THE KOSOVO CASE STUDY

Working Paper of the collaborative NATO-Harvard project:

TOWARDS A COMPREHENSIVE RESPONSE TO HEALTH SYSTEM STRENGTHENING IN CRISIS-AFFECTED FRAGILE STATES

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The Kosovo Case Study

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Towards a Comprehensive Response to Health System Strengthening in Crisis-affected Fragile States

This project was conducted jointly by researchers from Harvard University School of Medicine – Department of Global Health and Social Medicine and analysts from NATO’s Joint Analysis and Lessons Learned Centre under the sponsorship of NATO’s Allied Command Transformation. Additional funding for this case study was provided by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.

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A joint study team from NATO’s Joint Analysis and Lessons Learned Centre, Harvard Medical School, and the Harvard Humanitarian Initiative was engaged in an ongoing study project to infer elements of a strategic framework for health system strengthening in crisis-affected fragile states. The joint study team has adopted a multi-case study approach, and it is with great pleasure that we release this working paper documenting the findings from the Kosovo case study.

The paper addresses four key themes: the impact of the crisis and the international community response; the implementation of the new health system; the security community’s participation in health system recovery and reconstruction; and the coordination mechanisms that facilitated or directed the security community’s involvement.

Investigations into these four themes were focused through the use of the narratives presented in this paper.

The outcome of this case study is a number of key takeaways and food for thought which highlight the possible involvement of the security community in health system strengthening in crisis-affected fragile states.

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EXECUTIVE SUMMARY

An effective comprehensive response to health system strengthening in crisis-affected fragile states demands coherent action by all participating actors. Coordinating the desired outcomes and the actions of the humanitarian, development, and security communities required to meet them is a particularly complex challenge.

A team from NATO's Joint Analysis and Lessons Learned Centre and Harvard Medical School is engaged in a project whose overarching aim is to infer elements of a strategic framework for health system strengthening in crisis-affected fragile states, focusing on the optimal use of all global contributions. The approach adopted by the team to meet this aim relies predominantly on research using four case studies (Haiti, Kosovo, Afghanistan, and Libya). This report details the results of the Kosovo case study.

BACKGROUND

Kosovo, already one of the poorest regions of Europe, suffered the effects of a dramatic escalation in ethnic violence, persecution and segregation beginning in the 1980s. Years of devastation and violence culminated in the 77-day NATO air campaign in 1999 against the Milošević regime and what has been called “the largest refugee crisis in Europe since WWII”.

The health sector was deeply affected by this situation. Years of neglect, underfunding and, finally, the ravages of war left the Kosovar health sector in a wretched condition where poor sanitation resulted in the outbreak and spread of diseases and the ethnic divisions resulted in the formation of multiple parallel health systems. The international community took action, investing millions of dollars and much human effort in rebuilding Kosovo and its health sector as quickly as possible. Security community actors such as the UN's Interim Administration Mission in Kosovo (UNMIK), the EU's Rule of Law Mission in Kosovo (EULEX), and NATO's Kosovo Force (KFOR) were involved in the effort throughout, in a variety of different ways and scopes.

Four key questions were investigated during this study: how the crisis impacted Kosovo's health system and how did the international community respond; how successful was the implementation of Kosovo's new health system; what has been the security community's impact on Kosovo's health system; and how did the relevant security community actors coordinate their health system strengthening efforts—with each other and with the host nation—and how successful were they in doing so.

Investigations were focused through the use of three narratives, which are included in this report.

FINDINGS

Immediately after the war, international actors and donors were engaged in rebuilding the health sector, which had been underfunded and run down even before the war. The implementation of a new and modern health system was begun—less centralized and more sustainable was considered the best model for Kosovo—but this ambitious project met with mixed success:

- Health care delivery, such as decentralization to municipalities and reorientation to primary care, and workforce training were successfully implemented.
- However, poor participation of local health care workers in the design of the new health system, by both Kosovar Albanians and Kosovar Serbians, led to poor participation in its implementation as well.
Moreover, little investment had been dedicated to creating management structures that would have allowed for transparent governance of the health system, such as financial structures, procurements systems, and health information systems. This issue had, and continues to have, a dramatic impact, resulting in limited managerial capabilities in Kosovo’s official health system and a consequent high risk of corruption. Since 2008, EULEX has taken action to counter and prevent corruption in Kosovo as part of its Rule of Law Mission.

In addition to establishing a secure environment—a pre-requisite for the reconstruction and development effort—KFOR was heavily engaged in the humanitarian response to the immediate aftermath of the Kosovo crisis. Moreover, some military capabilities to detect public health threats were shown to be useful in the short term, but less so in the longer perspective. The Mitrovica mining facility is one such case, where KFOR’s initial actions to protect the health of its soldiers and the local population from very serious lead contamination had indirect consequences that still impact national health and the local economy today.

Yet, coordination was lacking at a number of different levels (governmental for ethnic reasons, among international actors and between national and international organizations), both during the initial crisis response and in the longer-term health system strengthening. This may have contributed to the slow implementation of the new health system.

**IDEAS TO TAKE FORWARD**

Three takeaways have been identified by this study for consideration by global crisis responders in developing future frameworks for strengthening health systems in fragile states.

**The importance of Governance**

The Kosovo crisis left a vacuum in health managerial skills in Kosovo. There has been little investment directed at rebuilding managerial structures and areas, even from international donors. The resulting lack of governance has delayed overall progress towards strengthening the health system and had a knock-on effect on other building blocks of the WHO health system framework: Health care delivery, infrastructure and workforce. The situation was further complicated by parallel health systems (Kosovar Serbian and Kosovar Albanian ethnic systems, but also public–private) with different financing procedures and reporting methods.

These issues not only led to inefficient health sector management, but opened the door to corruption, which thus continues to necessitate the involvement of security community actors, such as EULEX.

**Coordination of Efforts**

A general lack of coordination at national and international levels has been identified as one of the main issues in the strengthening Kosovo’s health system. Formal or informal coordination mechanisms were practically absent, which hindered the ability of actors to connect with each other in ways that would ensure an efficient response to a crisis situation. Some guidelines and regulations about coordination between security and humanitarian and development communities exist to cover short-term issues, but closer project coordination is required for longer term projects such as health system strengthening.

Separate and independent collection of health information invariably leads to gaps in knowledge or, conversely, duplication of effort in information collection. However, no formal comprehensive information sharing mechanism was adopted by the host nation, security community and humanitarian and development community. The general unwillingness to
share information is partly the result of the different purposes of the various communities operating in a crisis-affected fragile state.

**Long-Term Impact of the Security Community’s Actions**

The security community is often faced with a dilemma: the need to take action versus the potential long-term implications of that action. This is the case with the high level lead contamination discovered in the Mitrovica region. UNMIK, with KFOR’s assistance, shut down the main source of contamination, putting an end to the continued pollution of the environment and the immediate health risk to troops and the local population. The longer term socio-economic implications of that action to the region and its inhabitants, however, have been considerable: Kosovars did not know about or consider lead pollution to be a health threat until the security community arrived on the scene, but did rely upon jobs at the mine. Taking no action at all, however, was not a realistic option for the security community: KFOR would have been accused of acting only in its own interests and not considering the local population.

**FOOD FOR THOUGHT**

Health system strengthening is a mix of complex activities, all of which are interconnected and interdependent. This complexity is amplified in the case of a crisis-affected fragile state, as each scenario involves unique factors that require a tailored approach.

Certain key elements can be drawn from the Kosovo case study, however, which are of particular importance in relation to health system strengthening in a crisis-affected fragile state: Governance, Coordination and Long-Term Impact. Where the international community neglects these elements while acting in a crisis-affected fragile state, health system strengthening efforts will inevitably be affected. In a crisis situation, the security community’s clearest role in health system strengthening is the creation of a secure space in which all actors can safely provide immediate relief to those in need and, in the long term, begin the task of health system strengthening.

Achieving humanitarian relief and health system strengthening requires coordination and unity of efforts among all actors; security forces, in particular, must be aware of which elements of the health sector they should protect or in which way they can usefully contribute. The Security Community can also offer its capabilities in terms of crisis management, but without proper coordination between the relevant actors these capabilities may not be used to their best effect or may even be misapplied, with potentially detrimental effects in the long term.

Finally, there is very little in the way of formal or informal mechanisms in place to facilitate the required coordination. The Kosovo case shows that an uncoordinated response may be successful in the short term, but the longer term impact of these actions may be overlooked or ignored.
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INTRODUCTION

1. This report is one in a series of four case studies being undertaken by a joint study team from NATO’s Joint Analysis and Lessons Learned Centre (JALLC) and Harvard Medical School. The scope of the project is to examine the relationship between health system strengthening in crisis-affected fragile states and the activities of the security community, particularly through the employment of their military and civilian assets in those states. The intended audiences for the project's products are policy and decision-makers in the humanitarian, development and security communities who are interested in achieving a comprehensive response to health system strengthening in crisis-affected fragile states.

2. Kosovo was chosen for a case study because it was seen to meet the three criteria the team established for cases that would yield insight into the overall goal of the project. First, Kosovo is a fragile state whose health system had been affected not only by the war in 1999, but also by ethnic cleansing and a decade of general neglect prior to the war breaking out. Second, there was a global response to the crisis involving various actors from the international community—including the UN, the ICRC, donors, the Organization for Security and Co-operation in Europe (OSCE) and the Kosovar Ministry of Health (MOH)—which initially focused on the refugee crisis but which would also be directed towards health system strengthening. Third, multinational forces with peace-keeping/peace-building or stabilization/rule of law mandates were present.

3. A great deal of literature has been produced examining the Kosovo conflict and the international response to it, much of which has served as source material for this case study. It is not the intention of this report to duplicate that literature or to serve as a historical record of events in Kosovo. Instead, this case study’s findings are based on a carefully selected set of narratives that the team believes best illustrate the lessons from Kosovo that will be most useful in addressing the project’s overall aim. The narratives used to reach the case findings are presented immediately following this report.

METHODOLOGY

4. The research was carried out from August 2012 to April 2013. The interdisciplinary study team from Harvard and NATO progressed through four phases of data collection and iterative analysis: background research, background interviews, field-based data collection and data analysis and report writing. The joint civilian-military nature of the study team allowed unparalleled access to both military and civilian actors and perspectives.

5. The team used the WHO Health System “Building Block” Framework as a guide for considering how the security community may have impacted aspects of Kosovo’s health system. The framework, shown in Figure 1, describes health systems as consisting of six building blocks: service delivery, health workforce, information, medical products, vaccines & technologies, financing and leadership/governance. These building blocks contribute to

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* According to the OECD Fragile States 2013 report, Kosovo is a lower-middle-income fragile state.

† Unless the context otherwise suggests, where in this report we refer to the Kosovo conflict or crisis, it is intended to mean the conflict between Kosovar Albanians and Kosovar Serbians, spanning almost a decade, dating from the rise of Slobodan Milošević to power in Serbia proper in the late 1980’s through to June 1999 when Serbian troops were forced to withdraw from Kosovo in the aftermath of NATO’s Operation ALLIED FORCE.
improved health of the population, improved responsiveness to the population’s health needs, increased social and financial risk protection and improved efficiency.

