçitërna is a pediatrician from Rehovec/Orahovac who operated a large ambulanta attached to his home.⁴⁸ When the fighting reached Rehovec/Orahovac in July 1998, Dr. Vuçitërna evacuated to the Malisevo area along with other Albanians from Orahovac. He believed he would be targeted by the advancing Serb forces because he was a prominent local physician. Five days later, when Serb police officers and Yugoslav Army soldiers attacked Malishevë/Malisevo, Dr. Vuçitërna fled to Pagarusha with other Albanian refugees, believing it was safer for him to hide among the 70,000 displaced persons living in the mountains. He remained in Pagarusha until September 25, 1998 when a new Serb offensive forced him to flee to Prishtina/Pristina. He remained in hiding in Prishtina/Pristina until the NATO bombing campaign began in March 1999. At first Dr. Vuçitërna sought to return home but five days later he and his family were expelled and fled to Macedonia. He did not return to Rehovec/Orahovac until late July 1999 and today practices medicine in a private clinic there.

E. Discrimination against and attacks on Albanian patients

During the 1990's some Kosovar Albanian patients continued to seek care within the official Serbian-controlled state health system, particularly for secondary and tertiary care. Often when they did so they experienced discrimination and marginalization, such as being forced to wait long periods to be admitted or to receive surgery. As the conflict escalated in 1998, the discrimination intensified, access was severely restricted, and when patients did gain access they were threatened and even physically abused. Some patients were prematurely removed from hospitals and imprisoned, contrary to physician orders. Patients reported that Serb police, guards, and even hospital staff beat Albanian hospital patients, chained them to beds or radiators, or burned them with cigarettes. They also routinely interfered with the provision of medical care to Albanian patients. Albanian patients from conflict areas were often placed under surveillance or constant guard by armed Serbian soldiers or police.

The following table summarizes cases PHR identified where patients in 1998-99 reported fear of obtaining care, not having access to care or being abused⁴⁹

Act	Number
Patients fear obtaining medical care	74
Patients not have access to medical care	24
Patient physically abused	23

An extortion system began to flourish within the health care system in this period. Since fewer than half of Albanians had health insurance Serb police and hospital staff sometimes demanded large sums of money from Albanian patients before they would provide care, medicine or food. Dr. M.S. said, "If you don't have medical insurance or money, Serb doctors won't care for you, even if you might die. They don't give you medicine unless you are Serbian. They treat you terribly if you are Albanian... If you need surgery, you pay for everything... solutions, gloves, needles."

PHR documented 23 first-hand reports of Serb authorities physically abusing patients in 1998-99. Those Albanians most at risk for physical abuse in the health system were men who had come from areas of conflict, who Serb authorities apparently believed were either KLA supporters or fighters. However, all Albanian patients, regardless of their gender or city of origin or affiliation with the war, were at risk of physical abuse during their stay in a medical facility. Serb police and guards beat patients in toilets, halls, or while in their hospital beds. They extinguished cigarettes on post-operation patients and burned patients' genitalia, feet, arms, and open injuries. In one case, police

⁴⁸ Dr. Osman Vuçitërna is a pediatrician from Orahovac who was interviewed by PHR on several occasions, including November 1998 while he was in hiding, April 23, 1999, and again on August 6, 1999. In November 1999, PHR also interviewed Dr. Vuçitërna's brother and father. PHR also interviewed Dr. Vuçitërna's colleagues Drs. B.C. and T.U. (who are mentioned later) who worked in central Kosovo in the summer of 1998 with Dr. Vuçitërna and later, like him, were in hiding in Pristina when PHR interviewed them. PHR re-interviewed him in 2008.

⁴⁹ Additional cases are reported in Physicians for Human Rights, War Crimes in Kosovo: A Population-Based Assessment of Human Rights Violations Against Kosovar Albanians.

launched an assault on an intensive care unit with 30 armed officers and held a patient on a respirator at gun point. Many of these abuses occurred when doctors were not present. Doctors who attempted to protect their patients were themselves directly threatened by the police.

- Dr. Fehmi Vula described an incident in which one post-operative patient with a surgical device affixed to his thigh for stabilization was prematurely removed by police from the hospital. Dr. Vula described how the “patient was treated very badly, worse than an animal.” He saw the patient unable to walk and dragged into a police station and later imprisoned where he was seen being dragged across the prison grounds by prison guards.
- V.N., a 17-year-old girl from Glogovac, was hit by a sniper while standing in her backyard. After spending a day at a nearby makeshift clinic, where the surgeon could not operate because no anesthesiologist was available, she was eventually transported by private car to Pristina Hospital, also known as the University Clinical Center. While in tremendous pain as she was moved into a hospital room, a Serb doctor slapped her in the face several times, hit her with his fist on her right upper leg near the wound and insulted her. As V.N. was wheeled into the elevator, the physician and nurses slapped her repeatedly. V.N. was crying and begging her mother not to leave her. For the next two weeks, V.N.’s mother brought her drugs and many units of blood each day, as instructed by the attending Serb physicians as necessary for her daughter’s care, but V.N. eventually died.⁵⁰ The attending physician told the family that she ultimately died of overwhelming sepsis secondary to the delay in receiving care, and not from the mistreatment.

Beyond the physical abuse of individual patients, Serb authorities systematically sought to prevent Albanians from obtaining health care. Witnesses told PHR that Serb police routinely delayed the transfer of injured men to the hospital in order to interrogate or arrest them and prevented doctors from attending to their medical needs. Witnesses also told PHR that Serb hospital administrators prohibited doctors from providing care to Albanian patients. While these reports could not be confirmed, the consistency of the reporting suggests that this abusive pattern existed.

Restrictions on access to care extended to efforts by international NGO’s to provide medical care. The international humanitarian agency Mercy Corps conducted bimonthly mobile clinic visits to rural areas where clinics had been destroyed, in order to reach those who did not have access to medical care. But Serb authorities sometimes impeded Mercy Corps access to these areas. One humanitarian aid worker described an incident in which a medical team was turned back on December 25, 1998, while trying to visit an area known to be heavily inhabited by KLA members. “We’ve had threats to drivers,” he said, “[Serb forces say] ‘we’re going to put 38 bullets in your ass and kill you’.

When patients did gain access to medical facilities, witnesses reported that Serb police and hospital administrators instituted policies that restricted medical services for Albanian patients. In one hospital, Serb patients had access to the hospital’s entire blood reserve, but Albanian Kosovars only had access to the number of units donated on their behalf. Kosovar Albanian surgeons often had to seek authorization to operate on Albanian patients and were denied access to their Albanian patients while less critically ill Serb patients received care. Albanian families were also prevented from delivering food and clean clothing to their ill relatives for up to 24 hours and sometimes denied them the ability to bring blood and medications that were not supplied by the hospital. Since hospital staff who provided medicines to Albanian patients were at risk, patients had difficulty getting medicine. One physician said, “Distributing medicine is more dangerous than distributing guns.”

Among the reports of Serb authorities interfering with health professionals’ management of their patients’ care from 1998 through February 1999 were the following cases. In one case, two seriously injured victims of a car accident were brought to a hospital and kept under armed guards. One was handcuffed to the bed for six hours on three different occasions and forced to pay large sums of money for medication. One of them ultimately fled the hospital. In another case, a man with a health insurance card was told no hospital room was available for him, and was admitted only after paying substantial sums for the room and medical services; and even then the hospital staff refused to provide him food during his stay. In another case, a woman with gunshot wounds in her colon, rectum, vagina and sacroiliac was accused of being a KLA soldier and forced to wait three days for surgery; she died from sepsis due to the secondary consequences of the wound.

⁵⁰ V.N.’s family was the source of the information in this account.

F. Impact of the assaults on the larger Kosovar Albanian community

Knowledge of these abuses reverberated through the Kosovar Albanian community, especially among those living in areas where fighting was taking place. People in these areas became increasingly fearful of seeking medical care. PHR received 74 reports from informed observers of Albanian civilians who said that they were too afraid to obtain medical care. One humanitarian medical worker, Dr. M.K. explained, “People are scared to come to main urban centers if they are from conflict areas... they are afraid they’ll be abused... there are enough accounts of people being beaten, pulled off buses... that it scares people into avoiding the hospitals.” Critically ill people declined to seek care and patients requiring follow-up care after hospitalization were frequently too frightened and distrustful to return.

G. Destruction of Health Facilities, Illegal Searches and the Seizure of Medical Supplies

PHR received 20 first-hand reports of Serbian authorities committing destruction, serious damage or arbitrary search of medical facilities serving Albanian patients in 1998 and early 1999.⁵¹ As noted in section D, these raids were often accompanied by lengthy and threatening interrogations and, on occasion, resulted in criminal charges against health professionals. Serbian authorities often justified these raids on the grounds that they were looking for evidence of terrorist activity or simply enforcing an embargo on medical supplies coming from Serbia. The mere possession of medical supplies could serve as the basis for terrorism charges. These searches included physicians’ residences where any medical supplies found were seized. Searching for KLA members was widely regarded by Kosovar Albanian physicians as a pretense for confiscating medicine and closing Albanian clinics and preventing Albanian physicians from providing health care services to their patients.

The searches and/or destruction of health facilities were not only illegal, but had effects beyond mere damage to the buildings themselves. Combined with other practices described here, they instilled fear among the health professionals who had once worked there and the patients who had been treated in them. Albanian health care workers, in particular feared returning and being arrested for treating “terrorists.” Moreover, Albanian patients in areas where hospitals, Mother Teresa Clinics and *ambulantas* had been destroyed were forced to use the state-run hospitals, staffed predominantly by Serbian personnel where they feared abuse and inadequate care.

Some health clinics, though not directly targeted, were rendered virtually useless because of more generalized attacks on civilian utilities such as water, heat or electricity. PHR investigators visited Glogovac in December 1998 and found the medical staff huddled inside the hospital to keep warm. The town—and therefore the hospital—was without water, electricity or heat after Serb troops attacked weeks before. Dr. C.K., a pediatrician, described his concern for the health of children in Glogovac: “We lack medicines to care for them. There are not enough drugs. Our ability to help patients is very limited. Immunization is particularly difficult. We have pulmonary disease, hepatitis, thyroid disease, malnutrition, and anemia. Water in the city is unusable...no chlorinated water for the last eight months.”

Some examples of these destructive assaults on facilities include the following:

- In 1998, the Malisheva/Malisevo Health Care Center was the only government health center in the area. During the heavy fighting that summer, Serb police or soldiers forced the staff out of the health clinic and destroyed it. The clinic’s equipment and records were completely damaged, stolen, or vandalized. Broken green and brown beer bottle glass was strewn throughout the building and ethnic slurs were spray painted on the walls in Serbian. Following the clinic’s destruction, Dr. S.N. and his staff opened makeshift *ambulantas* in the neighboring village of Astrazub/Ostrozub. However, the *ambulantas* lacked labs, equipment, and proper places to deliver babies.
- In May 1998, Dr. D.S. and his wife tried to go to work at their clinic one morning when the fighting started in Deçan/Decani. They asked the police if they could go out. The police said that it was unsafe and that they

⁵¹ Physicians for Human Rights. War Crimes in Kosovo: A Population-Based Assessment of Human Rights Violations Against Kosovar Albanians found that 100 health facilities were physically attacked.

should stay in their apartment. Dr. D.S. and his family remained trapped in their apartment for about one month – from May 25-June 26, 1998. His *ambulanta* was completely destroyed during this time. He could also see from his apartment window that another medical office, across the street from the apartment, was destroyed. He told PHR that he saw Serb soldiers taking supplies out of the office. He also said, in apparent reference to international aid officials when trying to assess the situation,” When the internationals came, all the Serbs went into the streets and tried to hide any signs of violence.”

- In July 1998, about six days after the fighting in Rehovec/Orahovac began, Serb police and Dr. Vekoslav Simić, the Serb director of the Rehovec/Orahovac polyclinic (*dom zdravlja*, the government “health house”) entered the *ambulanta* of Dr. Vuçitërna, expecting to find it deserted. Instead, they encountered Dr. Vuçitërna’s brother and 85 year-old father, who were living there because they were unable to leave Rehovec/Orahovac when the fighting started. Dr. Simić gathered up most of the medicine and equipment (valued at more than US\$15,000) and carried it off in bed sheets. Sometime later, the police took all remaining supplies and equipment from the clinic. The clinic was completely destroyed soon after, apparently by explosives and fire. In total, Dr. Vuçitërna estimates his losses at about US\$89,000.
- In July 1998, Dr. Talat Gjinolli, the only Kosovar Albanian neurosurgeon at Prishtina/Pristina Hospital, was scheduled to open his own private clinic. He and his wife, also a surgeon at Prishtina/Pristina Hospital, had been working under regular police surveillance and sought another way to practice medicine. Just prior to the clinic’s opening, Serb police came and searched the premises on the pretense that they were looking for patients from the KLA. They confiscated all the medications and then closed the clinic due to alleged “non-compliance.”

H. Expulsion of physicians and patients from Pristina Hospital.

As the NATO intervention approached, armed Serbs – many apparently civilians – suddenly appeared on the streets in Pristina and, along with Serbian paramilitary forces, looted and burned ethnic Albanian stores and health clinics. Young ethnic Albanian men were rounded up while rumors of snipers kept the ethnic Albanian population indoors. Serb tanks, armored personnel carriers, and armed civilian cars filled the streets. The sound of gunfire was a constant background noise. The air was smoky and there were frequent explosions.

On the morning of March 25, 1999, two days after the NATO air campaign began, the Serbian director of Pristina Hospital, summoned all staff to a meeting. Serb military vehicles were parked in front of the hospital and armed Serb soldiers and paramilitaries patrolled the hospital grounds. Several Albanian physicians had been warned by friendly colleagues not to attend the meeting, although a few decided to go. At least a dozen Serb military casualties from the overnight bombing were being treated in the casualty area. At the meeting, Dr. Grbic dismissed the ethnic Albanian physicians and ordered them to leave at once. He also discharged all ethnic Albanian patients to make room for Serb military casualties. The Albanian physicians, fearing for their personal safety, left the hospital immediately.

Patients, many of whom were gravely ill, were also subject to peremptory discharge well before their clinical condition warranted it. Among the discharged patients were two young people receiving IVs and therapy for tuberculosis (TB) meningitis; a woman with gynecological sepsis; and about 10 patients who had been seriously wounded in a marketplace bombing and were a few days post-op from amputations and abdominal explorations.