Figure 1: The WHO Health System Framework

6. Four questions for this case were also formulated to guide the research within the context of the chosen health system framework and with the final project aim in mind. These four questions were:

   - How did the crisis impact Kosovo’s health system and how did the international community respond?
   - How successful was the implementation of Kosovo’s new health system?
   - What has been the security community’s impact on Kosovo’s health system?
   - How did the relevant security community actors coordinate their health system strengthening efforts with each other and with the host nation and how successful were they in doing so?

Phase one: Background Research

7. The study team conducted a comprehensive review of scholarly articles, written interviews, after action reviews, lectures, websites, relevant NATO and US doctrines, and newspaper and magazine reports about the international response to the Kosovo crisis. Particular focus was given to where military assets made direct contributions in health system response and reconstruction, and how these assets coordinated with other responders during participation. This phase took place from August to September 2012.

Phase two: Background Interviews

8. The study team held discussions with key personnel who were knowledgeable about Kosovo’s health sector, governance, and history. Based on information from these background interviews, the study team generated a data collection plan that included specific questions and an initial list of stakeholders to be interviewed. To encourage participants to share their candid views and protect them from political or social liability, we agreed comments would not be attributed nor would we disclose the identity of the participants or the specific organization for which they worked. This phase took place in September and in October 2012.
Phase three: Field-Based Data Collection

9. The study team travelled to Geneva and Kosovo for a total of 11 days and conducted interviews with those on the initial stakeholder list as well as subsequent stakeholders identified during these initial interviews. During field data collection the team also attended meetings, visited public and private clinics and health organizations, and held informal round table discussions with personnel from a variety of organizations. In total, the study team conducted some 20 interviews, including with representatives from:

- UN Interim Administrative Mission in Kosovo (UNMIK)
- European Rule of Law Mission in Kosovo (EULEX)
- NATO Kosovo Force (KFOR)
- World Health Organization (WHO)
- Ministry of Health
- Kosovar National Institute of Public Health (NIPH)

Phase four: Data Analysis and Report Writing

10. The data collected in the previous phases was reviewed and further investigated through targeted research—including additional interviews—which refined and deepened the team’s understanding of the salient findings. With this deeper understanding, the team identified the key themes and issues and selected the major stories to develop into narratives that would best illustrate these themes. Narratives were built around instances of when the security community impacted one or more aspects of Kosovo’s health system.

11. A draft report was written and circulated for comments and feedback to informal advisors familiar with health system strengthening issues, military policy, and civilian-military interactions. Based on this feedback the final draft of the case study report was prepared.

Limitations

12. A twelve-month exploratory study possesses inherent limitations for a context as complex as Kosovo, not least owing to the length of the crisis and the number of actors involved. The time elapsed since the events occurred may have shaped participants' recollections and influenced their judgments of what events were important and which stakeholders they now consider influential.

13. Additionally, the time-limited nature of the study prevented the research from continuing until all possible leads had been followed and forced the study team to focus their research on the most accessible parts of the story. We confronted constant trade-offs between exploring specific issues in depth and capturing the breadth of issues relevant to the security community’s involvement in the health sector. These trades-offs and decisions were discussed among the study team systematically and at length during both the data collection and the production of this report.
During the summer of 1998, a quarter of a million Kosovar Albanians were forced to flee as their homes and crops were destroyed by Serbian forces during the Milošević regime’s ethnic cleansing campaign. By the end of May 1999, an estimated 1.5 million people (i.e. around 90% of the Kosovar population) had been displaced. Some 225,000 Kosovar men were believed to be missing and at least 5000 Kosovars had been executed.

The 77-day long NATO-led air campaign against the Serbian forces and Milošević’s government—Operation ALLIED FORCE—which ended on 10 June 1999, ultimately forced a withdrawal of Serbian forces and an end to the war in Kosovo. Operation ALLIED FORCE also marked the start of the international humanitarian efforts to deal with the largest refugee crisis Europe had seen since the Second World War.

In the aftermath of the air campaign, the international community sought to provide immediate humanitarian aid and establish a secure environment for returning refugees. But to ensure a lasting peace and secure environment in Kosovo, longer-term reconstruction of the country and its infrastructure would be required, including for the health system.

In order to properly analyse and understand the impact of the international community’s contribution, and in particular the security community’s contribution, to Kosovo’s health system and how it was shaped and developed pre- and post-Kosovo crisis, we must first understand what the health system looked like in the period leading up to and during the Kosovo war.

Kosovo is a small, landlocked, state bordered by the former Yugoslav Republic of Macedonia to the south, Albania to the west, Montenegro to the northwest and Serbia to the east. The region has long been racked by conflict: from battles during the reign of the Ottoman Empire to more recent, 20th century conflicts such as the First Balkan War, First World War and Second World War. Tensions between the Serbian and Albanian communities in Kosovo have simmered along throughout history, violently erupting at times as the two ethnic groups clashed over supremacy in the region.

Following the end of the Second World War and the establishment of Josip Broz Tito's Communist regime in, what was then (just) Yugoslavia, Kosovo was granted the status of an autonomous region of the constituent Socialist Republic of Serbia in 1946. By late 1960s it was a more autonomous province and by 1974 almost completely self-governing.

Growing Albanian separatism in the mid-1980s led to tensions arising between Kosovar Serbs and Kosovar Albanians; the Albanians were demanding independence from Serbia while the Serbian population was pushing for closer ties with it. By 1988 Slobodan Milošević had become President of Serbia and, in 1990, amidst much Kosovar Albanian protest, Kosovo’s autonomous status within Serbia was revoked by the Serbian government. A new Serbian constitution was introduced and implemented, aimed at changing the ethnic composition of Kosovo and which effectively placed much of Kosovo directly under Serbian control. Subsequently, the Serbian government began systematically firing or otherwise removing Kosovar Albanians from positions in public enterprises and institutions (including those in the health system). Albanian culture in Kosovo was also generally suppressed; for

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1 Turkey recognizes the Republic of Macedonia with its constitutional name.
example, the language was removed from the educational curriculum and the official Albanian language media was abolished and integrated with the Serbian equivalent.11

21. Kosovar Albanians responded with a non-violent separatist movement, employing widespread civil disobedience and creation of parallel structures in education, medical care, and taxation, with the ultimate goal of achieving independence.12 In July 1990, a majority of members of the (at this stage largely self-proclaimed) Kosovo Assembly passed a resolution declaring the Republic of Kosovo within the Yugoslav Federation.13 This initial bid for independence went widely unrecognized by the international community and the persecution of Albanians in Kosovo continued under the Milošević regime.14

22. By 1996, Kosovar Albanian guerrilla forces, the Kosovo Liberation Army, initiated armed resistance as tensions escalated into the early stages of what would become the Kosovo War.15 During 1998, open conflict between Serbian military and police forces and the Kosovar Albanian forces resulted in the deaths of over 1500 Kosovar Albanians and forced 400 000 people from their homes. The escalating conflict in Kosovo, President Milosevic’s disregard for diplomatic efforts aimed at peacefully resolving the crisis, and the destabilizing role of militant Kosovar Albanian forces caused the international community to become aware of the situation and gravely concerned about it.16

23. On 23 March 1999, following the further deterioration of the situation in Kosovo, the order was given by the North Atlantic Council to commence air strikes on Serbian targets (Operation ALLIED FORCE). The ensuing 77-day air campaign ultimately led to the withdrawal of Serbian forces from Kosovo and Milosevic’s acceptance of international peace terms. A new NATO mission in Kosovo could begin, as NATO’s Secretary General at the time expressed “to bring the people back to their homes and build a lasting and just peace in Kosovo”.17

24. On 10 June 1999, in the wake of the NATO led intervention, the UN Security Council issued resolution (UNSCR) 1244, which called for (inter alia) an: "immediate and verifiable end to violence", a “complete verifiable phased withdrawal from Kosovo of all military, police and paramilitary forces” and the “establishment of an interim administration for Kosovo as a part of the international civil presence”,18 paving the way for the UNMIK.

25. UNMIK’s mandate was to ensure "conditions for a peaceful and normal life for all inhabitants of Kosovo and advance regional stability in the western Balkans". The Mission was headed by the Special Representative of the UN Secretary-General whose job it was to ensure a coordinated approach by the international civil presence operating under UNSCR 1244. UNMIK has continued to implement its mandate in a neutral manner and to operate under UNSCR1244 (1999).19

26. In the period that followed, the international community, including the UN and EU, agreed, endorsed and helped to implement (with varying degrees of success) various plans, such as the “Standards for Kosovo”20 and the so called “Ahtisaari Plan”21 geared towards state (re)building, ultimately resulting in Kosovo unilaterally declaring its independence from Serbia on 17 February 2008.22

27. Pursuant to a request from Serbia, on 08 October 2008, the UN General Assembly resolved to request the International Court of Justice (ICJ) to render an advisory opinion on whether Kosovo’s unilateral declaration was in violation of international law. On 22 July 2010 the ICJ rendered its opinion that it was not.23

28. As of 25 September 2013, 106 of the 193 UN Member States have recognized Kosovo as an independent state, including 23 out of the 28 Member States of the EU.24 Kosovo has also joined the International Monetary Fund, the World Bank and other international organizations as an independent state.25 Despite Serbia continues to reject Kosovo’s independence, the latest agreement between Serbian and Kosovar Governments, mediated
from EU and signed on 19 April 2013, may open the door for a future possible normalization of relations.26

A CRISIS-AFFECTED FRAGILE STATE

29. According to the OECD 2013 report on fragile states:27

“A fragile region or state has weak capacity to carry out basic governance functions, and lacks the ability to develop mutually constructive relations with society. Fragile states are also more vulnerable to internal or external shocks such as economic crises or natural disasters. More resilient states exhibit the capacity and legitimacy of governing a population and its territory. They can manage and adapt to changing social needs and expectations, shifts in elite and other political agreements, and growing institutional complexity. Fragility and resilience should be seen as shifting points along a spectrum”.