This discharge policy meant there was no treatment available for Albanian patients wounded by shelling or gunfire. On March 28, Drs. Fllanza and Talat Gjinolli heard gunfire along the road leading to the Pristina ICRC headquarters. They saw smoke and fire coming from the hills of Sofalia, a section of Pristina, and heard gunfire and grenades. Serb police vehicles then approached, spraying gunfire in all directions. At about 1:00 p.m., a 23-year-old internally displaced woman from the Decani/ Pec area was hit with a bullet that lodged in her lower thoracic spine. A Pristina state hospital nurse, an Albanian, rushed to aid her, took her home and then called for Dr. Talat Gjinolli’s help. He went to the house and examined her; the woman was hypotensive and paraplegic, but could breathe. It had been very dangerous for him to come to see her, and there was nothing he could do for her, given the shooting and police traffic.

In the first few days after the onset of the NATO bombing, thousands of ethnic Albanians in Pristina were expelled from their homes. Groups of armed men would burst through the doors of a family's home, place the barrel of a Kalashnikov against the forehead or cheek of a child or infant, and order the occupants to leave immediately. Residents often had no time to gather clothes, documents, photographs, or shoes. They were told not to bother to lock their flats, as it was clear people's homes would be looted once they left. Attackers demanded hundreds or thousands of German Deutsche Marks. Some families were allowed to drive away; others were denied access to their car and forced to flee on foot. Those who resisted were shot, often in front of their families. Soon there were few Albanians left in the city.

VI. The Albanian and Serbian medical communities in the immediate post-war period and plans for a new health system, 1999-2001.

In June and July, 1999, immediately upon the signing of an agreement to end the war, Kosovar Albanians streamed back to a devastated country. Many towns and villages – and even some cities – had been largely or even totally destroyed, medical services were in shambles, supplies were short, equipment damaged, and much of the population – including many Albanian health professionals – were traumatized from the experience of war, expulsion, displacement and fear. The structure of the previous health system, with its centralized control from Belgrade, also came to an immediate end. Kosovar Albanian physicians assumed control of the medical school as well as clinical leadership in hospitals.

Hundreds of international NGO's arrived on the scene to provide emergency health services as well as shelter and other critical needs. International agencies immediately initiated planning for longer term health services. Within weeks, UNMIK delegated most responsibility for health policy and planning to the World Health Organization and gained support from the World Bank and other international organizations to integrate planning for a future health system into emergency relief efforts.

A. Kosovo after the war

The hundreds of thousands of displaced Kosovar Albanians who returned to Kosovo immediately after the war found that more than one thousand residential areas had been partially or totally burned; about a third of all housing had been damaged and more than 15% was destroyed altogether.⁵² About 70% of health clinics in towns and villages had been extensively destroyed; supplies, material, and equipment were in short supply. There was little data on population health status. What data there was, supplemented by surveys and clinic and hospital logs, identified severe health concerns including low immunization rates, high infant mortality rates, high prevalence of chronic diseases of an aging population, widespread psychological stress, and a high volume of surgical trauma cases arising from immediate post-conflict conditions including landmines, cluster bombs, and interpersonal violence. One survey by the Centers for Disease Control (CDC) conducted after the war found that from February, 1998 through the end of the war, 87% of the Kosovar Albanian population had been displaced and in September, 1999, three months after the war, 12% remained displaced.⁵³

The population was also traumatized from experiencing or witnessing war crimes. A survey of Kosovar Albanian refugees in Macedonia and Albania during the NATO-bombing campaign conducted by PHR revealed that half of the respondents witnessed the burning of homes and 14% witnessed Serb soldiers or police killing people; 31% of respondents reported that a member of his or her household was subjected to a violent act including rape, gunshot wound, beating, torture, disappearance or separation, threat at gunpoint or killing.⁵⁴ A study by the CDC in September, 1999 reported that between 15 and 20% of the population was suffering from Post Traumatic Stress Disorder (PTSD) and that the prevalence of psychiatric morbidity was 47%.⁵⁵

Data on public health were limited, in part because the health information system had been neglected and in part because of the destruction of health facilities. But it was clear that poverty and the discrimination of the 1990s had taken a toll on health. A significant number of children had not completed a full course of vaccinations and children suffered relatively high rates of acute respiratory tract infections and diarrhea, likely a result of inadequate sanitation, lack of clean water and poor shelter.⁵⁶ A UNFPA survey in 1999 revealed an infant mortality rate of 35

⁵² US Agency for International Development. Shelter in Kosovo: Challenges and Solutions Fact Sheet November 10, 1999.

⁵³ P. Spiegel and P. Salama, Kosovar Albanian Health Survey Report, September 1999. International Emergencies and Refugee Health Branch, Centers for Disease Control and Prevention

⁵⁴ Physicians for Human Rights. War Crimes in Kosovo: A Population-Based Assessment of Human Rights Violations Against Kosovar Albanians

⁵⁵ B. Cardozo and A. Vergara. Report: Mental Health in Complex Emergencies: The Kosovo Experience. Centers for Disease Control. 1999.

⁵⁶ Id.

per 1000, the highest in Europe.⁵⁷ Among adults, chronic diseases were relatively common, chiefly among them cardiovascular disease, chronic back pain and/or arthritis and lung diseases. Tuberculosis rates were also the highest in Europe.⁵⁸ Antipersonnel land mines brought additional injuries and death⁵⁹

Many primary health care facilities were in poor condition. At least 100 clinics, pharmacies and other facilities had been destroyed or seriously damaged.⁶⁰ Major hospitals remained intact, but the returning Albanian physicians told PHR that some Serbian staff had stripped facilities of equipment when they left. In addition to destruction and looting, health facilities and systems for water and sanitation had not been maintained during the 1990s, and systems for control of communicable diseases, particularly tuberculosis, had deteriorated during the decade.

Where care was available, access was impeded by financial burdens, especially for medication. The Albanian Health Survey report, conducted in the summer of 1998, noted that in the two weeks prior to the survey, 55% of all households questioned had spent funds on medication, which represented three quarters of their out of pocket health spending.⁶¹ Roma, Ashkali and Egyptian minorities were subjected to discrimination and lacked the support of Serbia. Many remained housed in refugee camps. Members of these minorities had the worst health indicators among the Kosovo population, a product of poverty, lack of access to health facilities, lack of education, harassment, intimidation, lack of transportation, and discrimination in both access to and quality of care.⁶² Residents of displaced persons camps in North Mitrovica were exposed to lead poisoning from mines. In 2000, high levels of lead among Roma, Ashkali and Egyptians who were internally displaced were identified.⁶³

B. Serbian physicians and patients in Kosovo after the war.

Serbian physicians were deeply affected by the anti-Serbian violence in the post-war period. Some became targets of retaliation by the KLA or Albanian extremists and were murdered or disappeared,⁶⁴ although it is unclear in most cases whether they were targeted as Serbian physicians or simply as Serbs. It does not appear that any Albanian physicians were involved in this violence. A Serbian physician, Dr. T.O., who was physically threatened by a KLA member admitted to the hospital as a patient, told PHR, “I must say I am afraid. But I am not afraid of my Albanian colleagues. I had an incident with a [KLA] patient who attempted to beat me and my [Albanian] colleagues protected me. It is even more dangerous on the street and at market places where there is no one to protect us.” Other Serbian physicians were driven out by the climate of intimidation created by the large KLA military presence at health facilities in the months after the war.

In its investigations, PHR confirmed the disappearance of one Serb physician and the death of another.

- Dr. Andrija Tomanovic was a very well know Serbian surgeon at Pristina Hospital, a full-time professor and vice president of the Red Cross of Serbia and Kosovo. Dr. Tomanovic was kidnapped in June 1999 at Pristina

⁵⁷ World Bank Technical Paper no. 509, Kosovo: Economic and Social Reforms for Peace and Reconciliation 2001. Other sources reported the infant figure as even higher. A Jones, et al. Lessons from Nation-Building Mission. Rand Corporation 2006 at p, 154.

⁵⁸ P. Spiegel and P. Salama. Kosovar Albanian Health Survey Report. September 1999. International Emergencies and Refugee Health Branch, Centers for Disease Control and Prevention.

⁵⁹ Physicians for Human Rights. War Crimes in Kosovo 90-91.

⁶⁰ Physicians for Human Rights. War Crimes in Kosovo, Table 3 pages 98, 110-111.

⁶¹ Id.

⁶² Marta Schaaf, Kosovo's Roma: A Challenge for Public Health (2002).

<http://www.eumap.org/journal/features/2002/sep02/romainkosovo>

⁶³ As late as 2004, WHO found alarming levels of lead in three internally displaced persons camps housing members of these minorities. While WHO called the extent of lead in the blood a severe health crisis, little action was taken for years. See Refugees International, Kosovo: Lead Pollution Requires Immediate Evacuation of Roma Camps, June 12, 2005.

<http://www.refugeesinternational.org/content/article/detail/6063/>

⁶⁴ PHR learned that abuses against Serbian health professionals had also occurred before the 1999 peace agreements, although to a lesser extent. These abuses, including KLA attacks on Orahovec in July 1998 where several Serb civilians and health professionals were detained and disappeared, were documented at the time by PHR and other agencies.

Hospital. His wife, Verica Tomanovic, founded the Belgrade-based Association of Family Members of Missing and Kidnapped Individuals, and on September 25, 2003 testified at a hearing before the Commission on Security and Cooperation in Europe.⁶⁵ Dr Tomanovic was still listed as missing by a Serbian organization in 2007.⁶⁶

- On August 4, 1999 an Albanian woman came to the Pristina clinic of Dr. Zlatoje Gligorijevic, a prominent Serbian pediatrician who provided care to people of all ethnicities, seeking an antibiotic for her child. A few hours later, the woman returned to the clinic accompanied by a man dressed in civilian clothes. The man, whom Dr. Gligorijevic later said was Albanian, shot Dr. Gligorijevic at close range. Dr. Gligorijevic was rushed to Pristina Hospital, where Kosovar Albanian physicians performed surgery to remove his right kidney, gallbladder, and parts of his liver, stomach, pancreas, and small bowel. However, without electrical power or functioning laboratory equipment at the hospital, the physicians were unable to obtain urgent laboratory data, perform X-Rays, or monitor his condition. In critical condition, Dr. Gligorijevic was transferred to the KFOR British Field Hospital in Lipljan and subsequently to the intensive care unit at the Skopje Hospital in Macedonia. On or about August 25, 1999, Dr. Gligorijevic died from sepsis, a likely complication of his prolonged hospital stay.⁶⁷

Many other Serbian health professionals received physical threats. In the summer of 1999 PHR interviewed three Serb physicians who reported threats they received in Pristina Hospital right after the war and soon left Kosovo.

In this tense time, Albanian physicians, many of whom had been dismissed from their positions in 1990-91, returned to Kosovo and demanded reinstatement in their old positions, and in leadership of the medical school and hospitals. On June 18, 1999, a group of approximately 100 Albanian physicians, former staff of the Pristina Hospital and its clinics, walked into the hospital and demanded that all Albanian doctors, nurses and other staff dismissed since 1990 be reinstated. Representatives of UN agencies, KFOR, and NGOs participated in the negotiations among the physicians. The parties agreed to a temporary compromise in which Albanian, Serbian and international representatives would serve on the hospital's board and Albanian hospital staff would be slowly reinstated. Within one week, however, virtually all Serb physicians quit the hospital and Albanian physicians and staff returned in great numbers. Serbian physicians claimed that Albanian physicians told them to leave, though Dr. Arben Grazhdani, a Kosovar Albanian physician who remained at the hospital throughout the war and participated in the negotiations, told PHR that the Albanian staff wanted the Serbian staff to stay and that it was the Serbian physicians who decided en masse to leave. KFOR posted an armored personnel carrier outside the hospital, checked all visitors, and attempted to prevent looting by Serbian staff as they left. Most Serbian patients also left the hospital. In August 2000, only one ethnic Serb physician worked there.

In late June, 1999, an ophthalmologist at Peja Hospital reported to PHR that all Serbian staff left within two weeks of the peace agreement. A large, disorganized pile of drugs that had been confiscated from private pharmacies during the war was found on the third floor of the facility. Other physicians at the hospital reported to PHR that supplies in many hospitals had been taken upon the exodus of the Serb medical staff. According to Kosovar Albanian physicians at Urosevac Hospital, the facility was empty when Albanian doctors arrived. Albanian patients began to come to the facility shortly after the doctors took their posts there. According to some of the Albanian doctors at Urosevac Hospital, the Serbian staff's departure was the result of actions by the KLA that incited fear among the general Serb population in the area and caused most to flee. While there, PHR investigators observed a major KLA military presence in and around the hospital in late June 1999.

The difficulties Serbian doctors faced are illustrated by the experience of Dr. M.L., a young physician who worked at Pristina Hospital. He told PHR that he was on good terms with his Albanian colleagues and said he brought food to their homes during the war, when it was dangerous for them to go out. He planned to remain in practice under

⁶⁵ http://www.csce.gov/index_cfm?FuseAction=UserGroups.Home&ContentRecord_id=56&ContentType=G&ContentRecordType=G&UserGroup_id=59&Subaction=PressReleases&CFID=1366012&CFTOKEN=33565979.

⁶⁶ <http://www.srbijazemljaheroja.com/forum/viewtopic.php?t=1253&sid=813bc9ab7dad79fe629ed761bc19b4f>

⁶⁷ The attack on Dr. Gligorijevic occurred three days after an agreement was reached between Russian KFOR, British KFOR, and the Serbian and Albanian directors of six clinics providing primary care to the population of Pristina to provide safety in the workplace. It was agreed at that time that Serbian physicians could continue to work in predominantly Albanian clinics.

Kosovar Albanian leadership. Soon after the cease-fire, Dr. M.L. and some young Serbian medical colleagues met regularly to support each other and determine their role in the new Kosovo. Although they felt that discrimination and insecurity limited their options, they sought to remain. After the ceasefire in June, 1999, Dr. M.L. returned to the hospital daily to determine his role in the new scheme. Over the course of three days, and with the support of the new international administrator, Dr. M.L. was not able to obtain the required new identification badge that would allow him access. Additionally, the Kosovar Albanian physician who now was chief of the service could not assure Dr. M.L. that he would have a place in the hospital. On the third day, as he was going home, Dr. M.L. was attacked by five men who stole his gold neck chain, a medical school graduation gift from his mother, and his watch. After these events, the international administrator of the hospital invited him to remain and also offered him escort services to and from the hospital. But by that point Dr. M.L. decided not to return because the environment was too difficult. He remained in Kosovo during the summer, meeting regularly with other young Serbian physicians hoping that violence would subside. However, five months after the cease-fire, Dr. M.L. left Pristina, his life-long home, and moved to Mitrovica.