30. According to the report, Kosovo is a lower-middle-income fragile state and the combination of slow growth, projected falling aid and high aid-dependency places Kosovo on the OECD’s list of countries of particular concern for economic failure and instability.28

31. Over recent years, Kosovo’s Human Development Index (HDI)1 has seen a slight improvement. However, according to the UNDP, Kosovo’s HDI remains the lowest in the region and in Europe.29 Kosovo is one of the poorest countries in Europe with 29.7% of the population living below the poverty line.30 Kosovo’s population is young; the average age is 27.4 years31 and unemployment rates are very high; 30.9% of the working population is unemployed and youth unemployment (defined as ages 15–24) is at 55.3%.32 Just 17% of the rural population has access to safe water (access to public water supply);33 the rest of rural population uses domestic wells, which are more vulnerable to contamination and pollution.34

32. The persistent and continuous political instability in Kosovo during the last three decades, the lack of clarity regarding its present status within the international community, as well as longstanding tensions between its Albanian and Serbian inhabitants, make Kosovo’s continued recovery and bid for independence an ongoing struggle. Riots among the population are still easily sparked amid the constant high level of ethnic tension throughout the country, often erupting in violence that results in a spiral of further rioting and retaliation.35

THE HEALTH SYSTEM PRIOR THE CRISIS

33. Prior to the Kosovo crisis, the health system throughout the Former Republic of Yugoslavia, and therefore the Kosovo region, was based on the Soviet Union’s Semashko health system. In summary, the Semashko health system was characterized by heavy centralization; the state was both the purchaser and provider of care and placed an emphasis on specialist rather than primary care.36 Vertical (or stand-alone) health programmes were commonplace while integrated basic health care programmes were virtually non-existent. For example, ad hoc immunization programmes, such as those against sexually transmitted diseases, were given priority over general antenatal care and mental health care programmes.37

34. Prior to Milošević’s rise to power, health care was provided by health professionals from both ethnic groups (Kosovar Albanian and Kosovar Serbian) working together in publicly funded health facilities on the government pay-roll. However, by the early 1990’s, the central Serbian government under Milošević’s rule had begun persecuting Kosovar Albanians,

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1 The HDI is an index published by the UNDP and is a composite statistic of life expectancy, education, and income indices used to rank countries into four tiers of human development. The 2013 Human Development Report, which contains the HDI, was released on 14 March 2013.
systematically forcing Albanians out of management and senior positions in the public sector, including the health sector, and placing the majority of Kosovo's health care facilities under the control of the Serbian government.\textsuperscript{38} In addition, Kosovo's medical school in Pristina was closed, leaving no available place for continued medical training to Kosovar Albanians (at least not in their own language). All of the aforementioned led to a significant reduction in the number of Kosovar Albanians working in the public health system.\textsuperscript{39}

35. Although the now predominantly Serbian-managed health system remained officially available to Kosovar Albanian patients, in practice they faced the same level of persecution as the Kosovar Albanian health system workers, so that obtaining health care in public health care facilities was unrealistic.\textsuperscript{40}

36. The subsequent vacuum in health care service facing the Kosovar Albanians led to the creation of an alternative, or parallel, health system: the Mother Teresa Society. Those working for and with the Mother Teresa Society managed to organize and staff around 90 clinics throughout Kosovo,\textsuperscript{41} paid for, in part, by the Kosovar Albanians via a shadow tax collection system.\textsuperscript{42} With no formal medical training in Albanian available to Kosovar Albanian health system workers, an underground medical school, connected to the Mother Teresa Society, was established,\textsuperscript{43} which allowed access to medical training, albeit without any clinical training component. Without public medical facilities to work in or run, the managerial skills among Albanians required to run public clinics and hospitals dwindled, resulting in a generation of health system workers with little or no practical management skills.\textsuperscript{44} This loss was to have a long-term effect on the ability of these health system workers to implement the proposed reforms to the Kosovar health system after the Kosovo crisis.

37. During this period of uncertainty for the Kosovar health system, the official Serbian-run public health system was also suffering greatly from neglect and general lack of public funding. Decreasing governmental budgets left the health system crippled, with run down facilities which were ill equipped and understaffed.\textsuperscript{45}

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<th>Summary:</th>
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<td>• Kosovo is a country divided by its multi-ethnic history and culture and this is reflected in the country’s health system.</td>
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<tr>
<td>• Kosovo’s independent status has not been recognized by all members of the international community, including its neighbour: Serbia.</td>
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<td>• Kosovo’s heavily centralized Semashko-style health system was already weakened before the crisis by decades of general neglect.</td>
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<td>• The Kosovar Albanian parallel health system—the Mother Teresa Society—served to provide those forced out of the public health system with provisional health care services, albeit limited in scope and quality.</td>
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</tbody>
</table>
38. War, ethnic conflict, and political violence have a detrimental impact on health and health systems. Immediately after the Kosovo crisis, Kosovo’s health system was in a state of ruin; long standing ethnic conflict, years of neglect and the violence of war had all taken their toll. In 1999, as part of its wider mandate, UNMIK set about addressing the state of the Kosovar health system. UNMIK appointed WHO, as the UN’s specialized health agency, to lead the formation of Kosovo’s new Department of Health—a precursor to what would later become the Kosovo MOH—and to prepare the reform of the Kosovar health system.

**THE CRISIS’ IMPACT ON KOSOVO’S HEALTH SYSTEM**

**How did the crisis impact Kosovo’s health system?**

39. During the war, some 70% of health clinics in towns and villages were destroyed. The main hospitals remained intact but had been stripped of equipment, and medical supplies were scarce. Many Kosovar Albanian health system workers had been displaced, depleting the workforce. Those who stayed behind had been persecuted, often suffering torture, confinement, or worse if they were suspected of providing care to Kosovar Albanian fighters. 

40. Immediately after the war and during the early months of the UNMIK interim administration, displaced Kosovar Albanian health care workers returned in large numbers; many after almost ten years of exclusion from the official public health system. What they returned to was a public health system that had greatly deteriorated, due to the years of neglect and decreasing budgets under Serbian control, but also damage and destruction during the conflict.

**Parallel Health Systems**

41. The now largely redundant parallel Kosovar Albanian health system—the Mother Teresa Society—created out of necessity prior to the war, was abandoned as Kosovar Albanians (both health system workers and patients) returned to the official public health system. However, a new parallel health system run by and for the benefit of Kosovar Serbians developed instead. The Kosovar Serbians, much like Kosovar Albanians previously, found themselves unable to access the new public health system.

42. Paid for by the Serbian government and supported by a well-functioning Serbian health insurance system, this rival health system boasted high salaries for Serbian health system workers willing to remain in the Kosovo region and free health care for Kosovar Serbian patients. The quality of the health care was deemed high, or at least better than that of the official Kosovar Albanian health system and facilities were relatively well equipped and staffed. The high salaries, free health care and perceived high quality of care was an incentive to Kosovar Serbians to participate in this parallel health care system. But another

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*Serbian doctors willing to remain in the Kosovo region and provide health care to Kosovo Serbians were initially paid double the salary of their colleagues located in the Serbian territories by the Serbian government. Later, the “additional payment” for working in Kosovo would be reduced due to budget constraints, but salary levels and budget lines from Serbia still, to this day, remain significantly higher in this parallel health system compared to those in the official health system.*
critical reason was Serbian concerns about providing medical care to or receiving it from Kosovar Albanians. Kosovar Serbians would even travel great distances to reach a Serbian facility even if a Kosovar one were closer.\(^{54}\)

43. Even today, despite evidence from some studies which points towards a lack of utilization and inefficient use of Kosovar Serbian health facilities,\(^{55}\) there is reluctance among responsible individuals on both sides of the ethnic divide to close, or even merge them into the official Kosovar public health system. In fact, for the cost, quality and cultural reasons given above, many believe that it would be a practical challenge to create a single well-functioning Kosovar health system at this stage in the country’s development.\(^{56}\)

44. And yet, while the two health systems are functioning in one society, there is a duplication of effort which is a burden, and potentially a costly one, to the local population. For example, the existence of parallel Health Information Systems (HIS) in Kosovo which are poorly connected to one another prevents critical information from being shared and leaves the country and its population vulnerable to various preventable health-related risks, such as outbreaks and diseases.

**The Health Information System**

45. The Kosovar HIS had been badly compromised as a result of the Kosovo crisis; health information reporting facilities (mainly functioning on the basis of paper records at the time) had been damaged or even destroyed in the violence, along with the health information they housed.\(^ {57}\) Health information collection and reporting was slow to recover in the post-crisis Kosovo and was often performed by different stakeholders, who reported on different issues to different ends. Health information that was collected and collated was of poor quality and rarely generated a comprehensive picture of the health system.\(^ {58}\) This lack of comprehensiveness was emphasized by two factors: the existence of a Kosovar Serbian parallel health system which reported its health information directly to Belgrade, and a lack of coordination between public and private health care workers.\(^ {59}\) The resulting patchy and unreliable overview of the state of the population’s health in Kosovo prevented—and continues to prevent—basing important health related decisions on proper data; this potentially exposed the country and its population to increased risks to public health.

**Public Health Threats**

46. Prior to the Kosovo crisis, the Kosovar population was already at risk from a number of public health threats including long-standing environmental pollution (see Narrative C), lack of access to clean water and poor sanitary conditions. The risk of these public health threats increased significantly during the crisis due to the large number of returning refugees, the direct consequences of military intervention, and the exacerbating effect of civil war on an already poor health system (by European standards).\(^ {60}\) For example:

a. Minefields in Kosovo were (and largely still are) unmapped and the detonation of Unexploded Ordnance (UXO) has directly caused many casualties. UXO also results in other less direct effects on public health, such as limiting access to safe water supplies which often forced locals to build impromptu wells close to their houses and too close to septic tanks, increasing the risk of water-borne diseases.\(^ {61}\)

\(^{*}\) Concerns have also often been raised about the potential negative health effects of the use of depleted uranium in air-to-ground munitions. However, studies from the WHO, the United Nations Environment Programme, and the International Atomic Energy Agency continue to disprove relationship between depleted uranium and health. The international community continues to monitor the long-term impacts of depleted uranium and, in particular, groundwater contamination, calling for a “precautionary approach to the use of depleted uranium.”
b. Hospitals and other health care facilities were damaged or destroyed during military intervention, leading to a general lack of ability to provide sufficient health care.62

c. In the aftermath of the war, the proportion of the population that suffered from post-traumatic stress disorders increased from 17.1% to 25%.63 More than a decade since the end of the war, this issue continues to have an impact on the Kosovar population.64

How did the international community respond to the crisis?

Implementing a New Health System

47. As described above, years of neglect and the results of the conflict had left the Kosovar health system crippled. Donors and participating NGOs were willing to channel funds and resources into Kosovo’s health system, but were not prepared to support rebuilding the outdated, inefficient, centralized system based on the pre-crisis Semashko model, deemed unsustainable.66 Instead, a new health system was designed and implemented which would apply a new, more modern approach to public health care.