Two other young Serbian doctors, with whom PHR met in August, 1999 described direct physical threats against Serbian health professionals while they were in Pristina Hospital. All three expressed to PHR that they were desperate to continue practicing, in part because they did not believe there were professional opportunities for them elsewhere.

When the three were asked about their relationship with Albanian colleagues, the physicians denied any hostility toward Kosovar Albanians, and felt they were not responsible for the wrongs done. One said, "Sometimes it is very difficult. I wish that they would understand that those who are responsible for bad things have left and I am still here because I feel innocent." Another told PHR, "I was never interested in politics. I have told my Serbian colleagues that politics is something that should be kept out of the doors of the hospital. In our ward, we have treated both Serbs and Albanians equally – they were always just people in need." He added, however, that his attitude was not consistently shared by all Serbian staff. "Some of my colleagues, and I must add very few, were so involved in the conflict that they reported to work in military uniforms and with guns." Others refused to discuss the past. Dr. M.L., for example, would not acknowledge human rights abuses by Serbian forces, including attacks on physicians or killing of civilians, saying that he simply wished to avoid those topics. He said he was subjected to a bad government and whatever events that took place had nothing to do with him.

Almost all Serbian patients left Pristina Hospital after the cease-fire, with only a handful remaining in the surgery ward. Dr. Talat Gjinolli noted that on the day that he returned to the neurosurgery ward at the hospital, there were no Albanian patients, only wounded Serbs, but the week after the June 18 hospital agreement, the situation had reversed. Interviews with those few remaining Serbian patients revealed that the presence of the KLA and other Albanian hard-liners both inside and outside of the hospital left them feeling uncomfortable and in some cases fearing for their safety, leading them to depart.

The Serbian patients PHR interviewed at Pristina Hospital in June-July, 1999 who received treatment from Albanian doctors did not accuse any Albanian medical staff of not providing proper medical treatment. Indeed, they generally expressed confidence in the physicians and satisfaction with their treatment. They said that therapy had remained the same after the Albanians had taken over the hospital that physician visits had continued normally, and that nurses were attentive. At the same time, Serbian patients indicated that they simply did not feel comfortable in a hospital run primarily by Albanians: "I can't complain about the treatment I am receiving here, but this is not the place for me," said one patient.

Many Serbians came to regard Albanian medical facilities, such as Pristina Hospital, as off-limits to them, despite the dangers Serbs faced in traveling to and from their enclaves. Their fears served to dissuade them from coming to the nearest medical facility, even in extreme circumstances. On August 7, 1999, a group of four critically injured Serbian victims of an unprovoked drive-by shooting, reported to PHR that they bypassed Pristina Hospital (the closest medical facility) and traveled over 20 kilometers to go to a Serb-dominated clinic. Fearful of receiving care at the almost exclusively Albanian Pristina Hospital, the group chose to make the longer journey to seek care at the Serbian run clinic at Fushë Kosovë/Kosovo Polje. The group entered the clinic while a PHR investigator, who interviewed the driver for the group, was present. The patients had been in a group of 10 to 20 civilians, including women and elderly that were sprayed with automatic gunfire. The perpetrator was an unknown single individual

driving by the group in an automobile. The four patients were all young men. One died and one lost the use of his left arm.

By August 2000 several doctors working at Pristina Hospital told PHR's investigator that no Serbian patients were in the hospital at that time. The high level of insecurity and violence, and KFOR and UNMIK's inability to protect freedom of movement of Serbs, led to the consolidation of the Serbian population of Kosovo into separate enclaves, within which all aspects of work and home life were incorporated. The notion was that since Serbs could not safely travel for health care, health care would be brought to their enclaves, supplemented in this immediate post-war period by mobile clinics run by international NGOs. KFOR provided the escort for secondary or tertiary care to hospitals run by Serbian physicians.

A pervading climate of hostility and insecurity in Kosovo more generally led most Serbs, including the Serbian physicians, to stay in enclaves or leave Kosovo altogether. At the same time, beginning in the summer of 1999, the retreating Serbian population established a beachhead in Mitrovica, a city in northern Kosovo divided by the Ibar River. Serbs took over the northern half of the city, expelling Albanians who lived there. They took control of the hospital, located in the northern sector, and forced Kosovar Albanian doctors out. By mid-2000, Kosovo's medical facilities were ethnically segregated, and patients sought care with providers of their own ethnicity in very separate geographic regions.

During these early post-war months the pattern was set for a prolonged impasse. What began as a tactical improvisation in the face of Serbian insecurity (the enclaves) and as an accommodation to a troublesome left-over of the war (Mitrovica) had become, by the end of 1999, a hardened de-facto ethnic segmentation of Kosovo. For this state of affairs, the international authorities – KFOR and UNMIK – bear responsibility. It was on their watch that these population movements and settlements were tolerated. The ongoing burden of this divide, in terms of intense discrimination, established segregation, and venomous politicization, began with the indecision and inaction on the part of the international community during the first months following the war.

C. The Kosovar Albanian medical community after the war

Many Kosovar Albanian physicians who, along with the rest of the population, had been forced out of Kosovo as the NATO campaign began, found work with humanitarian organizations serving refugees in Albanian and Macedonia. Upon returning, the provider community faced the profound issues of integration, professional education, and credentialing; and there were no functioning systems of finance, referral, information flow, public health surveillance, or preventative outreach. The returning physicians sought to control the institutions that had excluded them and told PHR they were highly motivated to play a major role in the construction of a new health system. But they faced enormous challenges concerning the organization, culture and strategic direction of their profession. One challenge was the divide between the older generation that had received traditional medical training, most in medical schools in the former Yugoslavia, and the more than 700 physicians and 1200 nurses who had been trained in the parallel system without access to adequate clinical experiences. Within this divide were others relating to class, ethnicity, geography, and politics, all of which had not been resolved during the previous decade of the parallel system.

Many physicians and other health workers had also suffered grievously from discrimination, targeting, and experience or fear of violence against them. In interviews with dozens of physicians immediately after the war, PHR found that many expressed a profound sense of moral confusion and weariness. Many physicians told PHR they felt unprepared—both psychologically and in terms of their training—to come to terms with what they had experienced and the implications that experience might have for future medical practice, in terms of focus, commitment, priorities. Many had to cope with the combination of trauma, displacement and the need for skills to enter a modern health care system. One expatriate trainer reported:

How could we motivate our Albanian colleagues to stay in the training program when their own day to day lives were not secured, and they themselves were the victims of war? . . . They were concerned that they were being left behind from the progress of medicine due to the total devastation of societal infrastructures

by war. Often they were frustrated and asked for quicker solutions, rather than tedious training, so that they could improve or catch their medical skills up to modern standards.⁶⁸

In interviews with PHR, physicians also noted that performing what they had thought were necessary professional obligations had put them at personal risk—and questioned how their ethical standards would continue to hold up. Upon their return to Kosovo, they confronted problems not only in assessing the competence of other physicians but their culpability in the excesses of the war. They needed to renew and indeed rethink the meaning of medical ethics and professional obligations, and to find ways to infuse their medical culture with respect for human rights that crossed ethnic divides. They recognized that they had to prepare themselves to build an effective and participatory organization that was foreign to the repressive climate through which they had lived. They knew that their profession faced an acute crisis of moral consciousness and that the health system itself had to change.

Finally, they had to figure out where they would fit in any new system. The physician leaders had no doubt that they wanted to be in control of the medical faculty and Pristina Hospital, but beyond that, roles and even aspirations were unclear. The default position was the system of private practice that had characterized the parallel system of the 1990s, and most of the physicians interviewed by PHR in this immediate post-war period, saw succumbing to that position as a defeat of their dreams for a new Kosovo.

In 1999 and 2000, at the initiative of some leading physicians in Kosovo, PHR conducted training and discussions of human rights and ethics with about two hundred Kosovar Albanian physicians (Serbian physicians were also invited but declined to attend, so separate discussions were held with them).⁶⁹ They expressed great enthusiasm in reflecting on their experiences and hoped that those experiences could influence medical practice in the future. Participants analyzed the central ethical issues of their recent experience: the protection of civilians during war; adherence (or lack of adherence) by the Serbian medical and military authorities to principles of human rights and medical neutrality; the difficulty of documenting specific forms of torture; and the treatment of psychiatric trauma. Many physicians, both Albanian and Serbian, were familiar with the tenets of medical ethics and human rights, including principles of non-discrimination and treatment irrespective of ethnicity or political belief. But the training also demonstrated the deep difficulties of these discussions, since as physicians they felt compelled to acknowledge that they could often not separate their personal feelings of revenge and rage from their sense of professional obligation.

These physicians, many of them in prominent positions, found themselves struggling in their efforts to transcend their experience of trauma. Many seemed able to commit, abstractly or theoretically, to protecting and promoting health and human rights for all people in Kosovo, including the Serbians. Acting on those beliefs, though, proved much more problematic. The physicians talked about how overwhelmed they felt as care providers--dealing with their own grief, fear, loss--and as parents of children whose lives had been altered by the conflict. Some felt it was “too soon” to talk about human rights. One stated: “It is very difficult to put aside the feelings of the last 10 years ... I worry that I will have trouble treating a Serb patient without having a feeling of hate inside. I don’t think I can forgive them for teaching me how to hate.”⁷⁰

Nevertheless, the physicians sought to come to terms with the past and its implications for their roles in the future. One stated, “As doctors, we are used to a very different type of training. We are used to learning about how to treat and cure medical ailments. We rarely get a chance to talk about these issues.” What followed were animated discussions regarding medical neutrality, non-partisanship, protection of civilians, and principles of human rights and medical ethics. The discussions even yielded proposals to OSCE and the ICRC to strengthen the protection of medical personnel during conflict and detailed ideas about how to incorporate human rights into medical education.⁷¹

⁶⁸ M. Morikawa, Primary Care Training in Kosovo. *Family Medicine* 2003;35:440-444.

⁶⁹ In Peja, in March 1999, a seminar with three prominent Serb physicians was organized by the PHR team to begin a dialogue with the Serb medical community on issues of medical ethics and human rights.

⁷⁰ When PHR conducted trainings with ethnic Albanian physicians in the same time period (just days before NATO bombing) they stated to PHR: “We will not do what was done to us.” Many said that if they were in positions of power, they would protect and promote the human rights of all people in Kosovo.

⁷¹ The proposal produced was based on a set of recommendations by a group of Albanian physicians in the March 1999, just before the NATO air campaign began. Working under the auspices of PHR, several Albanian physicians drafted a set of

At the core, these physicians believed that the ethical practice of medicine was possible only after central issues such as justice, law and security had been adequately addressed. One physician told PHR:

The people of Kosovo are much traumatized. I was among those who were arrested and sent to prison in Serbia. I could never describe my feelings about this. I thought they would kill me or burn me or cut me into small pieces. There were many times I thought of ending my own life to end this situation. Now you ask me to treat one of them. I would say that I would do the best I could but my hand would be shaking the entire time ... All of your personal feelings must be put under the table because of your commitment to the Hippocratic Oath as doctors ... but these feelings are very raw and new. It is very hard to separate. The only solution I see is a Serbia in which the leader can say, 'We are sorry for what happened.' ... I am asking for a 'time out' for Kosovo. When I think about last March when they burned our homes and killed our people and made us leave – I thought we were leaving forever. On our way out, Serbian people were watching from their windows and some were even throwing stones and cheering. I thought to myself that if we came back and I as a doctor was asked to treat such a person, that I would have to treat them because of my commitment to the Hippocratic Oath.

Subsequent PHR interviews with leaders in the Albanian medical community led to the affirmation of the obligation to provide medical care to all in a non-discriminatory manner. But the Kosovar Albanian physicians were not prepared to share leadership in medical institutions with Serbian physicians whom they held responsible for or complicit in their exclusion during the 1990s. Kosovar Albanians still felt beleaguered and under threat by the persistence of unsolved issues in their midst (such as the status of the province), the ongoing hostile presence of Serbian forces (mainly in Mitrovica and the north of Kosovo), and the perceived fickleness and unreliability of the international community. Many wanted an apology from Serbian physicians for their own roles in the exclusion of Kosovar Albanian physicians from the medical system and for their silence in the face of abuses. As far as PHR knows, these were not forthcoming.

Dr. Gani Demolli, who ran the successful Mother Teresa operation, as well as other leaders, turned their energy to reviving the Kosovo Medical Association as a means of addressing key health system issues, including how Serbian health professionals could participate. The human rights and ethics trainings stimulated interest in more robust incorporation of medical ethics and human rights into the medical curriculum. But strong unresolved emotions, the struggle for position in Pristina Hospital and the medical faculty, and the lack of any serious effort by the international planners to provide a role for such an organization led most of these efforts to fail. Moreover, the continuing violence in Kosovo, though mostly directed against Serbs, reinforced a sense of insecurity and vulnerability, leading to a pulling back from these first few months of tentative exploration of new directions.

Some of the most prominent leaders of the medical community devoted their energies to the larger human rights and political situation rather than on the reconstitution of medical services. Dr. Nashed Asllani, based in Peja, founded the Kosova Center for Human Rights, an organization that sought to investigate extra-judicial executions in 1998 and 1999. The Center also began educational initiatives on democracy and human rights. Dr. Flora Brovina, the president of Center for the Protection of Women and Children, who had been arrested by the Serbian authorities in April 1999 and not released from jail until November 2000, sought release of other Kosovars held in Serbian prisons. Dr. Vjosa Dobruna, who had not only run the Center for the Protection of Women and Children but who had played a major role in alerting the world to abuses against Kosovar Albanians, assumed a key position within UNMIK to develop legislation to address the issue of international trafficking of women and girls.

D. Planning for a new health system.

Almost as soon as NATO troops entered Kosovo, and even as hundreds of humanitarian organizations sought to meet the acute health, shelter and other needs of the population, plans for an entirely new health system got

recommendations for the OSCE and the ICRC to follow during the impending conflict. The recommendations were intended to promote the concept of medical neutrality and included: sending mixed medical teams of Kosovar Serbs and Albanians to take care of civilians trapped in the countryside, using OSCE vehicles and personnel to assist in transporting injured or ill patients across armed checkpoints, and having OSCE help Kosovar Albanian and Serb physicians secure needed medical supplies and pharmaceuticals.

underway. UNMIK was determined to avoid the mistake of allowing the international NGO's to set up programs that would determine the future of health services in the country. Donors were also committed to provide major financial support for building a new system.⁷² These positions allowed momentum for reform to develop and prevented systems issues from being sidelined as humanitarian needs were being addressed.⁷³ Planners accepted that access to health care was a basic human right. Equity, acceptability, effectiveness, flexibility, sustainability, appropriateness, and non-discrimination were to be the guiding principles.⁷⁴

WHO took the lead, with support from UNICEF, UNHCR and major NGOs. Population health assessments were undertaken and public health needs identified. The premise of the new system was that the communist-style centralized state system focusing on secondary and tertiary care would be replaced by more decentralized system with an orientation toward primary health care. It was to be a truly public system, and the Mother Teresa services, which were a response to Serbian oppression in the 1990s and financed by contributions from donors, would end.

Communities, too, would have to adjust to an entirely new system of health services and needed to be consulted to assure any new structures and arrangements would be acceptable to them, particularly if they were asked to forgo self-referral to specialist care and embrace a new model for public services.⁷⁵ The voice of minorities, including non-Serbian minorities, would need to be sought out, particularly given their vulnerability after the war.

However, planning by UNMIK and WHO for the health system followed a very different course. Though planners largely avoided the pitfall of allowing agencies providing humanitarian assistance to dominate the process, the initial stage of planning in 1999 was almost exclusively the province of international agencies. In the rush to develop a plan, the planners consulted only marginally with the health provider communities and civil society representatives of Kosovo.⁷⁶ These communities were themselves fragmented and traumatized, and lacked skills in health planning and policy, but rather than engage them in the necessary participatory processes, the planners largely ignored them.

In September, 1999, only a few months after planning commenced, UNMIK's health department produced guidelines for future health facilities that called for decentralization of day to day operations to the district and local levels. These guidelines established tasks for the future Ministry of Health to set policy and strategic direction, regulate health, and promote a "public-private mixture of health services, adopt modern management principles and develop sustainable and equitable financing mechanisms."⁷⁷

The goals set out in the UNMIK/WHO plan for health reconstruction were designed to address key health needs of the population. They included reducing neonatal, infant, and maternal mortality and morbidity; improving the health of young people, including protecting them from the negative effects of tobacco, alcohol, drugs, unwanted pregnancies and sexually transmitted diseases; improving mental health, including the burden of mental health problems, injuries and violence in a manner that respects the autonomy and rights of those with mental health problems; managing for quality of care at all levels of service; and developing human resources for health.⁷⁸

To achieve these goals, planners designed a system with an emphasis on primary care, with eight features: decentralization, specialized care through referrals to hospital-based specialists; facility size based on population in catchment area; financing of all aspects of care within the limits of available resources; predominance of public

⁷² A Jones, et al. *Lessons from Nation-Building Mission*. Rand Corporation 2006 at p. 163. .

⁷³ J. Campell, V. Percival and A. Zwi. *Ministerial Challenges: Post-conflict, post-election issues in Kosovo's health sector*. *European Journal of Public Health* 2003;13 (2):177-181.

⁷⁴ World Health Organization, *Interim Health Policy Guidelines for Kosovo* (2000).

⁷⁵ Jambell, Perciva and Zwi, *Ministerial Challenges: Post-conflict, post-election issues in Kosovo's health sector*.

⁷⁶ Those involved in the process acknowledge the minimal involvement and said that consultations that did take place "seem to be dominated by international staff." D.Shuey, F. Qosaj, E. Schouten, and A Zwi/ *Planning for health sector reform in post-conflict situations: Kosovo 1999-2000*. *Health Policy* 2003;63:299-310; A Jones, et al. *Lessons from Nation-Building Mission*, pages 166-167, 171-174.160-

⁷⁷ UN Civil Administration, *Health and Social Services. Interim policy guidelines for Kosova and six month action plan*. September 1999.

⁷⁸ Id,

services; private practice allowed but regulated; an essential drugs program based on evidenced-based prescribing; and non-discrimination in service and employment.⁷⁹

Primary care was to be dispensed through new primary care family health centers that were supposed to address 80-90% of presenting problems.⁸⁰ At the time, family medicine was virtually unknown to Kosovo and indeed was in conflict with existing models of service and health-seeking behavior of Kosovars. In larger districts, the long-standing Kosovar tradition was to seek care at “health houses,” or larger clinics that generally included pediatricians, internists, and obstetricians/ gynecologists as well as dentists. Patients were accustomed to coming to the health house and seeing the specialist as they chose, without a referral. Health posts in villages were generally staffed by general practitioners. Under the new scheme, new specialists in family medicine physicians were supposed to provide primary care and act as gatekeepers for referrals to specialists and secondary and tertiary care facilities.

Discontent among Kosovars with the first interim health plan produced by WHO and other international actors, as well as more general frustration at the lack of opportunity for local leaders to participate in the UNMIK civil administration in 1999, ultimately led to a second round of planning. The second round involved participation by more stakeholders. But the group of people consulted remained limited and individuals engaged in the process told PHR that the participation was not effective. Every Kosovar Albanian physician PHR interviewed, including those who had exercised positions of leadership at the University Clinical Center or the Medical Faculty, believed that, even in the second round, participation of the medical community amounted to a “fig leaf.” As one participant said, despite the appearance of participation, the plan was “a policy written by donors.” Others saw it as entirely political in nature. Dr. Demolli, the director of the Mother Teresa Society, who participated in the UNMIK planning group, said he “saw that it was wrong.” One physician said, “... As physicians of the new Kosovo ... we have a responsibility to not only be healers, but also to raise our voices to condemn violations. ... We are the first to try to solve the problems of our community. But ... the international community doesn’t want to hear our voice.”

At the time of the planning process PHR observed a distinct bias in UNMIK toward international experts and NGOs as well a disconnect from the people in the region, to such an extent that policies established by the administration could be virtually unknown to the general Kosovar population. One example of this dynamic was the licensing process for doctors that followed the June 1, 2000, Administrative Instruction (Health 18/2000) establishing the licensing body. In August 2000, many doctors PHR spoke to, including several actively seeking to revive the Kosovar Physicians Association (KPA), did not know about the agreement or the licensing process.

Responsibility for this failure in participation also rests with the Kosovar physician community. Despite their interest in involvement in planning for Kosovo’s future, physicians had preoccupations and grievances that diffused their interest in health system planning: the residual trauma of abuses by Serbian authorities, preoccupation with restoring what they saw as their rightful place in the medical school and Prishtina/Pristina Hospital, and competition for leadership within their group. Their anger at Serbian physicians also led them to be mute in the face of the serious abuses against Serbs in the aftermath of the armed conflict.

E. Human resources and financing in health reconstruction.

The major transformation of Kosovo’s health system that planners envisioned called for significant attention to the human resources for health. One challenge was the skills deficit among the 700 doctors and 1200 nurses who had been educated in the parallel system and who had been without access to the clinical and laboratory resources of a medical and nursing school. Planners also needed to take into account the experiences and skills of specialty physicians who had developed private practices in the parallel system. Further, the traumatic history of the previous decade and the very recent war had to be recognized as psychological and social barriers to easy integration and collaboration among various groups of physicians. Given the fragile and divided state of the medical community after the war, innovative and sustained efforts would need to be made in order to assure participation of the Kosovar health care profession in the rebuilding process.

⁷⁹ Shuey, Qosaj, Schouten, and Zwi, Planning for health sector reform in post-conflict situations: Kosovo 1999-2000.

⁸⁰ Department of Health and Social Welfare, Health Policy for Kosovo. 2001, p. 3.

The plan included a robust training program for nurses and gained international support. Planners acknowledged the skills deficit among recently-trained physicians, but were vague on how to address this. The initial plan briefly mentioned the need for “upgrading and refresher” courses for doctors whose specialty training and practice had been disrupted,⁸¹ but contained no further explanation. A later health policy document similarly referenced the skills gap and the need for additional medical training, but contained no plan for providing it.⁸² Additionally, the policy document almost entirely ignored the experiences and the needs of the older generations of physicians except to note that family physicians would make referrals to secondary and tertiary care specialists.

The centerpiece of the human resources strategy was a new medical specialty, family medicine, to serve the new family health centers. Planners anticipated training 900-1000 doctors in the new primary care field, which would represent about half the medical graduates each year. The generation of specialists who had been trained before the parallel system was in place wanted to be assured, on the one hand, that quality care would be available from family physicians, and on the other hand, that specialists would not become marginalized.

Neither concern was addressed. Planners decided to establish a new Center for Family Medicine in the Ministry of Health rather than bringing it into the medical school, a decision that immediately alienated the medical faculty and made the option less attractive to students. The Center established partnerships with organizations including the Royal College of General Practitioners and the American Academy of Family Physicians. Even so, it was also not clear that this new practice of family medicine would be able to provide quality care or be sufficiently compensated to maintain motivation.

The human resources strategy was tied to the need to find a means of financing health services in Kosovo, since the employment-based insurance scheme that existed during the Yugoslav Federation was no longer in existence and donor contributions to Mother Teresa clinics were expected to – and did – decline. An integrated and well-financed public health system was essential to pay the costs of the new system and absorb health workers expelled from their jobs during the 1990s and who had worked in charitable clinics through the Mother Teresa Society and/or in the private sector.⁸³ Even though the private sector was expected to survive the reform, albeit in some regulated form, it made sense to integrate the most well trained physicians into the new system. Without financing, physicians who had migrated under duress to the private sector would be forced to remain outside the public system. Furthermore, to assure that the new human resource – family practitioners – was effective, the system required a sound financial base that would provide coverage for all in need and salaries that would attract qualified candidates.

The danger was that, without a sound financing structure, there would be one system for the well off and another for the poor. Yet in the event, as one participant in the process explained, there was little coordination between the plan and the means to finance it. Integrating the two would have been a challenge, given the poverty of the country and the disruption in employment. Even so, there remained an imperative to design and implement an equitable financing system. It was, however, put off to another day.

F. Implementation, 2000-2008.

Initially implementation of the plan was hampered by lack of leadership from WHO,⁸⁴ but it eventually got underway. As ministries within Kosovo came into being, administration was eventually turned over to the Ministry of Health and Social Welfare, and later the Ministry of Health. Over the past eight years, the plan has achieved some very positive results. Immunization rates now exceed 95%. Most births now take place in facilities where emergency obstetrical care is available if needed. Infant and maternal mortality have declined notably, though they remain high by European standards. Disease surveillance has improved and Kosovo has made progress on partnerships to address tuberculosis, though it remains a serious problem.⁸⁵ A nascent, if not yet effective, community mental health

⁸¹ Interim Health Policy Guidelines, p. 23.

⁸² Health Policy for Kosovo, p. 15. For example, the plan states the responsibilities of various agencies and boards for licensing and specialization, but states that “short-term training courses will be organized” without assigning responsibility for this task.

⁸³ Initially, there was an intent as well to include as well the Serbian doctors who worked in the Kosovo public health institutions.)

⁸⁴ A. Jones et al. *Securing Health*, pp. 165, 171-72.

⁸⁵ Interview with WHO country director, August 2009.

system is in place.⁸⁶ Telemedicine programs are functioning and progress has been made on emergency medicine and disaster planning.

These achievements are not to be underestimated.⁸⁷ However, the health system as a whole is inequitable and weak and many of the most important goals of the plan have not been achieved. Health was not a priority of the political leadership, and for much of the period the Ministry was run by members of ethnic minorities who had little political influence. The Ministry has also suffered from shortages of staff skilled in management, administration, policy development planning and oversight; skills needed for such an ambitious transformation. The presence of corruption also drained resources. Lack of sufficient local responsibility for development, planning and administration of health services and the unstable leadership of the implementation effort have also proved problematic.⁸⁸ The plan may have over-emphasized primary care and communicable diseases.⁸⁹ The lack of economic development and uncertainty about Kosovo's political future also has made implementation complicated, as they led to low investments in health. Licensing and regulatory mechanisms remain weak; the first law on private hospitals only went into effect in 2008. Accountability and transparency at the Ministry of Health has been lacking.

The decisions made about human resources for health have had a major impact on the development of the quality and equity of health services. The family medicine initiative was underway quickly, with significant support from donors and engagement of trainers from the U.K. and U.S.⁹⁰ These partnerships have contributed to training more than 500 family physicians. The medical education curriculum includes six hours of lectures on family medicine in the final year.⁹¹ Job descriptions, standards, norms, and quality standards are in place.

The lack of participation by leaders in the medical community in the original planning in the Center for Family Medicine and its placement outside the Medical Faculty also meant however, that the medical leadership did not have a stake in the program. Moreover, competitive tension between specialists and family practitioners (and concomitant resentment over the resources spent on family medicine) worsened the situation. The medical community's concerns also focused on the quality of training family physicians received, not least because it was located outside the medical school. PHR found that this tension continues today, with prominent physicians and medical school faculty dismissive of the initiative and the quality of services family practitioners are able to offer. Many specialists and academic leaders PHR interviewed, consider family physicians ill-trained and largely incompetent to do anything more than refer patients to specialists. Dr. Arben Grazhdani, who was for at time the Director of the University Clinical Center, told PHR that family physicians need broad knowledge but don't have it and "need to do more than refer patients." PHR also found that medical students continue to prefer to go into more prestigious and higher paying specialties if they can be admitted to residency programs so that family practice has become the field for those without sufficient connections.

Additionally, acceptance of family medicine by Kosovar citizens remains marginal. Without a group of community leaders to help prepare them for the required behavioral and cultural shift in one of the most intimate activities of life, seeking medical care, the general public simply behaved as they had in the past: they continued to seek out specialists without first going through a family practitioner.⁹² This pattern continues almost ten years later. Patients continue to behave as they always have, self-referring to specialists. Although there are some exceptional family

⁸⁶According to the United Nations Kosovo Team, "the current capacities of the mental health sector in Kosovo are far from being sufficient in effectively addressing the population needs in terms of mental illness." Initial Observations of Gaps in Health Care Services in Kosovo. January 2007. Only 3% of the health budget is devoted to mental health care. Moreover, the Shtime psychiatric hospital, identified soon after the war as a place of unrelenting abuse of patients, including unhygienic conditions, inappropriate care, and lack of protection from sexual assaults, Mental Disability Rights International. Not on the Agenda: Human Rights of People with Mental Disabilities in Kosovo (2002). The situation there has only marginally improved for the patients, mostly Serbian, who are still there.

⁸⁷ O. Bornemisza and E. Sondorp, Health Policy Formulation in Complex Political Emergencies and Post-Conflict Settings: A Literature Review. London School of Hygiene and Tropical Medicine. 2002.