48. After its 1999 UNMIK appointment at the end of the conflict in 1999, the WHO found itself under pressure from donors and international stakeholders to show progress and urgently began the policy forming process. The WHO assembled a health policy group, including international and national experts. The aim of this group was to prepare proposals for a series of health system reforms that would serve as the foundation for Kosovo’s future health system. The WHO based its policies on three main inputs:

   a. Assessment of major population-based health issues based on available health data;†

   b. European standards set out in the WHO’s Health for All Policy for the Twenty-First Century;67 and

   c. Consultations with local physicians.68

49. The consultations with physicians initially included Kosovar Serbs and Kosovar Albanians. However, while well intentioned, they were ultimately not very productive. Concerned their contributions would not be taken into consideration in a new Albanian-governed health system, the participation of Kosovar Serbian physicians, while experienced and well versed in how to design, implement, and manage a health system, gradually declined. In addition—despite the UN and NATO forces (KFOR) protection of health facilities—Kosovar Serbian physicians were targeted and attacked by Kosovar Albanians and as a result moved in mass to the enclaves.69 Kosovar Albanian physicians, after a decade of exclusion from the official health system, and little to no experience in how a health system should function, found that they had little to contribute to the process that would shape their new health system.70

50. Instead, it was external advisers who designed the new Kosovar health system policy based on international standards; however, they did not adequately take local requirements into consideration. The resulting lack of participation of local health care workers in the policy planning process would later lead to a sense of lack of ownership of the end product, the health system, which in turn would result in poor implementation of it.71

51. The planned reforms to the health system were intended not only to meet the immediate (emergency) medical needs, but also to contribute to a longer term reform of the

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† Health related data was however limited and unreliable; see paragraphs 45 and 58 for more information on the shortcomings of Kosovo’s Health Information System.
The resulting interim health reform policy, called the **Blue Book**, had eight key features. Just over a year later in the revised interim health policy guidelines in August 2000, known as the **Yellow Book** (Interim Health Policy), twelve key features were described. These features included, for example:

- **a.** Access to service through primary care via family medicine centres based on population catchment areas;
- **b.** Specialist care provided in hospitals on a referral basis from a primary care doctor;
- **c.** Size and location of facilities based on population catchment;
- **d.** Funding (during the interim administration period) derived from external donations and internal tax revenues and co-payments;
- **e.** A mix of public and private provision of services to be available; and
- **f.** Non-discrimination in service or employment.

This new post-crisis health system was radically different from the pre-crisis health system. The pre-crisis health system was heavily centralized and based on specialist care, whereas the cornerstone of the post-crisis health system was primary care via the new *family medicine centres*. Specialist secondary and tertiary care was to be provided in hospitals or other specialist facilities, only available on referral from a primary care health worker.

The new health system received a cool reception from health care workers who felt bypassed in its design and development and its implementation was deemed ambitious:

"The reorientation of the system towards primary care was ambitious, requiring the introduction of the family medicine concept; the establishment of a strong interface between primary and secondary or tertiary levels of care; the management of the decentralisation process to ensure that this led to increased responsiveness to local needs rather than deterioration in the quality of health services provided; and careful oversight by authorities to ensure that physicians did not abuse their ability to work in both the public and private sectors."**

As mentioned above, while the policy contained in the Interim Health Policy set the stage for the reform of the Kosovar health system, it had been largely based on non-Kosovar (i.e. international) standards and had been developed by international experts with little Kosovar national input. The resulting sense of a lack of *ownership* of the Interim Health Policy by those Kosovar health care workers involved in its implementation would later have a negative impact on its success as the new health system for Kosovo.

The Kosovar MOH took control of the Kosovar health system from the UNMIK Department of Health on 04 March 2002. Since then, the Interim Health Policy has been expanded and incorporated into the wider regime of Kosovar Health Law (including various administrative rules and regulations).

**THE NEW HEALTH SYSTEM**

**How successful has the implementation of the new health system in Kosovo been?**

Arguably the biggest impact the international community had on the Kosovar health system was introducing an entirely new model of health care delivery. This is sometimes referred to as the “Big Bang” approach to health care reform. UNMIK, as the region’s official administrator, together with the WHO, had taken responsibility for designing and implementing an entirely new health system for a country that was suffering from the effects of decades of neglect and conflict and recovering from civil war and international intervention.
In this section, we discuss how successful the implementation of this new health system has actually been.

**Primary Health Care – Family Medicine**

57. Implementation of the new health system at all care levels—primary, secondary and tertiary—has been poor and the general concept of *family medicine* has been slow to take root throughout Kosovo. The various reasons for the slow implementation include the following:

a. Despite having received some theoretical training during the Kosovo crisis via the Mother Teresa Society, Kosovar Albanian health care workers returning to the public health system had little or no practical experience in managing and administering a *real* public health system. Initial training programmes provided by NGOs, intended to kick start the primary care sector, were unsystematic and generally too short.\(^{80}\)

b. Primary care health workers struggled to understand the value of and subsequently implement the concept of family medicine. As far as they were concerned, it had been introduced by the international community with little local input. As one local health care worker explained in an interview with the Study Team: *“If no one local responds, the international community and donors make their decision and impose their agendas.”*\(^{81}\) Secondary and tertiary care health care workers were equally reluctant to implement the concept at their level because it generally implied less patients, and therefore less funds and remuneration for them.

c. The slow implementation of the family medicine concept meant that those involved (including patients) saw the primary health care sector more as a referral point for secondary and tertiary care than as a place for primary treatment. This led to oversubscription of the secondary and tertiary facilities, which in turn led to funding issues.\(^{82}\)

d. The general malaise towards the health system in the public health sector was compounded by the fact that the average salary of the public sector health care worker was extremely low. The private sector was generally more lucrative, creating an incentive for health care works to enter private practice and resulting in a lack of competent health care workers in the public sector. A compounding factor was the fact that the MOH lacked the regulatory capacity to oversee private clinics, raising concerns of whether health sector regulations were being adequately met across the board.\(^{83}\)

**Health Information**

58. There were general concerns regarding the new HIS put in place as a matter of urgency by the MOH and the Kosovar NIPH immediately after the conflict. The ability of the HIS to generate and provide reliable information to the MOH was debatable. This was due in part to the fact that health care workers did not have the necessary training to feed information into the HIS and in part because those that did have training didn't use it, preferring to do things the way they were accustomed to, severely undermining the generation of reliable data in the HIS.\(^{84}\) In addition, Kosovar Serbian health care workers would report into their own HIS via Belgrade, resulting in the loss of the health information of that part of the Kosovar population. The disease surveillance system, which forms part of the wider HIS, was also affected: (see paragraphs 81 to 82 and Narrative B).

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\(^{80}\) By way of example, according to an interview from the Ministry of Health, the average salary of health care workers is EUR270 per month while the average cost for accommodation is EUR300 – EUR400 per month.
Governance and Finance

59. Funding was another pressing problem in the implementation of the new health system. International donors—such as Luxembourg (which provided EUR7.8 million in their KSV/014 budget)—provided ample funding for Kosovo’s new health system. While the “Big Bang” reform effort focused on health care delivery, less was done to restructure health sector governance. Some governance aspects of the Semashko model remain in place including that care was to be publically purchased and publically delivered and, at least at the secondary and tertiary levels, would be centrally managed. However, the central government allocated funds to the municipalities for primary care. Here a lack of basic accounting and (financial) managerial skills, practices and resources, compounded by a lack of structural (governmental) oversight, meant that reforming the health care financing system was challenging for those involved. Despite the strict bureaucratic rules at central level, fund allocation tended to be ad hoc and not well documented, presenting a risk of corruption (See Narrative A, which addresses this topic in more depth).

60. The MOH's lack of ability to really implement the Interim Health Policy into a functioning health system was compounded by the fact that donors were governed by their own short time horizons and specific objectives. These donors were generally "focused on quantitative outputs, such as the number of health clinics re-equipped, and nurses trained. Projects that would contribute to the broader reform process, such as establishing standardized training and building the capacity of the Kosovo civil service, were secondary considerations."

A decade of change

61. The Interim Health Policy tried to change the Kosovar health system in various ways:
   a. Attitudes, habits and training of health care professionals;
   b. Orientation and organization of the health system;
   c. Management structures and practices; and
   d. Management tools—such as the HIS and medical records.

62. In its 2004 report on the development of Kosovo's health system, the WHO recognized that to change the health system so completely would, “be a tall order under any circumstance. It is a very tall order in a post-crisis, poor society.”

63. How successful has the implementation been? Generally, according to the WHO, reform has been most successful where it has tried to change external factors, such as training and organization. For example, as Kosovo’s health system has been established the training of health care workers and managers has improved, some elements of the health information system were established (like the outbreak surveillance system) and vertical programmes have been dismantled and integrated into the main health system.

64. While progress has been made in training and health care delivery, problems persist in health governance and the implementation of family medicine. Implementation seems to have been least successful where there was not transparency to give confidence in the new system or appropriate incentives for either management or providers. In particular:
   a. There have been poor investments in management structures and lack of incentives for family physicians. This resulted in a lack of responsibility for primary care at municipality level and positions are often awarded as political prizes.
   b. Secondary health care workers ignore the primary care sector which is still seen as more of a referral system by both professionals and patients.
c. Doctors prefer the better paid specialist work or private practice to working in the public primary care sector. Many doctors even see working in the public sector as a necessary evil until they have enough expertise to specialize or enter private practice.65

65. In addition, the general undertone of ethnic conflict between Kosovar Albanians and Kosovar Serbians continues to hamper any national and international efforts to strengthen Kosovo’s health system. This is perhaps the largest problem facing Kosovo’s health system today and is also the most difficult to address.

66. Table 1 summarizes health system progress based on the components of the WHO Health Systems Building Blocks Framework.

<table>
<thead>
<tr>
<th>WHO Framework Component</th>
<th>Before June 1999</th>
<th>After June 1999</th>
</tr>
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<tbody>
<tr>
<td><strong>Service Delivery</strong></td>
<td></td>
<td></td>
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<tr>
<td>(Infrastructure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Heavily centralized structure.</td>
<td>• Decentralized structure.</td>
<td></td>
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<tr>
<td>• State is the purchaser and provider of health care.</td>
<td>• Emphasis on primary care and family medicine concept.</td>
<td></td>
</tr>
<tr>
<td>• Generally outdated and poorly maintained equipment and infrastructure.</td>
<td>• International investment in health infrastructure and medical equipment.</td>
<td></td>
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<tr>
<td>• Vertical (stand-alone) programmes common-place.</td>
<td>• Private sector practice permitted.</td>
<td></td>
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<tr>
<td>• Kosovar Albanian parallel health system.</td>
<td>• Kosovar Serbian parallel health system.</td>
<td></td>
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<tr>
<td><strong>Health Workforce</strong></td>
<td></td>
<td></td>
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<tr>
<td>(Human Resources)</td>
<td></td>
<td></td>
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<tr>
<td>• Before the Milošević regime:</td>
<td>• Kosovar Albanians dominate public workforce.</td>
<td></td>
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<tr>
<td>o combined Albanian/Serbian public health care workforce.</td>
<td>• Kosovar Serbian parallel workforce paid for by Belgrade.</td>
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<tr>
<td>• During the Milošević regime: Serbian only public work force:</td>
<td>• Public sector clinical training provided.</td>
<td></td>
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<tr>
<td>o Albanian parallel health system workforce.</td>
<td>• Brain drain of professionals from public sector to private sector due to lack of funding in public sector.</td>
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<td>o Limited training Albanian language training facilities.</td>
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<tr>
<td><strong>Information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Systems)</td>
<td></td>
<td></td>
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<tr>
<td>• Non-functioning HIS due to prolonged neglect, damage and/or destruction.</td>
<td>• New HIS implemented.</td>
<td></td>
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<tr>
<td>• Patchy reporting from public and private sectors.</td>
<td>• Provided health information is of poor quality and unreliable.</td>
<td></td>
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<tr>
<td>• Serbian parallel health system reporting to Belgrade resulting in loss of health information.</td>
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<tr>
<td><strong>Medical Products, Vaccines &amp; Technologies</strong></td>
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<tr>
<td>(Supplies)</td>
<td>• Pharmaceutical supply system based on centralized pharmacies of the MOH.</td>
<td>• Centralized pharmaceutical procurement</td>
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<td></td>
<td>• Poor demand/supply management resulting in stock-outs and waste.</td>
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<tr>
<td><strong>Financing</strong></td>
<td></td>
<td></td>
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<tr>
<td>• Socialist funding model.</td>
<td>• Reliant on external donors.</td>
<td></td>
</tr>
<tr>
<td>• Generally underfunded.</td>
<td>• Public sector salaries comparatively low.</td>
<td></td>
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<tr>
<td>• Kosovar parallel health system funded by parallel tax collection system.</td>
<td>• Private sector financing largely unregulated and irregular payments common.</td>
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<td></td>
<td>• Lack of transparency and accountability resulting in perceived corruption.</td>
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<td></td>
<td>• Serbian parallel health system funded via Belgrade.</td>
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<tr>
<td><strong>Leadership</strong></td>
<td></td>
<td></td>
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<tr>
<td>(Governance)</td>
<td></td>
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<tr>
<td>• Socialist, centralized model administered in Belgrade.</td>
<td>• Decentralized model administered by MOH in Pristina.</td>
<td></td>
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<tr>
<td>• Lack of Kosovar Albanians in managerial positions in public health system.</td>
<td>• Bilateral international community cooperation aid implementation of reforms.</td>
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<tr>
<td></td>
<td>• Frequent turnovers in leadership hindered health system reform.</td>
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The Security Community and the Health System