⁸⁸ S. Jones et al., Securing Health, p. 183.

⁸⁹ Campbell, Percival and Zwi; S Jones, et al, Securing Health, pp 166-167, 171-174.

⁹⁰ Id at 173-74

⁹¹ Id at 202.

⁹² R. Hedley and B. Maxhuni, Development of family medicine in Kosovo. BMJ 2005;331:201-203.

medicine facilities, such as the large and well-staffed and equipped family care center PHR visited in Prizren, Kosovars have not embraced family medicine. Dr. Genc Ymerhalili, the Director of Center for Family Medicine, told PHR that 85% of Kosovar Albanians live in areas covered by a family medicine program, but the Deputy Minister of Health acknowledged that the utilization rate for primary care now is at only 30-40 per cent.⁹³ In 2006, the visit rate for all primary health care was lower than any other country in southeastern Europe except Albania.

Some officials involved in the decision to move to family practice for primary care blame the medical community for these problems. A case could be made that the medical community abdicated its responsibility because it was never able to organize itself into an effective medical association as a vehicle for input. Parochial interests also led it to protect its turf in existing specialties. But the larger cause was the failure of international agencies – UNMIK and WHO – to fulfill their obligations to take into account the unique human resources situation after the war, and to assure participation of the medical community in the planning process. Some of the planners have sought to shift blame for the deficiencies of the system to the specialist leaders among the older generation of physicians. A WHO official, who described himself as the “de facto Minister of Health” during the planning process, writes that “... the older generation looks backward. Before the oppression, some of them had a powerful position. They want it back. They also want the old system without any dubious additions, such as PHC.”⁹⁴ It may well be true that physicians of the older generation would have resisted change to a new model of primary care; but it is also true that no serious effort was made to hear their concerns, take advantage of their experience and skills, or take into account all the disruption and suffering they had experienced.

Although a major and successful nursing education initiative got underway with international support, no companion effort addressed the training deficits of doctors educated in the parallel system. Instead, immediately after the war, as one physician explained, many doctors were awarded residencies even though they lacked a foundation in medical education and were ill-prepared for specialty training. Undergraduate medical education has been neglected, too, exacerbated by the lack of essential capital improvements and availability of essential supplies in the University Clinical Center, which in the past few years led to student protests over such basic issues as sanitary conditions at the school.

Competition for position among Kosovar Albanian physicians and demoralization from dashed hopes have compromised teaching and residency decisions. Both young doctors and experienced specialists told PHR that political considerations have intruded on faculty appointments that have led to a lowering of teaching standards. One recent graduate told PHR that some people in power “want to maintain the old system that would accommodate their needs for power and control and lack of transparency.” One way of doing this, he said, is to help “children of professors, politicians and high profile people get in the medical school, take exams in a facilitated manner and get in residency training through political connections.” In some respects this is understandable given the income gap between specialists in private practice and general and family practitioners in the public sector.

According to both recent graduates and experienced physicians, the medical school curriculum went through a series of changes without increasing the quality of education, though a partnership with the University of Bologna now seeks to standardize teaching. Some physicians, however, are skeptical as to whether the Faculty of Medicine has the capacity to implement these reforms. Admission and residency decisions are also seen by students as based on political and personal connections.⁹⁵

To add to the problems, the Ministry of Health has never developed a strategic plan for human resource capacity development beyond family medicine, and the lack of a functioning health information system makes assessment

⁹³ Interview with Mubera Felizi, Deputy Minister of Health, August 2008. The country director for WHO also affirmed that the referral system was not working well.

⁹⁴ D. Buwa and H. Vuori. Rebuilding a health care system: war, reconstruction and health care reform in Kosovo. *European J. of Public Health* 2007;17;226-230.

⁹⁵ The perception that political connections are needed for higher education in Kosovo extends well beyond medical education. A survey by the United Nations Development Program in 2006 showed that in the intense competition for slots at the University of Pristina, showed that 54% of youth surveyed believed political connections played a role in admission and 57% of Kosovar Albanian youths believe that paying a bribe is necessary for admission. United Nations Development Program. *Youth: A New Generation for Kosovo*. Human Development Report 2006, p. 47. PHR also received reports that grades at the Faculty of Medicine were the subject of bribes, but was not able to gain sufficient information to substantiate or discredit these reports.

and proper allocation of resources difficult.⁹⁶ The results are obvious in the mismatch between training and needs for human resources for health. Recent medical graduate physicians and those who had completed training in a specialty revealed to PHR that on completion of training, there are no jobs available.

These problems in the use of human resources for health have been compounded by the management, leadership, planning, policy and capacity limitations affecting other aspects of the health system, noted above. Peer review mechanisms to assure quality care are very weak. Health professionals in Kosovo provide care in the absence of oversight and without the supportive and constraining rules and regulations that maintain standards of integrity, competence, and compassion. The Ministry of Health has recently established quality control coordinators in each institution, but standards to measure quality are unclear. Mechanisms for credentialing and licensing, including ethics and human rights, have been very weak, though a new Kosovo Chamber of Doctors is slated to take over responsibility for licensing, continuing medical education, residencies and ethics.

The lack of follow through on a financing system has exacerbated the human resources problems. Although the original plan contemplated a mix of private and public services, the goal was integrate them into a single system that could assure equity. To achieve that goal, a sophisticated health financing system is essential. But the reform has been repeatedly postponed. Since the end of the war, Kosovo's health services have been paid for by general revenues pooled in the Kosovo Consolidated Budget and allocated through the Ministry of Economy and Finance through budget planning process. The health sector budget is a line item in the consolidated budget, and there are too few resources to pay for the health care expenditures that are needed. A law authorizing a health insurance fund was drafted in 2004 but was not approved by the Special Representative of the Secretary General due to questions about its financial sustainability. It was only in 2008 that the World Bank issued a report analyzing health financing and presenting options to develop a health financing system that can meet the needs of Kosovars.⁹⁷ A co-payment system was established after the war, with exceptions for the elderly, children, war veterans, families of war victims, and people with chronic conditions, but PHR was told repeatedly that the system is both overbroad and haphazardly and arbitrarily administered, creating yet additional room for inequity and inefficiency. The result is that individuals must pay for key elements of their care. According to the World Bank, about half of health spending in Kosovo comes from out-of-pocket payments from patients, much of it for medication.⁹⁸

One consequence of reliance on a budget appropriation alone is that in the public system doctors are paid only €200-250 a month and nurses about €125-150. Physicians working in the public sector, including family physicians, told PHR how difficult it is to support families on these salaries and how demoralized they are as a result. The lack of financing also makes work in the public sector unsatisfying because other key resource needs are not met, resulting in lack of supplies and functioning equipment. This is the situation for many primary health care clinics. Even at the University Clinical Center, the air conditioning units in the surgical suites have been malfunctioning for more than a year, the CT scanners lack film, and staff must take patients undergoing surgery outside in the middle of winter to move them to a surgery suite.

The low salaries and poor support also undermine the integrity of the health system. PHR was told that most physicians who work in the public system try, wherever possible, to set up a private practice as a way to make ends meet. This encourages conflicts of interest as well, as physicians refer patients to their private offices and labs. Across the road from the public-financed University Clinical Center in Pristina are private laboratory and other services in which physicians at the Center have a financial interest and to which PHR was told they self-refer. PHR was told that patients, too, are recruited from the public sector to private practice.

⁹⁶ According to a 2008 report for a donor conference:

Health information is scattered across different sources, and is often outdated, incomplete, poor in quality and unutilized. The process of collecting, validating, interpreting and analyzing data remains a major challenge, especially as related to monitoring, evidence based management, improving the system performance, transparency and accountability. Strengthening the human capital of Kosovo: Avenue to accelerated human development. Paper prepared by the United Nations Kosovo Team for International Donor Conference for Kosovo, Brussels, July 11 2008

⁹⁷ World Bank Human Development Sector Unit, Europe and Central Asia, Kosovo Health Financing Study, Report No. 43183-XK. 2008

⁹⁸ Id.

Moreover, some physicians trained in family medicine leave the field for more lucrative and satisfying forms of practice. Dr. Jusuf Dedushaj, who until 2006 was the Director of the Institute of Public Health, told PHR that 70 family health centers have no physician, not because of an insufficient number of trained family practitioners but because of low salaries and the lack of incentives to go to rural areas. As noted earlier, at the same time, general practitioners and other specialists are unemployed.

The Ministry of Health recognized the impact of the lack of financing on human resources early on⁹⁹ and the implications for patient care were clear as implementation proceeded:

The working conditions in the public sector were poor. The salaries were low; the progress to refurbish and re-equip damaged and looted equipment was slow; drugs, reagents and other medical supplies were in short supply; heating, electricity and water supply remained unreliable; the people preferred the private sector if they could afford it.¹⁰⁰

The combination of low public sector salaries and alienation from the Ministry leadership and new structures, led well-trained specialists who constituted the backbone of the medical community in the 1990s, to remain in private practice, leading to a two-tiered system and a tremendous gap in quality of services between public and private care. In the absence of a reimbursement system, private providers have no source of compensation for the care they provide other than patient fees they receive from the minority of Kosovars who can afford to pay them. While some of these physicians devote a portion of their time to public practice, especially in hospital-based practice such as surgery, the overall structure denies the public health system their skills. The result is a dearth of highly skilled professionals in the public sector.

The result is a highly inequitable system of care: decent private care for those who can afford it and far lower quality of care in the public system. The poor, and especially the very poor such as Roma and other non-Serb minorities, suffer the most from an under-resourced health system and the failure to have a financing scheme that takes advantage of the resources that are available. A physician at the Prizren family health center, one of the best in Kosovo, told PHR that sometimes the clinic lacks drugs for hypertension, insulin or key essential antibiotics for their poor patients. The clinic has no electrocardiogram equipment. Dr. Gani Demolli, the Director of the Mother Teresa society, whose clinic serves low-income patients who cannot afford co-payments - but which meets only a tiny fraction of the need - is despondent over current inequities in health care. He attributes the problems in part to failures of participation. In his view, the “medical community has no influence. People risked their lives to be helpful. But they had no courage to speak up.”

In a survey among patients and doctors in 2004, the following benefits of the private sector as compared to the public sector were identified: free choice of doctor; shorter waiting times; preferential treatment in public facilities when seeing a doctor in private practice; better continuity of care; confidentiality; perception of more thorough information on the patient’s condition; and better bedside manner.¹⁰¹ The Ministry recognized the challenges, to say nothing of the inequities posed by a respected and reasonably well-functioning private sector and a decrepit public sector, but no effective steps have been taken to address these issues. The same situation exists today, though it is more entrenched and the inequities are, if anything, greater.

The challenges of developing a health financing system are significant, including low economic development and the need for greater capacity to collect and distribute funds efficiently. But as the World Bank report makes it clear, that there are good models to follow. At the same time, Kosovo’s Ministry of Health bears responsibility for inefficiencies and inequities in the use of available funds.

The human resources problem is also linked closely to the lack of essential medicines. Concerns about the availability and affordability of medicine were apparent from the beginning of the planning process, particularly given the significant household expenditures for medicines at the time the plans developed. From the start of post-war planning, obtaining essential medicines was a priority. In 1999 Kosovo established its first essential medicines

⁹⁹ Buwa and Vuori, *Rebuilding a health care system: war, reconstruction and health care reform in Kosovo*.

¹⁰⁰ *Health and Health Care in Kosovo*.

¹⁰¹ *Id* at 58.

list, which is updated periodically. But a policy on access, organization and distribution was not developed and the resources to obtain medicines were lacking from the start.¹⁰² The Ministry of Health distributes those essential drugs that it obtains for free through public clinics. The government spends about 10 percent of its health budget on drugs,¹⁰³ so the lack of drugs is in part, a product of the lack of resources in the country and the inadequate health financing system. Per capita drug public expenditure is less than €3 per capita, with annual public drug expenditure of €7 million and out of pocket drug expenditure of more than €40-50 million.¹⁰⁴

Contributing to the problem is that funds appropriated for procurement of drugs are not all spent for that purpose due to inefficiencies and mismanagement and corruption. PHR was told repeatedly, including by staff at the Ministry of Health, that the procurement process is not transparent and there is insufficient public monitoring and accountability.¹⁰⁵ As a result, many essential medicines are in fact not available in health center and hospital pharmacies, either because they have not been procured at all or because the supply chain has not been replenished. These medicines must then be purchased in the very large number of unregulated private pharmacies that have proliferated. According to Dr. Demolli, there are 300 such pharmacies in Pristina alone. The new Minister of Health has committed to address the problem.

Until the matter is addressed, the inefficiencies and inadequacies hit hardest the most vulnerable people – including Roma, other minorities and low income Kosovar Albanians among the poor.¹⁰⁶ That the system gives no priority to serving poor and vulnerable people shows the presence of non-financial obstacles that further worsen the population health status. Virtually everyone PHR consulted in 2008 identified the lack of medicine as one of the most serious deficiencies in Kosovo's health system. A large group of impoverished Roma who PHR questioned about health services in Kosovo confirmed what physicians and policy-makers all said; the lack of medicine for very serious conditions is the most serious problem they face in meeting their health needs.

The lack of availability of medicines has a dramatic impact on the population, especially the poor, driving them further into poverty. It also reduces the ability of physicians in the public sector to provide quality medical care. A World Bank study in 2008 found that 80% of drugs purchased are paid for out-of-pocket and 65% of out-of-pocket health expenses in Kosovo are for medicines; for the poorest quintile of the population, total out-of-pocket health expenses represent 13% of total consumption (as compared to 4% for the top quintile). Out-of-pocket health expenses increase the poverty rate by 3-4 percent.¹⁰⁷ The one remaining clinic run by the Mother Teresa society is used by the poor in part because it is a place where they can obtain medicines they would otherwise have to pay for; but it serves only a tiny percentage of the population.

In sum, while human resources and related financing decisions were not the only reason for the inequities and inefficiencies in Kosovo's health system, they have played a central role in determining structure and severe

¹⁰² S. Jones et al., *Securing Health: Lessons from Nation-Building Missions*.

¹⁰³ World Bank. *Kosovo Pharmaceutical Sector Analyses*. May, 2007

¹⁰⁴ *Id.*

¹⁰⁵ The International Crisis Group reported in 2008 that the Ministry of Health's "large and opaquely-run pharmaceutical budget [is] seen as a prize by competing groups in government." International Crisis Group. *Kosovo's Fragile Transition*. Europe Report No. 199-25 September 2008.

¹⁰⁶ In the immediate post-war years, non-Serbian minorities experienced discrimination in health services. As of 2003, there were continuing credible reports of discrimination against Roma, Ashkali and Egyptian minorities in accessing health services, and they considered services poor. Organization for Security and Cooperation in Europe. M. Arrigoni, A.M Biro, S. Shok, and C Vallings, *Joining in Minority Voices*. 2003. These minorities continue to suffer social exclusion, lack of full freedom of movement and inadequate access to health care, all exacerbated by their poverty, with Roma particularly vulnerable. See statement of Knut Vollebeck, High Commissioner for National Minorities, OSCE, before the Helsinki Commission, June 3, 2008. The extent of discrimination against minorities today was beyond the scope of this investigation, though NGOs and others working with Roma told PHR that for Roma, Ashkali and Egyptian minorities the degree of access to health care had improved since 2003. They described increased freedom of movement and only infrequent reports of overt discrimination in health. Observed restrictions on access were more a problem of poverty, lack of information, lack of trust and lack of facilities, personnel and supplies. PHR interviews with Bekim Blakaj, Humanitarian Law Center; Bella Murati, Ombudsperson, Bujar Hoxha, Mission Director, CARE International, Bujar Reshtani, UNHCR. Dija Krasniqi, European Roma Rights Centre, August, 2008.

¹⁰⁷ World Bank, *Kosovo Health Financing Reform Study*, Report No. 42183-XK May 6, 2008.

limitations of Kosovo's health care system today. Many of the deficiencies and inequities stem from the failure of the plan to take proper account of the circumstances of human resources for health at the end of the war, to take advantage of those resources in a new health system, and to enable the traumatized medical community to participate in the system's development. These weaknesses are directly attributable to the failure in the immediate post-conflict period to make the effort to understand the people and the communities who would take charge of and live within the health care system that was being planned. Little heed was given to the experiences and trauma of the Kosovar medical community from the pre- and intra-war period. No real effort was undertaken to develop financing mechanisms that would integrate the highly qualified private sector into the system and assure adequate compensation for health providers. Little was done to find primary care models or design an overall integrated system that would be acceptable to Kosovars and medical providers. It is also the case that the inability of the physicians themselves to create a functioning medical society also contributed to this fundamental failure in the participatory process.

G. The parallel health system for Serbians.

The separation of health care for Serbians living in Mitrovica region and in enclaves in the south after the war soon became a new kind of parallel health system. The Mitrovica Hospital is a Serbian institution and off limits to Kosovar Albanians. In most enclaves, the Serbian Ministry of Health supervisors and pays salaries to staff, usually at amounts double or more the salaries paid to Albanian staff working in Albanian facilities. In part the differential is the result of differences between salaries in Serbia and salaries in Kosovo, but it also a product of a deliberate policy by Serbia to induce Serb health professionals to continue to work in Kosovo. In one region, Gjilan, a "half-parallel" system has evolved, where staff receives salaries from both the government and from the Serbian Ministry of Health. The differential not only breeds anger and resentment among Albanian health professionals who earn so much less, but encourages Serbian health professionals to reinforce ties with Belgrade by looking to Serbian colleagues for professional support as well tertiary care referrals. There exists little professional communication between Serbian and Albanian physicians and nurses even when practicing within a few kilometers of each other.

Though these parallel institutions began as a means to enable Serbians in Kosovo to receive services despite their precarious security, they soon became a means by which Serbia, through financial and political support, sought to undermine Kosovo's emergence as a successful multi-ethnic state. In other enclaves, Serbia supported parallel institutions that remain to this day and have been used to destabilize Kosovo and ultimately to seek partition of Serb areas in the north of Kosovo.¹⁰⁸ Ever since the war, many observers urged UNMIK, KFOR and their supporters in Europe and the United States to take the difficult but concerted action needed to integrate Mitrovica as a Serb-dominated municipality within Kosovo and reduce if not eliminate parallel institutions.¹⁰⁹ Even as security has improved, however, albeit not reaching the level needed, the parallel structures have become ever more entrenched.

In 2003, a study of parallel structures by the Organization for Security and Cooperation in Europe noted that both Serb and Albanian health professionals in Kosovo believed that members of the other group lacked the same level of professional skills it possessed. The study found little willingness of communities to cooperate on healthcare matters and noted no genuine spirit of tolerance and no willingness to find a common ground between the Kosovo Albanian and Kosovo Serb communities on these issues. As a result, even at a time when the level of ethnic tension and insecurity remained high – and it would get much worse in 2004 – OSCE recommended that "UNMIK/PISG should make a thorough assessment of the implications that the parallel healthcare system has in Kosovo and take proactive measures to reach out to certain communities to help them overcome their fears of seeking aid from the UNMIK healthcare system." More to the point, it urged that "UNMIK/PISG should make an agreement with Belgrade, with the view of creating one consolidated healthcare system in Kosovo, which is open to all communities, under the ultimate leadership of the PISG."¹¹⁰

Following the violence of 2004 the international community did not take the difficult but essential steps needed to end the use of parallel structures and Serbia continued to undermine Kosovar institutions, refusing to recognize the

¹⁰⁸ International Crisis Group, Policy Briefing, Europe Briefing No. 47, 18 March 2008.

¹⁰⁹ International Crisis Group, UNMIK's Kosovo Albatross: Tackling Division in Mitrovica, Europe Report No. 131, 3 June 2002; International Crisis Group, Bridging Kosovo's Mitrovica Divide, Europe Report No. 165, 13 September 2005.

¹¹⁰ Organization for Security and Cooperation in Europe, Parallel Structures in Kosovo (2003).

Ministry of Health and licensing bodies.¹¹¹ While there are reports of physicians from across the divide sharing information, this attitude appeared to be the exception. Two Serb physicians PHR interviewed in 2008, one in a tiny *ambulata* and one in a secondary care facility in an enclave, expressed satisfaction with their orientation toward Serbia, where they received their licenses and their support, and had not the slightest interest in communicating with Albanian colleagues a few kilometers away. Perhaps even more important, arduous efforts by the Kosovo Ministry of Communities and Integration to integrate and share staffs at two facilities, one Albanian and one Serb, have gone nowhere.¹¹² The Ministry, established in 2005, was designed to work with all communities to move toward integrated life and is headed by a Serb. Kosovo's Deputy Minister of Health told PHR about an effort to integrate healthcare between a majority Albanian and a majority Serb community by sending two or three doctors from one community's clinic to the other and vice versa; the medical staff agreed. It seemed a good opportunity because the communities were relatively mixed rather than being mono-ethnic. The experiment commenced and appeared to be succeeding, however, it was halted by Serbian politicians.

The parallel health system is now undermining the rule of law. The most notable example is the effort by Serbia to prevent Kosovo from enforcing regulations on the safety of pharmaceutical imports bound for Serbs in the enclaves. The inspection of drugs for quality is a legitimate and important responsibility of government, but when Kosovo has attempted to carry out this function, Serbian spokespeople claimed the lives of Serbians were in jeopardy.¹¹³

¹¹¹ J. Bloom, E. Sondorp, and O Bornemisza, Serbs, Albanians the the International Community Share Responsibility for Kosovo's Ethnically Divided Healthcare System. *British Medical Journal Rapid Response* (Aug. 10, 2005). Available at <http://www.bmj.com/cgi/eletters/331/7510/201#114305>.

¹¹² Surveys conducted by UNDP show that since the period March-June, 2007, when the final status of Kosovo became front and center, the percentage of Kosovar Serbs who believe that inter-ethnic relationships are tense and not improving has increased dramatically. The top reason given in the most recent survey, published in June 2008, was the influence of Belgrade; the second reason was the lack of readiness to be integrated. UNDP and UNAID, *Early Warning Report: Kosovo*. Report #20/21 Special Edition January-June 2008.

¹¹³ The problem of medicine supplies in Kosovo continues (no oxygen for Serbs). *Free republic*. September 19, 2008. <http://www.freerepublic.com/focus/f-news/2085686/posts>; Medical Supplies Arrives in Serb Enclaves. B92, April 3, 2008. http://www.b92.net/eng/news/society-article.php?yyyy=2008&mm=04&dd=03&nav_id=49069.

VII. Legal Analysis

Health personnel are a precious resource for a nation's health system, and indeed the role of health providers in their societies often well exceeds their professional role. They often act as community leaders and can also serve to legitimate the health system itself as one designed to serve the people.

In recognition of the central role health personnel play in attending to the health of the population, both international humanitarian law and international human rights law address the need for and protection of human resources for health. International humanitarian law, which applies to armed conflict, protects medical personnel, facilities and transports from attack or interference so that they can attend to the health needs of civilians and wounded combatants. Human rights law is concerned both with protection against state-inflicted violence, torture, and arbitrary arrest and prosecution, and in assuring that human resources are available and qualified to fulfill everyone's right to the highest attainable standard of health.

The violations of human rights law began in the 1990's, a period not covered by this report, when the government of Yugoslavia systematically discriminated against Kosovar Albanian health professionals. Physicians and nurses were excluded from state-operated hospitals and clinics, as well as from the ministries that oversaw health functions. Kosovar Albanian patients were also subjected to discrimination. These practices violated the International Covenant on Civil and Political Rights (ICCPR), which Yugoslavia had ratified.¹¹⁴ It provides that "All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."¹¹⁵ The conduct also violated the International Convention on the Elimination of all Forms of Racial Discrimination, outlawing discrimination on the basis of national or ethnic origin, which Yugoslavia had also ratified.¹¹⁶

A. Attacks on Kosovar Albanian medical personnel and patients

By July, 1998, the conflict in Kosovo reached a level of organized internal armed conflict that triggered the application of the Geneva Conventions.¹¹⁷ Serbian authorities, including quasi-military security units, attacked, arrested, detained and tortured Kosovar Albanian physicians and improperly invoked the mechanisms of the criminal justice system for their having engaged in the ethical practice of medicine. These practices violated both international humanitarian and human rights law.

1. International humanitarian law.

The Geneva Conventions establish principles and laws designed to protect non-combatants and civilian institutions from intentional and avoidable harm during armed conflicts. One central principle is that parties to a conflict at all times distinguish between the civilian population and combatants in order to spare the civilian population and civilian property. Under this principle, neither the civilian population as a whole nor any individual civilians may be attacked. Another principle is that no party to a conflict may engage in murder, hostage taking, looting, torture or

¹¹⁴ International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976. Available at <http://www1.umn.edu/humanrts/instreet/b3ccpr.htm>. The Covenant was ratified by Yugoslavia in 1971.

¹¹⁵ *Id.* Article 26.

¹¹⁶ International Convention on the Elimination of All Forms of Racial Discrimination, G.A. res. 2106 (XX), Annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, *entered into force* Jan. 4, 1969. Available at <http://www1.umn.edu/humanrts/instreet/dlcerd.htm>. The former Yugoslavia ratified the Convention in 1967.

¹¹⁷ Justice Louise Arbour, Chief Prosecutor of the International Criminal Tribunal for the former Yugoslavia (ICTY) declared in July 1998, "[T]he nature and scale of the fighting indicate that an 'armed conflict,' within the meaning of international law, exists in Kosovo."

other forms of cruel, inhuman or degrading treatment and the “passing of sentences” by any body other than a regularly constituted court that affords procedural guarantees recognized in international law.

The Conventions provide for the protection of medical personnel, transports and facilities so that non-combatants, including wounded soldiers, can receive care during armed conflicts. Generally, they require that unless medical facilities or personnel are used for a military purpose – e.g., placing artillery in a hospital – neither side in a conflict may interfere in any way with the medical functions of treating the sick and wounded. Under this principle of medical neutrality, hospitals must be allowed to function, ambulances allowed to collect and transport the wounded, and principles of medical ethics respected.

In 1977 new protocols for the Conventions were adopted, one of which, Protocol II, was designed to elaborate on these obligations in the course on an internal armed conflict such as took place in Kosovo.¹¹⁸ Yugoslavia had ratified Protocol II.¹¹⁹ Part III of Protocol II calls for protection of medical care to all persons not in combat without discrimination: “Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed *hors de combat* by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, color, religion or faith, sex, birth or wealth, or any other similar criteria.” No matter whether combatant or civilian, patients “shall receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition.”¹²⁰ It also requires that medical personnel have freedom of movement to reach wounded people.

For the medical provider, the protection for engaging in patient care is absolute: “Under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom.” Protocol II elaborates on the application on medical ethics, enabling health personnel to comply with the professional standards of their profession, such as respecting patient confidentiality and treating all sick and wounded without regard to their belligerent status, military affiliation, ethnicity, or religious or political views.¹²¹ Moreover, medical units and transports shall be respected and protected at all times and shall not be the object of attack.¹²² Protocol II’s protections apply to a physician who provided medical care to a civilian or a KLA soldier who happened to make his way to a clinic and to a physician who volunteered to set up medical services for the KLA. Serbia’s act of labeling of the KLA a terrorist organization under domestic law does not obviate the obligation to comply with Protocol II. Rather, interference with medical functions, and of course arrest, detention, torture, prosecution and conviction of doctors under anti-terrorism laws for allegedly providing medical care to KLA members, all violated Protocol II.

Attacks on patients also violate Protocol II. The duty of combatants is unequivocal: “All the wounded, sick and shipwrecked, whether or not they have taken part in the armed conflict, shall be respected and protected,¹²³ and, regarding patients, “In all circumstances they shall be treated humanely and shall receive to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. There shall be no distinction among them founded on any grounds other than medical ones.”¹²⁴ Yet in Kosovo during the period of the conflict, Kosovar Albanian patients, and later some Serbian patients, were subjected not only to gross forms of discrimination, but even physical attack and abuse.

¹¹⁸ Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), art. 2, Geneva 8 June 1977; Available at <http://www.icrc.org/ihl.nsf/FULL/475?OpenDocument>.

¹¹⁹ These standards applied to the KLA as well and the KLA explicitly agreed to abide by applicable provisions of international law. Human Rights Watch, Federal Republic of Yugoslavia: Humanitarian Law Violations in Kosovo, October 1998; p. 55.

¹²⁰ Protocol II, Part III, art. 7(2).

¹²¹ See World Medical Association, Declaration of Geneva

¹²² Protocol II, Part III, arts.10(1) ,11(1).

¹²³ Protocol II, Article 10, section 1.

¹²⁴ Id. Section 2.

Finally, assaults on medical facilities breached Protocol II, which states that “medical units,” which include all health facilities, “shall be respected and protected at all times and shall not be the object of attack.”¹²⁵ During the war in Kosovo, however, health facilities were wantonly destroyed.