What has been the security community's impact on Kosovo's health system?

67. The security community was heavily engaged in addressing the refugee crisis during and after the war, so as to relieve the suffering of the many thousands of refugees forced to flee Kosovo by the Serbian ethnic cleansing campaign.

68. NATO and other security community actors, such as UNMIK and the OSCE, as well as those from the humanitarian and development communities, such as UNHCR—who would lead the international relief efforts—national and international NGOs, and donor nations all worked together to support the international humanitarian effort in Kosovo. The success of this coordination effort was debatable.

69. Below and in the respective Narratives, we discuss the impact of the security community on Kosovo’s health system; both during and immediately after the war. We also examine the longer term projects that have contributed to the reform of the health system.

The European Union Rule of Law Mission for Kosovo and Anti-corruption

70. UNMIK was charged by the international community with establishing an interim administration in Kosovo, including the Rule of Law. The Rule of Law is a basic precondition for political, social and economic development with the intention to make a society more stable and secure; it provides systems for criminality to be prosecuted and human rights to be protected. Several groups were involved in reconstituting Kosovo’s justice and security sectors and ensuring that the Rule of Law was properly addressed. In 2009, the EU took a prominent role in Rule of Law sector by, with the blessing of UNMIK, deploying EULEX.

71. Part of EULEX’s mission is to investigate and prosecute instances of government corruption. For example in 2011, EULEX investigated instances of high-level corruption in the health sector. EULEX charged the sitting Deputy Prime Minister, a former Minister of Health, and 10 of his staff with receiving bribes for awarding health contracts and for medicine procurement fraud. Narrative A examines how corruption impacts in Kosovo’s health sector and explores how anti-corruption and rule of law missions might be more effective in preventing health sector corruption in fragile settings.

KFOR and the Refugee Crisis

72. The security community was contributing to strengthening Kosovo’s health system, albeit in a limited way, by 1999. Against this backdrop, on 12 June 1999, KFOR deployed into Kosovo, to provide a secure environment, emergency medical care and assistance with the refugee crisis. KFOR was acting pursuant to the mandate granted in UNSCR 1244 and the Military Technical Agreement between NATO and the Former Republic of Yugoslavia, operating under Chapter VII of the UN Charter as a peace enforcement operation.

73. The exodus of refugees from Kosovo into neighbouring countries that had occurred early on in the crisis produced one of the first opportunities for NATO to work together with the humanitarian and development communities, notably with UNHCR. UNHCR needed NATO’s support managing the refugee situation in Albania and the former Yugoslav Republic of Macedonia; this support was coordinated by NATO’s Euro-Atlantic Disaster Response Coordination Centre. NATO, through KFOR, was more than ready to undertake a humanitarian role in that respect:
The ink on Ogata’s letter to Solana was hardly dry before the British engineer brigade in KFOR on Saturday morning started levelling the ground near the abandoned airfield just south of Blace [Macedonia]. Initial supplies of tents, blankets, water and food were brought in from NATO; UNHCR helped to lay out the camp and later organized blankets. During the late evening of 4 April—Easter Sunday in the Gregorian calendar—the first buses brought refugees from the “holding area” at Blace to two newly established transit camps (Stenkovec 1 and 2). Initially 5,000 were transferred, and gradually more followed. 107

74. In terms of the immediate health response to the crisis, KFOR assisted in setting up Internally Displaced Persons (IDP) camps, and also played a significant role in supporting emergency health care delivery making medical supplies and equipment available to refugees in IDP camps. 108

75. But KFOR also contributed to a longer term resolution of this aspect of the health crisis. The various Multinational Task Forces (MNTF), whose health care facilities’ main mission was to provide medical assistance to military personnel, also provided assistance on request and as resources were available, in the form of civilian medical evacuations and first aid to civilians who needed it. 109 In some cases, they also provided training to local doctors and nurses. 110 This training not only benefited the health system in the short-term by providing immediate assistance in the form of local health care workers (able to speak the language of their patients), but also generally benefited the health system in the longer term as well.

76. In its response, KFOR was careful not to seem biased and provided Kosovar Serbs and other minorities with access to the same facilities and support as Kosovar Albanians. 112 This helped KFOR build a reputation as an impartial actor that would work alongside both Kosovar Albanians and Kosovar Serbs. 113

77. However, the MNTF’s efforts were ad hoc and rarely properly coordinated with each other or with other international and national actors, resulting in the local perception of localized and isolated support, rather than a concerted effort by KFOR to contribute to the wider international and national long-term health system recovery efforts. 114

78. Having said that, without NATO’s logistics capabilities, 1.5 million displaced human beings would likely have suffered longer and more profoundly. As set out in the NATO Review of Summer 1999, “While NATO is not a humanitarian organisation, its considerable capabilities complement those of relief agencies and can assist in meeting many of the basic needs of refugees.” 115

79. However, health care assistance provided by the security community, KFOR specifically in this case, was really only limited to what was strictly necessary, i.e. emergency care, and there were only some instances of where the support provided could be deemed to have had a more long-term impact. One example of this is the KFOR’s role in mentoring and training the Kosovo Security Force to develop its national emergency response capabilities, such as responses to environmental emergencies like earthquakes, floods, epidemics (H1N1), avalanches, and hazardous material, including UXO. 116

80. The lack of long-term action was perhaps partly due to the fact that no one asked the security community to do anything more than provide emergency support and partly due to the fact that there was no (formal) coordination mechanism in place for the security community to be asked. There was no formal way for the security community to interact with local authorities and the humanitarian and development community. The result was that KFOR’s assistance and support, while extremely important, appeared to be localized and

1 Mrs. Sadako Ogata was the High Commissioner of UNHCR during the years 1990–2000

† Mr. Javier Solana was the NATO Secretary General during the years 1995–1999
isolated and was never able to feed into a wider national health strategy. Local political authorities perceived this to be a missed opportunity for NATO and the health sector.\footnote{118}

**EpiNATO – NATO’s Health Surveillance System (HSS)**

81. NATO monitors the health status of its troops in areas where they are deployed. NATO’s own epidemiological monitoring system (EpiNATO) was first created in 1995 and was recently improved (EpiNATO-2). The EpiNATO-2 system is used to monitor and report on any incidences of disease or injury of (deployed) NATO troops and feeds into NATO’s wider Deployment Health Surveillance Capability (DHSC) to allow for analysis and dissemination. Both EpiNATO systems have been implemented for KFOR.\footnote{119}

82. The health-related information NATO gathers from the use of EpiNATO-2 is currently restricted to military use. But its usefulness to the host nation authorities and humanitarian and development community actors working in a crisis-affected fragile state is self-evident. Where a national HSS is missing—as is often the case in crisis-affected fragile states where the crisis at hand may have rendered all/some of any such system useless—military health surveillance information could fill the resulting information gap or could be used to complement existing international HSS such as the WHO’s Early Warning Alert and Response Network (EWARN). This topic is further discussed in Narrative B.

**Detecting Lead Contamination**

83. In October 1999, when KFOR troops moved into the northern region of Mitrovića, in the vicinity of the Trepça mining complex, they detected an extremely high level of lead contamination in the environment, presenting a potential health risk to the troops. Force protection surveys, carried out as a matter of military routine, soon highlighted the real risk of lead poisoning, not only to the troops, but also to the local population.\footnote{120}

84. UNMIK, in charge of the region at the time, assisted by KFOR, closed down the main source of the pollution: the Zveçan smelter. However, the longer term effects of not only decades of pollution, but also the action taken by KFOR to protect its troops and the population from that pollution, have had a profound socio-economic impact on the region.\footnote{121}

85. Pollution in Mitrovića, and indeed in Kosovo in general, is deemed one of the main challenges to the future of the country. The related health problems mean a weakened work force, which undermines economic recovery and political stability.\footnote{122} However, persisting ethnic tensions in the affected regions continue to hamper local and international efforts to get the pollution under control and provide those suffering from its consequences—both in terms of health and economy—with the help they need. This situation represents an area where the interests of the security community and the humanitarian and development community sharply but unexpectedly overlapped. More information on this story can be found in Narrative C.

**The impact of security community contributions in terms of the WHO Health System Building Blocks**

86. Overall contributions by the security community have had an impact on many of the WHO Health System Building Blocks as depicted below in the following figure:
COORDINATION MECHANISMS

How did the relevant security community actors coordinate their health system strengthening efforts with each other and with the host nation and how successful were they in doing so?

87. From analysis of the Kosovo case study, we find that one of the main problems hindering the effectiveness of health system strengthening efforts in Kosovo was a general lack of coordination among the actors involved in the response to the crisis, both in the short and longer term. This lack of coordination appears in three levels of interaction; national, national–international and international.

88. At the national level, one of the most obvious causes for the lack of coordination is the ethnic divide between Kosovar Albanians and Kosovar Serbians which has resulted in the existence of parallel health systems preventing any attempts at state-wide implementation of a general health system from having much success. This is most easily illustrated in terms of Kosovo’s HIS which is reliant on state-wide input from local health care workers. But with Kosovar Albanians reporting to Pristina and Kosovar Serbians to Belgrade, Kosovo’s official health picture can never be complete or, therefore, reliable.