2. International human rights law.

The ICCPR also applied as a restraint on what a government can do to people within its borders. The ICCPR guarantees freedom from arbitrary arrest and detention as well as from torture and other forms of cruel, inhuman or degrading treatment or punishment. It also requires due process for people accused of crimes, including the right of access to a lawyer. Article 9 of the ICCPR prohibits arbitrary arrest or detention and requires that any individual who is arrested or detained be informed of the reasons for the arrest and any charges against him/her. Any detention or arrest must be on grounds specified in domestic legislation and in compliance with procedural rules established in domestic legislation. Article 14 sets forth the right to due process at criminal trials including the requirements that the accused be informed of the charges against him/her, have adequate time and facilities and access to counsel and be considered innocent until proven guilty.

Article 7 of the ICCPR prohibits the practice of torture. Although some of these rights and others such as freedom of movement, expression, association and assembly and right to privacy, are subject to limitations – but not complete derogation – by governments in times of public emergency, the ICCPR recognizes some rights as absolute and therefore protected at all times, even in times of public emergency or during the height of the conflict such as in Kosovo. These include the rights to life, to recognition as a person before the law, to freedom of thought, to religion, to be protected against torture and the right not to be forced into slavery.¹²⁶ In addition, this permanent prohibition requires that investigations be conducted when reasonable suspicion of torture, cruel, inhuman or degrading treatment or punishment exists.

The arbitrary arrests, torture, denial of access to counsel and other violations of due process documented in this report all violate the ICCPR.

In addition to being bound by the ICCPR, Yugoslavia had also ratified the Convention Against Torture (CAT), which has more detailed provisions to assure protection against torture and other forms of cruel, inhuman or degrading treatment or punishment.¹²⁷ Torture is defined in CAT as “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information, for any reason based on discrimination of any kind.”¹²⁸ The beatings and other forms of brutality used to obtain confessions have long been considered a form of torture, and the conditions of detention in which physicians were held amounted to cruel, inhuman and degrading treatment.

Attacks on Kosovar Albanian patients also violated the ICCPR, including the rights to life, to liberty and security of person, and to be protected against discrimination. Moreover, insofar as the attacks on Kosovar Albanian physicians led them to flee or deny care to people in their communities, Serbia violated the International Covenant on Economic, Social and Cultural Rights (ICESCR or the Covenant), which Yugoslavia had ratified.¹²⁹ Article 12 of The ICESCR recognizes a right to the enjoyment of the highest attainable standard of physical and mental health (the right to health), which includes an obligation by states to create “conditions which would assure to all medical service and medical attention in the event of sickness.”¹³⁰ That obligation not only entails the provision of services,

¹²⁵ Protocol II Article 11, section 1. The immunity for medical units is forfeited when used for military purposes, but only after a warning has been given. *Id.*, section 2.

¹²⁶ *Id.*, Arts. 4,6,8,16,18.

¹²⁷ Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. G .A Res. 39/46, 10 December 1984, *entry into force* 26 June 1987. Available http://www.unhchr.ch/html/menu3/b/h_cat39.htm.

¹²⁸ CAT, Art. 1(1).

¹²⁹ International Covenant on Economic, Social and Cultural Rights. General Assembly Resolution 2200A (XXI) 16 December 1966, *entered into force* The former Yugoslavia had signed and ratified the Covenant on 8 August 1967 and 2 June 1971, respectively. (Are you not going to bother with the UNTS for CAT or ICESCR?)

¹³⁰ Covenant on Economic, Social and Cultural Rights, Article 12.2(d).

but non-interference in the efforts by others to provide services, i.e., “refraining from denying or limiting equal access for all persons” to health services.¹³¹

B. Human resources for health in post-conflict health reconstruction

1. The right to health

As noted above, the ICESCR recognizes a right to health. Article 12, section 2 of the Covenant provides:

The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

- a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- b. The improvement of all aspects of environmental and industrial hygiene;
- c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

In 2000, the U.N. Committee on Economic, Social and Cultural Rights (ESC Rights Committee), responsible for interpreting the Covenant, released General Comment No. 14, which provides an authoritative understanding of the content and the right to health.¹³² The General Comment sets out a way to analyze the right to health, thereby making it easier to identify government obligations.

The right to health is an inclusive right extending to both medical care and the underlying determinants of health, such as adequate sanitation, safe water, adequate food, and access to health-related information.¹³³ It encompasses both freedoms and entitlements. The freedoms include, for example, the right to make decisions about one’s health, including sexual and reproductive freedom.¹³⁴ The entitlements include, for example, the right to emergency medical services and to the underlying determinants of health such as access to safe water, adequate sanitation and adequate food.¹³⁵ In all its forms and at all levels, the right contains the interrelated and essential elements of available, accessible, acceptable health facilities, goods and services that are appropriate and of good quality.¹³⁶ For example, good quality health facilities require skilled health workers who receive domestically competitive salaries and whose own human rights are protected (e.g., safe working environment and freedoms of association, assembly and expression).¹³⁷

Equality and non-discrimination are fundamental elements of the right to health. Governments have a legal obligation to ensure that a health system is accessible to all without discrimination, including those living in poverty.¹³⁸ If health facilities are accessible to the wealthy, but inaccessible to the rest of the population, the Government can be held accountable and be required to take remedial action.¹³⁹ Participation by individuals and groups in all health-related decision-making at the national and international levels is also essential.¹⁴⁰

¹³¹ UN Committee on Economic, Social and Cultural Rights. General Comment 14. E/C.12/2000/4 (2000). Paragraph 34.

¹³² General Comment No. 14. See also G. Backman P. Hunt, R Khosla et al. Health systems and the right to health: an assessment of 194 countries. *Lancet* 2008; 372: 2047-2085.

¹³³ General Comment No, 14, para. 11.

¹³⁴ *Id.* para. 8.

¹³⁵ *Id.*

¹³⁶ *Id.* para. 12.

¹³⁷ P. Hunt and G. Backman, Health systems and the right to the highest attainable standard of health. 2008.

¹³⁸ General Comment No, 14, paras. 18, 19.

¹³⁹ *Id.* para. 19.

¹⁴⁰ General Comment No. 14, para. 11.

Additionally, international law calls for “international assistance and cooperation” enabling countries with limited resources to meet their obligations.¹⁴¹ The UN Special Rapporteur on the Right to the Highest Attainable Standard of Health (the Special Rapporteur) has stated that “Developed states should ensure that their international development assistance, and other policies, support health systems’ strengthening and other relevant policies in developing countries.”¹⁴² This obligation is especially pressing where, as in Kosovo, the key decisions about the health system were being made by international agencies. These agencies responsible for health policy and planning, particularly UNMIK and WHO, were bound by the obligations regarding the right to health that would otherwise apply to states.

The right to health is subject to both progressive realization and resource availability.¹⁴³ Put simply, progressive realization means that a country must improve its right to health performance steadily, while resource availability means that what is required of a developed country is of a higher standard than what is required of a developing country.¹⁴⁴ But lower income countries may not escape responsibility for compliance with its obligations; on the contrary, under international law, a state must allocate the maximum resources to which it has access.¹⁴⁵ The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights echo this requirement and establish that the state bears the burden of proof to demonstrate measurable progress toward the realization of the given right.¹⁴⁶

Similarly, a state is not free to make arbitrary decisions as to what constitutes the “the maximum extent of its available resources.” According to the ESC Rights Committee, “States parties have a core obligation to ensure the satisfaction of, at the very least, *minimum essential levels* of each of the rights enunciated in the Covenant, including essential primary health care (emphasis added).”¹⁴⁷ The Special Rapporteur has stated that: “Progressive realization does not mean that a State is free to adopt any measures that are broadly going in the right direction.”¹⁴⁸ Even in the presence of limited resources, the government is required to give first priority to the most basic health needs of the population and to pay particular attention to protecting the most vulnerable sections of the population.¹⁴⁹

Moreover, even when a state has resource limitations, it is nevertheless obligated to meet certain core requirements. These core obligations require, at the very least, access to health facilities on a non-discriminatory basis, the provision of a minimum essential package of health-related services and facilities, including essential food, basic sanitation and adequate water, essential medicines, sexual and reproductive health services including prenatal and post-natal services, emergency obstetric care, and the development and adoption of a comprehensive national health plan.¹⁵⁰

¹⁴¹ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Human Rights Council, 4th Sess., Agenda Item 2, UN Doc. A/HRC/4/28. 2007: para 67. UN CESCR. “General Comment 14.” E/C.12/2000/4. 2000; paras 38-42.

¹⁴² United Nations General Assembly. “Note by the Secretary-General transmitting the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest standard of physical and mental health.” A/61/338. September 2006: para 20. Did you want to put in a footnote explaining the appointment of the Special Rapporteur??

¹⁴³ *Id.* para. 30.

¹⁴⁴ Hunt and Backman, Health systems and the right to the highest attainable standard of health.

¹⁴⁵ General comment No. 14.

¹⁴⁶ The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights. Human Rights Quarterly 1998: 8(20); 691, 694.

¹⁴⁷ General Comment No. 14 para 43.

¹⁴⁸ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Human Rights Council, 4th Sess., Agenda Item 2, UN Doc. A/HRC/4/28. 2007: para 66. See also UN CESCR. “General Comment No. 14.” E/C.12/2000/4. 2000.

¹⁴⁹ Committee on Economic, Social and Cultural Rights, *The nature of States parties’ obligations* (Art. 2, para. 1), 14/12/90. CESCR General Comment 3, 5th Session 1990, para. 12. <http://www2.ohchr.org/english/bodies/cescr/comments.htm> (accessed 6 Jan. 2009).

¹⁵⁰ *Id.* See also G. Backman P. Hunt, R. Khosla et al. Health systems and the right to health: an assessment of 194 countries.

Kosovo spends about the same on health as countries with comparable GDP levels,¹⁵¹ but much of this comes from out of pocket expenses for health, which amount to 40% of health spending. Households pay about the same amounts for health care regardless of income, such that people at the lowest quartile of income pay about three times higher a proportion of their income for health than do people at the highest quartile.¹⁵² Indeed spending on health pushes the near poor into poverty. At the same time, Kosovo spends less on health as a percentage of its budget on health than any country in the former Yugoslavia. Together, these figures demonstrate that Kosovo is not spending the maximum of available resources to meet the health needs of its population.

2. Standards for health services

Aside from these general requirements, the standards that derive from the right to health create a framework for analyzing health systems, including its planning, stewardship and use of human resources.¹⁵³ General Comment 14 employs four human rights requirements for health services: availability, acceptability, accessibility, and quality.¹⁵⁴

For human resources for health, the availability and accessibility requirements are linked. *Availability* means that a sufficient number of health care facilities and a sufficient quantity of goods must be made available throughout a country's territory to meet the preventive and curative health needs of the population, including specific needs of sub-populations. The obligation encompasses the provision of sufficient trained medical and other personnel to meet these identified health service needs. The availability requirement extends beyond the mere existence of trained personnel; the health system must assure that health professionals are given appropriate incentives and infrastructure support to permit them to use their skills. These necessary inputs range from acceptable salaries to adequate supplies facilities, equipment and pharmaceuticals.

Accessibility means not just physical and geographical access, and non-discrimination in access to services, but also financial access to services.¹⁵⁵ The ESC Rights Committee has made clear that health care goods and services should be affordable for all members of the population and that "Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households."¹⁵⁶

Applying these two standards to human resources for health in Kosovo,¹⁵⁷ it is evident that there is a mismatch in human resources to the needs of a country with a large number of impoverished people. Health financing is the most important mechanism policymakers have to influence the operation of a health system, and to assure access, efficiency and equity.¹⁵⁸ Kosovo has physicians in sufficient numbers to serve the population, but an inequitable health financing system that relies on inadequate state appropriations for the public sector and patient payments for the private sector has driven many of the most competent and experienced physicians into the private sector. The result is that skilled and appropriate health professionals are not broadly available to the population. Moreover, salaries in the public service are so low as to discourage doctors and nurses from participating if they have other options, while at the same time private services are well beyond the reach of most of the population. As the belated World Bank study shows, while creating a public health financing system appropriate for Kosovo's economic circumstances is complex, it is possible to design a scheme to redistribute existing resources to address these severe

¹⁵¹ World Bank Human Development Sector Unit, Europe and Central Asia, Kosovo Health Financing Study, page 43.

¹⁵² *Id.*, p. 44.

¹⁵³ G. Backman P. Hunt, R Khosla et al. Health systems and the right to health: an assessment of 194 countries. Physicians for Human Rights. The Right to Health and Health Workforce Planning, 2008.

¹⁵⁴ General Comment No. 14, para. 12.

¹⁵⁵ General Comment No. 14, para 12(b).

¹⁵⁶ *Id.*

¹⁵⁷ A more general analysis of the degree to which Kosovo's health system is consistent with the right to health is beyond the scope of this report.

¹⁵⁸ R. Rannan-Eliya, Strengthening Health Financing in Partner Developing Countries, in Task Force on Global Action for Health System Strengthening, Policy Recommendations to the G8 (2009).

inequities. Both international planners and Ministry officials knew from the start that issues of equity and financing needed to be dealt with, yet they postponed action. With this lapse, they have perpetuated serious infringements on the right to health in the use and distribution of human resources for health.

Tightly related to access to health professionals is the issue of access to essential drugs. Again, adequate financing, management and monitoring mechanisms are essential to meet the standards set under the right to health. According to the ESC Rights Committee, a core obligation of states is to provide essential drugs, as defined by WHO Action Programme on Essential Drugs, to their population;¹⁵⁹ and consistent with their general obligations, states must adopt a policy that specifically assures access on the part of the poor and vulnerable groups. The Special Rapporteur has identified four requirements to fulfill an essential medicine policy consistent with the right to health: a reliable, efficient and transparent system for the supply of affordable medicines; mechanisms to assure quality; adequate financing to avoid imposing the costs of medicine on the poor through unaffordable out-of-pocket payment requirements on households already impoverished; and mechanisms to avoid and monitor corruption.¹⁶⁰

In Kosovo, all these elements are lacking. Significant, though still inadequate, funds are spent on medications, but the system is neither efficient nor transparent. The result is that impoverished people must either spend their few resources on medications essential to their health or, as is often the case, go without them.