89. But there has also been a lack of coordination at the national–international level as well. For example, donors willing to finance Kosovo’s new health system, while having the best of intentions, have had their own timelines and targets to meet which have not always necessarily aligned with or been in the best interest of those of the Kosovar health system. The resulting pressure from donors has seemingly forced a hurried and fractured implementation of the new health system, perhaps denying Kosovar health care workers and their patients sufficient time to adjust to the new system. Ultimately this has resulted in, at
best, a delayed implementation of the health system, at worst outright rejection thereof and a return to the old ways.

90. Lack of coordination at the international level was apparent as well. The mandates of security organizations generally do not explicitly include protecting or reconstituting health systems in fragile states. In addition, their intervention in health and health sector affairs has not traditionally been welcomed by development and humanitarian actors because of the latter’s need to always be perceived as neutral. Yet, as described in the narratives, the security community was called upon to protect threatened health workers and health infrastructure as well as to participate in the humanitarian response to a massive refugee crisis. The lack of explicit mandate, focus and training to address these issues meant the security community was responding to them in an ad hoc manner and largely in isolation from international and local health actors. Joint forums and coordination mechanisms for anticipating, analysing and addressing public health issues were lacking.

91. While there are some guidelines and regulations governing the relationship between the security community and the humanitarian and development community, such as the Oslo Guidelines\textsuperscript{123} and the UN Civil-Military Guidelines & Reference for Complex Emergencies,\textsuperscript{124} such guidance invariably only covers the short term action required and does not cover long-term project coordination such as required for health system strengthening.

\begin{center}
\bf{Summary:}
\end{center}

\begin{itemize}
\item Health sector reform entailed an ambitious effort to restructure the governance and delivery of health care in Kosovo. The success of the implementation was mixed:
  \begin{itemize}
  \item \textbf{successful}, in training family physicians, decentralization to municipalities and, partially, health system reorientation to primary care;
  \item \textbf{less successful}, in building a management and oversight structure able to govern the sector (i.e. transparent financing/procurements system and health information systems)
  \end{itemize}
\item The lack of participation of local health care workers in the design of the new health system led to a lack of participation in its implementation as well.
\item Corruption is present in Kosovo’s health system. EULEX has taken, and continues to take, action as part of its Rule of Law Mission to counter and prevent it.
\item KFOR successfully assisted the humanitarian effort in the immediate aftermath of the Kosovo crisis.
\item KFOR’s actions to protect the health of its soldiers and the local population in Mitrovića had indirect consequences for the local population that still impact national health and economy today. However, taking no action was not a realistic option in this case.
\item Coordination was lacking between all actors involved in the initial crisis response and the longer term health system strengthening which may have contributed to slow implementation of the new health system.
\end{itemize}
FOOD FOR THOUGHT – A DISCUSSION OF OUR KEY TAKEAWAYS

92. Major social rifts still exist between the Kosovar Albanians and Kosovar Serbians and the resulting segregation is reflected in Kosovo’s health system. In the last two decades, both ethnic groups have, at different times, found themselves denied access to the official public health system and each has in turn created its own parallel health system as a consequence.

93. The Kosovar Serbian parallel health system still functions today, independently from the official Kosovar (Albanian controlled) health system. In this case, two independent health systems functioning in one society do not increase the level of health care for the population, but rather they decrease it. Neither system is able to provide a full and complete service without the cooperation of the other and cooperation between Kosovar Albanians and Kosovar Serbians is something that is still lacking more than a decade after the end of open fighting.

94. This lack of national level cooperation and coordination has certainly hampered health system strengthening efforts by the international community, but it is just one of many factors that has played a role in terms of the successes and failures of health system strengthening in Kosovo. Below we discuss our key takeaways from this case study.

The Importance of Strong Governance in Health System Strengthening

95. Absent, or weak governance of various aspects of the Kosovar health system, when poorly supported by international donors has undermined health system strengthening efforts in general. The connectivity and overlap among the different aspects of a health system—in terms of the WHO health system framework building blocks—means that a weakness in one area will have a knock-on effect in other areas.

96. One obvious factor that has undermined health system governance in Kosovo has been the existence of an independently functioning parallel health system. In addition to the obvious duplication of effort and cost, gaps in health information, caused by independent reporting methods and unreliable sources, leave the country more vulnerable to public health threats and prevent important decisions from being made. Another undermining factor is the divide in the official health system between the public and the, largely unregulated, private sector. This divide has been caused by poor implementation of the new health system and a lack of incentive for health system workers to remain in public health care.

97. Weak governance often leaves the door open to corruption, undermining not only the effective management of a state and its health system, but also the population’s perception thereof and any efforts being made to strengthen it. Governance and anti-corruption are areas where the security community can, and does, make a real contribution in terms of health system strengthening. For example, in Kosovo EULEX has already cracked down on corrupt practices within the MOH and arrested and prosecuted those involved.

Coordination of Efforts is Key

98. In this report we describe a lack of coordination in strengthening Kosovo’s health system on multiple levels that appears to have been caused by the absence of formal or informal coordination mechanisms which would allow all actors, be it from the security community, the humanitarian and development community, and/or the host nation, to
connect with each other in a way that would ensure the most efficient response to a crisis situation. With multiple national and international actors all acting in the same space, essentially trying to achieve the same thing—health system strengthening—a lack of coordination among them will almost certainly hamper each one’s efforts and the effort as a whole. Without the ability to function as a coordinated unit, actors will invariably either get in each other’s way or cause gaps in crisis response, producing less than optimal results and a sense of frustration at not being able to do more. According to Aristotle, the whole is more than the sum of its parts. This appears to be true when it comes to the international community’s response to health system strengthening in crisis-affected fragile states.

99. For example, the risks of public health threats due to post-crisis conditions (poor hygiene, inadequate sanitation, water contamination, etc.) are faced by all: the local population and actors from the security community and humanitarian and development community when operating in the crisis-affected fragile state. The separate and independent collection of health information by the host nation, security community and humanitarian and development community invariably leads to gaps in knowledge or conversely, duplication of effort in information collection. During a crisis, managing public health risks depends on having access to such information. Yet there is no formal comprehensive information sharing mechanism for the host nation, security community, and humanitarian and development community to make use of.

100. While there are some guidelines and regulations governing the relationship between the security community and the humanitarian and development community, such guidance invariably only covers the short-term action required and does not cover long-term project coordination such as would be required for health system strengthening.

101. This lack of coordination, especially in the area of long-term development, generally stems from a tradition of separatism between the security community and the humanitarian and development community based on some core principles: the security community cannot act beyond the scope of its mandate; and the humanitarian and development community needs to remain neutral (or at least be perceived to be unbiased). When these principles are applied together, they leave very little room for practical coordination.

The Long-Term Impact of the Security Community’s Actions

102. The security community is often faced with balancing the need to take immediate action versus the potential long-term implications of that action. This is illustrated in Narrative C which takes a closer look at pollution discovered in the Mitrovica region.

103. In that particular case, UNMIK, with KFOR’s assistance, shut down the Zveçan lead smelter, putting an end to the continued pollution of the environment and the immediate health risk to the troops and the local population. But the longer term socio-economic implications of that action to the region and its inhabitants have been considerable. Kosovars did not consider lead pollution to even be a health threat until the security community arrived on the scene.

104. The alternative to taking action—taking no action at all—is not often a realistic option for the security community. Indeed, sometimes taking no action could be more harmful than taking the wrong action. This may have been the case in Mitrovica. KFOR could have chosen to just remove its troops out of harm’s way and not share the information regarding the health threat with UNMIK and the host nation. But what would have been the (long-term) health outcome for the local population in that case? What would have been the result of the reduction in stability and security that KFOR’s presence in the region engendered? While we can never know the answers to these questions, we can speculate that KFOR would have been accused of only acting in its own interests and not considering the longer term needs of the host nation and local population.
CONCLUSION

105. This Kosovo Case Study shows that health system strengthening is a complex effort since all the elements are interconnected; a weakness or strength in one will have an impact on another. This is true under normal circumstances but becomes particularly apparent in the case of a crisis-affected fragile state. In addition, each fragile state and each crisis will be unique, requiring a bespoke approach every time.

106. However, certain key elements can be drawn from the Kosovo case study that are of particular importance in relation to health system strengthening in a crisis-affected fragile state; Governance, Coordination and Long-Term Impact. Health system strengthening efforts will inevitably be affected when these elements are neglected by the international community acting in a crisis-affected fragile state.

107. Perhaps the security community’s clearest role in health system strengthening is in creating the secure space in which all actors—from the security community, the humanitarian and development community and the host nation—are able to provide immediate relief to those in need; in terms of the health system, they can begin the task of health system strengthening. Providing a space for all actors to work successfully will require coordination among all actors. Security forces, in particular, must be aware of which elements of the health sector they should protect or in which ways they can or cannot effectively contribute. The Kosovo case study serves to show that the security community has capabilities that complement those of relief agencies and the host nation in terms of crisis management. Without proper coordination between the relevant actors, these capabilities may not be used to their best effect or, potentially worse, even be misapplied with potentially detrimental effects from a long-term perspective.

108. And yet, there is nothing or at best, very little in the way of formal or informal mechanisms in place to facilitate coordination. An ad hoc reaction may be successful in the short term, but longer term impacts may be overlooked without the input and coordination of all actors involved.
THE NARRATIVES
NARRATIVE A: 
CORRUPTION AND GOVERNANCE IN KOSOVO’S  
HEALTH SYSTEM

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1. Existing research shows that health systems are particularly vulnerable to corruption. As such, they deserve special attention on the part of international security missions with a mandate to establish Rule of Law and combat corruption. In Kosovo, concerns about weak governance and corruption in the health system are longstanding and public anger over poor and corrupt governance generally contributes to periodic civil unrest and violent riots.

2. With the exception of recent indictments of high-level government officials for health system procurement fraud, the security community in Kosovo has had limited involvement in supporting good governance in the health system. This narrative explores how some of the problems governing Kosovo’s health system arose, making it vulnerable to corruption, and how the experience in Kosovo suggests what the security community, in particular those elements concerned with promoting the rule of law, can do to promote good governance from an early stage in future similar missions.

TACKLING CORRUPTION IN KOSOVO – EULEX

3. On 06 July 2012, special prosecutors from EULEX charged 11 former and current Kosovar MOH officials with abuse of official position, entering into harmful contracts, and misuse of economic authorization. One of the accused, Bujar Bukoshi, the sitting deputy Prime Minister at the time, was accused of receiving bribes for awarding health contracts when he was Minister of Health. His second in command at the Ministry, permanent secretary Ilir Tolaj was also charged.

4. The charges were notable for several reasons. First, they represented the most prominent security community involvement addressing corruption in the health system in Kosovo to date. Second, brought by EULEX, they reflect the international community’s growing concern about corruption as a destabilizing force in Kosovo.

5. EULEX is the largest civilian crisis management operation ever launched under the European Security and Defence Policy. Starting in 2009, EULEX has employed upwards of 2,000 judges, police officers, prosecutors and administrators and boasts an annual budget of EUR 111–140 million. Its budget is now roughly twice UNMIKs (EUR111 million vs. US$45 million in 2013) and is about a quarter of what UNMIK’s entire budget was—US$460 million—at its height in 2000.