The third human rights-based requirement for health services is *acceptability*. It requires that health services be acceptable in the sense that “all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, *i.e.* respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.”¹⁶¹ From a human resources standpoint, this means that physicians, nurses and others must be respectful of cultural and ethnic differences. There has been some significant progress in Kosovo in assuring that health providers be respectful of minorities, particularly the Roma, who were alleged to have been sympathetic with, or even complicit in, abuses committed against Kosovar Albanians. In Kosovo, although there are some indications of continuing discrimination, poverty appears a greater barrier than lack of respect for culture or ethnicity. With respect to Serbians who have encounters with the Albanian-dominated health system, PHR found scant evidence of mistreatment or disrespect.

The last of the four human rights pillars of health services, *quality*, requires attention to medical education at all levels of training and professional development; availability of supplies and equipment for appropriate medical practice, including diagnosis and treatment; health information systems to assure that health resources are allocated appropriately to meet needs and priorities; and mechanisms to assure that appropriate care is given to individual patients and applied to specific conditions.¹⁶²

Except for the successful nurse education initiative and the family medicine training program, elements needed to assure quality of care are not in place. A robust training program for physicians trained in the parallel system never was established. Undergraduate medical education lacks an adequate curriculum, suffers from deficiencies tied to inadequate physical plant, supplies and equipment, and appears to be subject to favoritism in student selection and residency programs. A continuing medical education program is in place for physicians, although it is not linked to the identified needs of the health system. Quality also suffers because the lack of a health information system, with the result that the Ministry of Health lacks good information about how resources, including human resources, are being accessed and used and cannot track patterns of use or outcome parameters. According to a 2008 report for a donor conference:

Health information is scattered across different sources, and is often outdated, incomplete, poor in quality and unutilized. The process of collecting, validating, interpreting and analyzing data remains a major

¹⁵⁹ General Comment No. 14, paras 12(a), 17, 43(d).

¹⁶⁰ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. UN General Assembly, 61st Session, 13 September 2006.

¹⁶¹ General Comment No. 14, para 12(c)

¹⁶² General Comment No. 14, para 12(d).

challenge, especially as related to monitoring, evidence based management, improving the system performance, transparency and accountability.¹⁶³

The health system has no adequate mechanisms for assessing or monitoring clinical quality, since the processes for evaluating professional and system performance are at best rudimentary at all levels of care.

Finally, quality suffers because of the lack of adequate salaries for doctors and nurses in the public sector and lack of the tools, supplies and equipment – physicians need to provide adequate care. Kosovo lacks resources, but as the World Bank financing report makes clear, it could use them more effectively

3. Process requirements: participation and accountability.

The right to health also incorporates key process obligations of states, the most important of which in this context is meaningful participation by those who are affected by laws, policies and programs. Participation is crucial in all spheres of decision-making and implementation. According to the ESC Rights Committee, an “important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular participation in political decisions relating to the right to health taken at both the community and national levels.”¹⁶⁴

The right of individuals and groups to participate in decision-making processes must be an integral component of any policy, program or strategy developed to discharge governmental obligations under Article 12 of the ICESCR. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Participation is especially important in the context of development of a national strategy to meet the requirements of the right to health, which includes setting out objectives for human resources for health and developing policies to meet them.¹⁶⁵

Many of the deficiencies in Kosovo’s health system originate in the failure of the obligation to assure participation. It is widely accepted that the first round of planning by WHO so thoroughly excluded representatives from the medical and health communities in Kosovo that a second round had to be initiated. But our findings show that the second round, though including more consultations, continued to fail to elicit the voice of both the Kosovar medical community and civil society representatives. The problem was not, as some observers have said, simply a matter of buy-in. By excluding the views of Kosovar physicians, planners in the international community made the error of viewing the main concerns about human resources for health to be the need to increase the competence of nurses and to establish a new family medicine specialty.

This perspective took insufficient account of the recent historical experience and competencies of the different generations of Kosovar physicians and of the high expectations of the population as a whole for a new health system. Little recognition was given to the issue of how to increase the skills of physicians trained in the parallel system and to integrate the most well-trained and competent physicians into the new system. Nor was much attention paid to how to introduce an entirely new concept of primary care into a medical culture and social tradition that had little obvious place for it. The seriousness of these concerns cried out for a more participatory process. Had the planners invited greater participation of Kosovar physicians in the process they collectively might have found a way to take advantage of the resources they had, adjust their preconceived notions of the right primary care model, and help physicians come to terms with all they had experienced in the period of exclusion, persecution and conflict. Had they facilitated greater participation, planners would have discovered what PHR learned in its training sessions and discussions, that these experiences had profoundly affected the capacity of Kosovar health professionals to work together, to work with Serbian counterparts, and to trust elected or appointed authorities. These issues, however, had not extinguished their capacity to imagine and dream of a better way of organizing care. Had the planners structured

¹⁶³ Strengthening the human capital of Kosovo: Avenue to accelerated human development. Paper prepared by the United Nations Kosovo Team for International Donor Conference for Kosovo, Brussels, July 11 2008

¹⁶⁴ General Comment No. 14, para. 17.

¹⁶⁵ Physicians for Human Rights. The Right to Health and Health Workforce Planning, 2008.

a process of engaged listening and deliberate formation of healthy group processes, they might well have created a collaborative plan of action that the Kosovar physicians felt empowered to carry out.

Instead, by not seeking such robust participation, the international community designed and established a new health system that essentially ignored its most valuable human resource, the most educated and skilled physicians in the country. Relegated to act outside the new system of family practice and primary care, these physicians returned to private practice, which, because of cost, excluded the great majority of Kosovar Albanians from taking advantage of their services.

The lack of participation by representatives of civil society during these first years of health system planning was equally significant. In almost a decade since the change to the family physician model, the population has only barely adapted to it, resulting in greater inefficiencies and expense for the system. Had informed Kosovars been consulted, planners might have learned that demanding a radical change in behavior when it comes to seeking medical care was not likely to prove successful, given the population's previous reliance on specialists, renewed attachment to them in light of their prominence in the anti-Serbian struggle, and an inertia and conservatism born of displacement, trauma, and poverty.

The second key process requirement is accountability on the part of the government for implementation of the right to health.¹⁶⁶ The accountability process requires a government to show, explain, and justify how it has discharged its obligations regarding the right to health. Mechanisms of accountability for health include the setting out of objectives and policies can then be assessed through the use of appropriate indicators and benchmarks, which will identify resource gaps and the steps needed to meet them. Transparency, of course, is essential for accountability. If it is revealed that there has been a failure on the part of government to fulfill the obligations contained in the right to health, rights-holders are entitled to effective remedies to redress this failure.¹⁶⁷

In Kosovo, however, the Ministry of Health operates without the transparency needed to promote accountability and no mechanisms exist to hold the Ministry of Health accountable for its decisions on health. The absence of a functioning medical society and civil society institutions devoted to health means that no independent assessment is provided by established voices outside the official bureaucracy. Accountability in these circumstances is even more difficult to accomplish.

VIII. Conclusions and Recommendations

1. *Attacks on health providers.* Despite the worldwide attention to Kosovo in the months leading to war, attacks on members of the medical community and patients rarely received attention except as examples of atrocities committed by Serb forces on Kosovar Albanians generally, including journalists, intellectuals, and civil society leaders. All suffered from physical destruction of facilities, torture, political murders and disappearances. In the immediate aftermath of war, Serbian health providers and patients suffered from the generalized violence directed against Serbs.

Assaults on the Albanian medical community had one unique, even central feature, however; the use of legal process against physicians for adhering to their professional ethical obligations to provide treatment irrespective of political beliefs or agendas. No individuals responsible for these prosecutions have been held accountable for these acts, and even condemnation has been rare. Even worse, since the attacks of September 11, 2001, the very justification Serb authorities used for arresting and prosecuting physicians (though not for torturing them) – providing medical care for alleged terrorists – has been adopted by other countries, including the United States, in the name of fighting terrorism. This posture is most clearly expressed in the position of the U.S. Department of Justice in the legal position that providing medical care is a prohibited form of material support to terrorists.¹⁶⁸ The erosion of the norm protecting health workers in providing health care to anyone, including wounded combatants, is not only an affront

¹⁶⁶ General Comment No. 14, para. 55. See H. Potts. Accountability and Right to the Highest Attainable Standard of Health. University of Essex Human Rights Center 2008. Available at http://www2.essex.ac.uk/human_rights_centre/rth/docs/HRC_Accountability_Mar08.pdf.

¹⁶⁷ *Id.*

¹⁶⁸ See *In Re Bikram Thapa*, No. A098 415 637 U.S. Department of Justice, Board of Immigration Appeals. September 4, 2008.

to medical ethics and the Geneva Conventions, but undermines access to health care for the populations generally by making it risky for health professionals to provide care for people who may later be perceived or labeled as terrorists.

This posture must be firmly rejected by governments.

Recommendations

To members of the international community:

- In war and in peace, all governments must uphold and respect the principles of medical neutrality, which protect health workers in fulfilling their duty to provide medical care to individuals irrespective of political beliefs, allegiance or acts; they must not take any adverse action, including legal action, against health providers on the ground that they have provided medical care to alleged terrorists or other enemies of the state.
- Attacks on health workers during armed conflicts should be considered major violations of the Geneva Conventions and, in appropriate cases, war crimes.
- Human rights institutions and the organized medical community should insist on the protection of health professionals and the people they serve; they must not take any adverse action, including legal action, against health providers on the ground that they have provided medical care to alleged terrorists or other enemies of the state.

2. Human resources in health reconstruction

In the face of a legacy of violence and discrimination, war and destruction, health planners sought to rebuild the health system in a rational and effective way, engaging in surveys of health population health status and committing to maintain focus on long-term needs even as emergency relief was essential.¹⁶⁹ But by failing to assure that the process of development was consistent with human rights, and by neglecting the human resources for health available to Kosovo, they designed and implemented a system that, a decade later, is inequitable and denies the large number of impoverished Kosovars access to interventions and medicines they need. The failure of the medical community to come together after the war as many had hoped has contributed to these deficiencies, but that failure was in part a product of the very discrimination and violence heaped upon them over the course of a decade.

Discontinuities and tensions in the health system in Kosovo are also a product of the legacy of ethnic conflict and war. The failure of the international community over the course of a decade to integrate Serbs into Kosovo and to end the separation of Mitrovica and areas surrounding it from Kosovo has continued ethnic tensions. Serbia deliberately exacerbates these tensions through its financial and other support of medical institutions and personnel that serve Serbs, creating the paradoxical situation that Serbs in Kosovo have a strong financial disincentive to show any allegiance to the government of Kosovo.

The recommendations that follow identify actions needed to address these failures. Because this report was not designed to be a comprehensive assessment of health system in Kosovo, the recommendations below do not address other steps that would enhance the quality of health services and move toward meeting standards consistent with the right to highest attainable standard of health will require addressing steps beyond those documented in this report. It is, however, worth noting matters deserving attention. These include increasing the capacity of the Ministry of Health to engage in policy development and oversee implementation of these policies and strengthening management information systems and quality assurance programs and standards for supplies, equipment and physical plant. Attention is warranted, too, to increasing the low salaries of doctors and nurses and ending conflicts of interest in private medical practice. In medical education, attention should be paid to curriculum modernization. The international community can be supportive of these initiatives, as well as financing capital investments in hospitals and other facilities and support for drug affordability.

¹⁶⁹ Shuey, Qosaj, Schouten, and Zwi, Planning for health sector reform in post-conflict situations: Kosovo 1999-2000.

Recommendations

To the Kosovar medical community. The medical community should:

- Develop an independent voice and provide leadership through a medical association in order to support the development of professional bodies and institutions for credentialing, peer review, medical education at the graduate and post-graduate level, quality assurance, ethics standards and review, and other dimensions of professional medical practice and training.
- Assure that strict principles of non-discrimination on the basis of ethnicity, religion, and national origin are formulated and adhered to in all deliberations relating to medical practice and appointment to positions in medical facilities and institutions

To the Faculty of Medicine. The Faculty of Medicine should:

- Fully integrate family medicine into medical education.
- Introduce human rights training into the curriculum.
- Establish policies that prevent favoritism in admission and placement decisions.

To the Government of Kosovo. The Government should:

- Undertake a health financing study toward integrating private providers into a fully integrated system of care to assure equitable access to health care for all members of society
- Establish a body outside the Ministry of Health to set standards for licensing health professionals. Licensing should be based on independent examinations.
- Support dismantling of parallel structures and assure non-discrimination against Serbian health care providers and patients within an ethnically integrated health system.

To the Kosovo Ministry of Health. The Ministry should:

- In conjunction with a new financing mechanism for health, develop a plan for use of human resources for health plan to integrate private providers into a new public financing system that leads to available, acceptable, accessible, and quality care for all Kosovars.
- Encourage full integration of family medicine into medical education.
- Develop mechanisms for ensuring transparency and accountability in all health systems operations, including those relating to pharmaceuticals, medical supplies, equipment, and health care facilities.
- Reform drug procurement and distribution practices to assure that all Kosovars have access to essential medicines.

To the Government of Serbia. The Government of Serbia should:

- End support of parallel health structures in Kosovo for Serbian ethnic populations;
- End interference in the efforts of Kosovo's government to integrate all medical services and activities within its borders.

To the international community. The international community and donors should:

- Provide the resources and experts needed to implement these recommendations.
- Support the availability of prescription drugs to the population.
- Engage in political initiatives and support to end the use of parallel structures in health care delivery and medical training, and provide necessary guarantees against discrimination and marginalization of health providers and patients of any ethnic, religious and national group as all Kosovars integrate into a single health care system in Kosovo.¹⁷⁰

¹⁷⁰ The mechanisms to accomplish this are beyond the scope of this report.

GLOSSARY

CDC: Centers for Disease Control

ESC Rights

Committee: United Nations Committee on Economic, Social and Cultural Rights

GDP: Gross Domestic Product

ICCPR: International Covenant on Civil and Political Rights

ICESCR (or the Covenant):

International Covenant on Economic, Social and Cultural Rights

ICRC: International Committee of the Red Cross

ICTY: International Criminal Tribunal for former Yugoslavia

KFOR: The Kosovo Force

KLA: Kosovo Liberation Army

MSF: Médecins sans Frontières (Doctors Without Borders)

NATO: North Atlantic Treaty Organization

NGO: Non-governmental Organization

OSCE: Organization for Security and Cooperation in Europe

PHC: Primary Health Care

PHR: Physicians for Human Rights

PISG: Provisional Institutions of Self-Government

PTSD: Post Traumatic Stress Disorder

UN: United Nations

UNFPA: United Nations Population Fund

UNHCR: United Nations High Commissioner for Refugees

UNICEF: United Nations Children's Fund

UNMIK: United Nations Mission in Kosovo

WHO: United Nations World Health Organization



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