6. While conceived primarily as a mentoring program for Kosovar rule of law institutions, EULEX is considered part of the security community because it retains law enforcement powers: EULEX can independently investigate, charge, prosecute, and convict Kosovar citizens. It exercises these powers to address cases considered too sensitive or serious for Kosovar authorities to handle at present, such as inter-ethnic and organized crime, terrorism, political corruption and property-related crimes. EULEX publicizes its law enforcement functions in order to convey to both Kosovars and the international community that it takes corruption seriously. For example, one of its most recent public relations campaigns highlights its growing number of high-level investigations, arrests and prosecutions of Kosovar leadership.
While the security community has only recently addressed health system corruption, Kosovars’ concerns about health system corruption are longstanding

7. While the high profile investigations of fraud and embezzlement represent the security community’s most significant involvement addressing health system corruption to date, Kosovars concerns about corruption—in the health system in particular—have been a constant theme over the last decade in numerous health system analyses including:

   a. In 2003 the UNDP conducted the first of its biannual surveys on Kosovo corruption and perceptions of corruption. In 2003, 70% of Kosovars of all ethnic groups viewed hospitals as corrupt institutions with 36% of those who visited hospitals reporting direct experience with corrupt practices—more than any other institution. 135 This perception decreased somewhat but remained between 40–50% in the years 2010–2012. 136

   b. In 2009, investigative journalists undertook an independent investigation that confirmed the typical experiences Kosovars had when interacting with their health system. The investigation comprised of dozens of site visits over 18 months to health facilities around the country and over 400 interviews with officials and patients. 137 The journalists documented scores of directly observed instances of misappropriation of funds and resources in Kosovo’s public health system. Examples included physicians working in their private clinics while collecting salaries from public clinics, many of which were left unstaffed as a result; patients being charged for services and medicines that were supposed to be free; and apparent discrepancies between reported purchases of medications and what had actually been received. 138 Their report found:

   “[the health system is characterized by]...inadequately supplied pharmacies, limited and poorly maintained medical equipment, inconsistent and often delayed work of the medical staff, widespread engagement in both public and private institutions, staff redirecting patients to private clinics without acceptable reasons and various other forms of corruption.” 139

   c. A 2003 survey found that 53% of Kosovar Albanian respondents had had to make unofficial payments to receive health services. 140

Kosovar’s discontent with the quality of their governance leads to instability

8. The UNDP report monitoring attitudes and experiences with corruption also notes that more than 80% of Kosovars view corruption as a problem in their everyday life and distrust political leaders—both international and Kosovar—to address it. The report concludes:

   “Public perceptions of widespread corruption have the detrimental effect of undermining the legitimacy of government institutions in the eyes of their constituents, regardless of actual corruption levels. Kosovars will continue to take to the streets in protest rather than engage in constructive civic participation if they do not view government institutions as legitimate.” 141

9. Follow up surveys conducted annually since 2005 found that more than 50% of Kosovars, seeing no option through normal political processes to initiate change, are willing to take to the streets to protest poor governance. 142 And while Kosovars tend to blame their government for lack of economic progress and institutional development, they sometimes view the international community as complicit. The risk of violent protests over inept governance and perceived lack of international support to address it bears out in analyses of the anti-UNMIK riots of 2004 and the anti-EULEX protests of 2009. 143

10. Taken together, the findings of these reports regarding health sector corruption and analyses of violent protests suggest corruption and resulting poor governance fuels civil unrest, and interactions with the health sector is one of the primary ways Kosovars experience this corruption and poor governance. As one study participant commented, “The health clinic is one of the main places where Kosovars meet their government.” 144
Why has the security community taken so long to address corruption in Kosovo’s health system?

11. Given that health systems are prone to corruption and public grievance over their poor performance can contribute to civil unrest, why wasn’t the security community more involved in addressing health system corruption in Kosovo earlier in the post-conflict era?

12. One reason was the security community was initially distracted by a wide array of crises including preventing a reinvasion of the province by Serbia, trying to restore basic order, confront widespread criminality, and reconstitute the justice system.  

13. A second reason is the traditional separation between the spheres of health and security. Global health organizations and security groups, even when working under the umbrella of the same UN administration as in Kosovo, may have limited formal contact with one another. Security actors may view supporting the health sector as peripheral to their mandate. Health organizations may be wary of appearing too political by working with security actors, thereby compromising the impartial nature of health initiatives.

14. Reviewing the story of health reform in Kosovo, however, suggests several ways in which security community input may have improved the performance and transparency of Kosovo’s health system, yielding benefits for Kosovars in terms of both health and security. Three ways in which security community input may have been helpful are explored below.

**Preventing Health Sector Corruption**

15. Research on the effectiveness of foreign aid in crisis-affected fragile states affirms the need to lay the foundations for good governance as early as possible—even at the peace negotiating table. When anti-corruption and governance provisions are incorporated into peace negotiations, the risk of recidivism into violence is lessened. In addition, development and stability efforts, no matter how well funded, are unlikely to succeed in post-conflict settings if governance is not supported.

16. Health systems are complex and difficult to reform even in developed countries during peacetime. In fragile, newly formed and crisis-affected fragile states, stewards of the health sector must make critical decisions about the scope, scale and structure of the health system. For example, completely public health systems, like the one the international community established in Kosovo, carry a high governance burden. One part of the MOH must finance and purchase care, which includes collecting actuarial data of the population, establishing and administering health financing programmes, deciding which services it will pay for, and monitoring outcomes. Another autonomous part of the MOH must provide the care, which includes administering a medical civil service, building and managing health centres and hospitals, and securing supplies and medications. Meanwhile the MOH must also set general policies and health priorities, respond to emerging health crises, regulate the private sector, and manage relationships with multiple donors. The greater this governance burden the more complex the administration that carries it needs to be. And the more complex the administration, the higher the level of managerial and leadership skill required on the part of its stewards. Establishing such an administration and training its leaders in a fragile state depends upon sustained and carefully sequenced donor support.

17. Sustained and effective investment in establishing Kosovo’s health administration didn’t happen in Kosovo. While donor investment in the health sector was initially robust, it was not sustained. In 2002 when UNMIK turned control of the health system over to Kosovars under the Provisional Institutions of Self Governance (PISG), budgeting and auditing systems were weak or non-existent. The health civil service was not in place. Pharmaceutical procurement systems were primitive and impossible to monitor. Managers of health facilities had no budgetary discretion or control over hiring or procurement, and thus had
limited ways to manage facility performance.\textsuperscript{152} Health information reporting systems were poor or non-existent, so health needs of population remained difficult to assess and performance of sector difficult to gage.\textsuperscript{153} As one review noted:

“Government capacity was not enhanced by the activities of donors. Donors had short time horizons and dispersed most of their programming funds in the first two years of the mission (1999–2001). While this ensured that immediate humanitarian needs were met, it undermined efforts to achieve longer-term development goals. …They focused on quantitative outputs such as the number of health clinics re-equipped, and nurses trained. Projects that would contribute to the broader reform process such as establishing standardized training and building the capacity of the Kosovo civil service were secondary considerations…Most donor funds went to hundreds of NGOs not the Department of Health and the donors did not report to the Department.”\textsuperscript{154}

18. The result of failure to establish administrative and managerial capacity was a sector highly vulnerable to corruption. One illustrative example was the procurement system that was largely put in place as a matter of expediency by the international community at the beginning of the reconstruction process. Highly centralized, the MOH procures essential pharmaceuticals and consumables for all public health care facilities and all supplies and equipment for secondary and tertiary care centres.\textsuperscript{155} The money for drugs and supplies is dispersed annually with little opportunity to adjust this funding stream throughout the year.\textsuperscript{156} One problem with centralized procurement is it may be easily captured by one group of unscrupulous public employees. One study participant explained:

“Pooling all the purchasing at the top makes it an easy target for corrupt officials: it takes just one group to subvert a single system to get a significant payoff. If purchasing takes place through dozens of dispersed mechanisms, one or two might be corrupted, but the payoff won’t be as great and the whole system won’t be affected.”\textsuperscript{157}

19. Several study participants noted that procurement corruption at the central level potentially created a difficult political problem for Kosovar’s health system reformers—not just a rule of law problem. If legislators are financially benefiting from procurement system capture, they are less like to vote to dismantle and decentralize it. Reformers, then, must not only confront illegality, they must garner votes from those implicated to reform the sector. Some participants worried this was an issue in Kosovo. One was particularly blunt: “It’s hard for the Ministry of Health to get the political support for health reform because some in the legislative branch are benefiting from the corrupt procurement scheme.”\textsuperscript{158} The charges EULEX brought against high level government officials for health system procurement fraud, while they have yet to produce convictions, suggest these concerns may be valid.

20. For its part, anti-corruption security organizations like EULEX have largely focused on investigating and prosecuting corrupt officials rather than addressing the weaknesses in the health sector that make it easy for corruption to flourish. Participants in this study noted the absence of the security community’s involvement in Kosovo’s health sector, as did the UNDP when commenting on Kosovo’s state-wide Anti-Corruption Strategy and Action Plan. The UNDP report stated:

“While Kosovo’s anti-corruption strategy is quite comprehensive, it does not address the poor quality and delivery of public services in its discussion of the causes of corruption. As the findings of our surveys indicate, the prevalence and tolerance for corruption are very high in regard to institutions that are responsible for public service delivery. Hence efforts to enhance the quality of these services must be included in any anti-corruption effort.”\textsuperscript{159}

21. Thus, Kosovo’s story suggests that the critical period for improving health sector transparency and preventing corruption is during the health reform planning process. This is
when donor enthusiasm and funding is greatest and when donors make critical decisions about the timeframe of investments in budgeting, auditing, and procurement systems.

22. Had security actors been at the table for the health reform efforts in Kosovo in the early phases of health sector planning, they may have been able to promote good governance in the health sector in several ways. First, they could have presented to donors the security rational for long-term investments in budgeting, auditing and procurement systems in the health sector. Framing these investments in terms of enhancing security in the long-term could have potentially convinced health sector donors to make these investments, as well as attracted the attention of a wider circle of donors—not just those interested in health. They also may have been able to provide feedback to UNMIK as to the importance of quickly establishing a credible and competent MOH from a security perspective—an argument that may have gotten more traction if made by security officials rather than those from the health sector.

23. Further, if security actors understood the structure and functioning of the proposed health sector reforms, they would gain insight into the particular ways in which the health sector may be exploited. They would then be well positioned to train Kosovar law enforcement agencies on how to monitor and mitigate these vulnerabilities.

24. Similarly, security actors in Kosovo possess critical links to a wide array of civil society corruption watchdog groups. If involved in the health sector reform process, security actors could provide valuable information to these groups about how to improve the health sector’s transparency and performance.

DETECTING CORRUPTION

25. One source of power to generate the political will to reform and reconstruct health systems is good system performance data. Without systematic health management information, it is hard for health system leadership to know how to direct health resources. In Kosovo, HISs are rudimentary, with the result that there is limited data regarding utilization of facilities, demographics of the patient population, patterns in approaches to care, prescribing practices, the degree to which staffing and patient needs are matched, patient safety and reporting of adverse events, and infant and mortality data.

26. While donors and health sector leaders acknowledge the lack of a HIS is problematic, differences of opinion over how to best address it have emerged. The dominant view is that the structure of the Kosovar health system is unable to accommodate data driven practice: clinic and hospital managers, for example, do not control most aspects of their budgets or staffing and therefore cannot improve the management and outcomes of their institutions. Giving them performance information when they have no means to change performance, will be of little value. Thus, most donors have advocated that in Kosovo development and implementation of health information systems should take place within the larger context of health sector reform.

27. However, waiting to implement health information systems means monitoring corruption and exploitation of the sector is much more difficult. Supplies can’t be tracked, stock-outs can’t be monitored, and inappropriate staffing (for political gain or otherwise) can’t be criticized or addressed. From a security community perspective, having regular performance data—even short term independent audits—would help improve efforts to regulate the health system and help generate political will for health reforms.

28. Some short term temporizing solutions to gather health and health sector performance data have been suggested in Kosovo and in other post-conflict environments. In Kosovo the expansion of health information pilot programs is finally underway. In Afghanistan, the Ministry of Public Health and the World Bank worked with an independent academic
institution to develop a balanced score card to assess health clinic performance with good effect. ¹⁶⁴

29. These bridging solutions to the problem of lack of health information and health sector performance monitoring would be beneficial in monitoring misappropriation of funds. The security community’s input into developing and promoting health information systems could be beneficial in several respects.

30. Security actors may be able to advocate for collection of such health system data to donors, who might not necessarily understand how lack of this information could lead to rule of law problems down the road.

31. In some fragile state contexts securing access to health facilities so data collection can take place may be a problem. Security actors could help develop a plan to facilitate collection of this data by health officials.

32. Security actors could suggest what health sector performance data would be useful for anti-corruption law enforcement and anti-corruption civil society groups to know so they can more effectively monitor the sector for misappropriation of funds.

ADVOCATE THE IMPORTANCE OF HEALTH SECTOR TRANSPARENCY TO POLITICAL LEADERSHIP

33. Over the past decade, with the support of academic institutions and the World Bank, a credible pool of health system reformers has emerged in Kosovo. They face tremendous headwinds in reforming the health system: they must figure out how to establish a purchaser-provider split within the MOH; give health facility managers the autonomy and tools needed to improve performance; rein in overstaffing of health facilities, implement a modern and transparent procurement system, wrest control of the financing away from a political class that may be benefitting from opaque accounting practices, and regulate the ever growing private sector which has taken hold in the absence of a credible public one. All this while hoping the government doesn’t change and reverse the momentum for reform.

34. Nevertheless, new leadership has made progress in advancing a major health reform law that contains measures to improve the transparency and accountability of the health sector. However, at the time of this study, health sector leaders voiced concern they faced little political support from international and Kosovar politicians alike in advancing these reforms.¹⁶⁵ When asked how the security community could support these reforms aimed at enhancing transparency, one high level MOH official explained, “If only one representative from NATO would come with me to our intergovernmental meetings to put [health reform] on the national agenda that would be enough to make progress [in advancing the health reform law].”¹⁶⁶

35. Clearly in Kosovo, elements of the security community, particularly NATO, carry political and moral authority. Interestingly, health officials expressed a desire to leverage this authority to address other health issues they felt impacted security in Kosovo as well. One example was easing interethnic tensions through public health initiatives. WHO and MOH officials, as well as multiple Kosovar health care workers, provided examples of how working across ethnic lines to ensure a clean environment, access to care, access to medications, and professional development opportunities generated good will and softened stances on contentious issues. One high level official commented: “Of course Serb medical professionals will never say they want Kosovo to be independent from Serbia, but if we focus on offering them professional development opportunities, good hospitals to work with, a health system we can all be proud of, they will work with us in a heartbeat.”¹⁶⁷ Others pointed to the environmental contamination caused by a mine in Northern Kosovo as an issue that could also be tackled jointly by both Serbians and Albanians if framed as a public
health issue. “We all have an interest in reopening the mine and we all have an interest in making sure it doesn’t poison our water and land. If we started with this common interest, other contentious issues could be solved [e.g. work permits, travel and customs issues].”

36. Study participants indicated they felt security actors are better positioned to convince local political leadership to tackle these health issues than they were. “It would be much better—and so wonderful—if KFOR would draw attention to public health threats that affect both Serbs, Roma, and Albanians,” one OSCE representative acknowledged.

37. Security actors don’t always enjoy the broad public support or political influence that NATO currently does in Kosovo. Nor are issues of health sector reform laws and ethnic tensions present in every fragile state scenario. Rather, they serve as examples of opportunities where security actors can enhance political stability and rule of law through health system improvement. Only by working closely with health system leaders in fragile states will security actors gain the insight necessary to discern and capitalize on these opportunities.

CONCLUSION

38. The above discussions argue that the security community has a vested interest in improving health system governance in Kosovo and in cases like it for four reasons. First, EULEX has an interest because they are directly involved with anti-corruption investigations that result from weak governance. Second, KFOR and EULEX have an interest because both will be called upon to address protests that result from popular anger over poor governance—anger that sometimes is directed at the international community itself. Third, in general, populations with poor health will fail to develop economically and thus remain a source of regional instability. Fourth, in this case, Kosovo having a better health system may facilitate improved interethnic relations.

39. Health system reform is complex and costly in any environment. The security community could engage with other international actors to invest in transparent practices in health systems from the beginning of post-crisis management efforts. Right now the security community, and rule of law efforts are tilted toward law enforcement rather than addressing the underlying weaknesses in the health system that incentivize corrupt behaviour per se. The experience in Kosovo suggests four ways the security community in future similar cases could support health system governance:

a. Lobby for and, when possible, finance health system governance capacity building, including building transparent budgeting, auditing and procurement systems.

b. Analyse the emerging health system for vulnerabilities to corruption and develop an anti-corruption agenda that can respond to these vulnerabilities; engage anti-corruption civil society groups in health system governance and performance issues.

c. Support the rapid establishment of health information systems that can monitor sector performance and contribute to informed policy decision making.

d. Capitalize on opportunities to enhance political stability and rule of law through health system improvement.
NARRATIVE B: DISEASE SURVEILLANCE IN CRISIS-AFFECTED FRAGILE STATES

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INTRODUCTION

1. Disease surveillance is an epidemiological practice by which the spread of disease is monitored in order to establish patterns of progression and risk. The main role of disease surveillance in a crisis-affected situation is to predict, observe, and minimize the harm caused by outbreak, epidemic, and pandemic situations.

2. Detection and control of many emerging infectious diseases requires a functional health care system. Such a system requires investment in primary health care infrastructure, human resources, training, and provision of essential drugs, supplies, vaccines, and equipment. These things are often not in short supply or even unavailable in a crisis-affected fragile state.

3. During a conflict or crisis, public health deteriorates in areas such as the conduct of immunization programmes, access to clean water and sanitation facilities, or availability of treatment and medical supplies. Any disease surveillance system that may have been in place will likely be compromised, either by damage or destruction or simply from a lack of staff and functioning equipment caused by the conflict. These factors leave a country at risk from outbreaks of infectious diseases such as cholera, hepatitis A, measles, polio, influenza or tuberculosis (TB).

4. Nonetheless, all those acting in a crisis-affected fragile state, whether from the security community or the humanitarian and development communities, require access to comprehensive disease surveillance data to ensure their protection as well as to be able to monitor the health impact they may have on the affected region. Yet currently there is no comprehensive, coordinated and unrestricted disease surveillance system available to either set of actors. Instead each relies on their own health information data which is not, and in some cases, cannot be shared with others.

5. This Narrative discusses the challenges faced in terms of disease surveillance and prevention in Kosovo during and after the crisis. We then take a look at the current disease surveillance systems of the WHO and NATO and how they might be used in future when dealing with crisis-affected fragile states.

REBUILDING KOSOVO’S DISEASE SURVEILLANCE SYSTEM – THE EPIDEMIC PREVENTION AND PREPAREDNESS (EPP) PROGRAMME

6. Prior to the conflict, Kosovo’s regional health information was reported to, and collated in Belgrade, as part of the centralized, Semashko-based health system. However, as discussed also in Chapter 3 of this case study, the Kosovar HIS was badly compromised during the conflict; health information reporting facilities were damaged or even destroyed in the violence, along with the health information they housed. Reliable demographic data was scarce because no census had been performed in decades and generating reliable public health data was difficult without trained staff or proper equipment. Capabilities to respond to health threats such as epidemic outbreaks were very limited. The immediate humanitarian crisis, the damage and destruction of crucial health system infrastructure, lack of access to clean water, the poor sanitation increased the threat of illness and epidemic
outbreaks. Under such circumstances, the importance of having an effective disease surveillance system in preventing and managing the risk of potential major health threats becomes obvious.

7. However, health information collection and reporting was slow to recover in the post-Kosovo crisis environment and was often performed by different stakeholders, reporting on different issues to different ends. That health information which could be collected and collated rarely allowed compilation of a complete picture of the health system and the quality of the information itself was debatable. The lack of a complete picture was exacerbated by the existence of parallel health systems; the official (Albanian) health system reporting to Pristina and the parallel (Serbian) health system reporting to Belgrade. The result was a patchy and unreliable overview of the general state of the population's health in the Kosovo region.

8. Owing to the state of the country and its health system in the aftermath of the crisis, national authorities were not in a position to restore proper disease surveillance swiftly and comprehensively. The international community needed to step in, but no single agency had the capacity to deal with the surveillance of communicable diseases on the scale required. Instead, a joint effort was launched by the International Rescue Committee (IRC) and the WHO, which led to the development and implementation of the EPP programme.

9. The EPP programme was implemented between July 1999 and June 2000 and “aimed to increase the capacity of the [Kosovo NIPH] to reduce excess morbidity and mortality by re-establishing a surveillance system and response capacity.”

10. However, implementation of the EPP programme proved challenging. Incomplete data collection, little to no management experience at the local level—after a decade of exclusion from official health system facilities—and the scarcity of (working) modern communication media—the region has the lowest landline connectivity in Europe—resulted in poor oversight and delayed responses.

11. In addition, parallel surveillance systems tracking specific diseases, such as TB or HIV, continued to function independently and were not integrated into the EPP programme’s system. There was also very little cross-border cooperation regarding disease tracking arising from Kosovo’s uncertain international status. Kosovo’s neighbours did not provide data to Pristina. Instead disease surveillance information from Kosovo’s neighbours was reported to Belgrade where the information was not available to the Kosovar authorities.

12. The EPP programme, including the basic national disease surveillance system, which initially covered 20 diseases*, was handed over to the NIPH in June 2000 and functioned across most Kosovar municipalities, with the exception of the Serbian enclaves which continued to report directly to Belgrade. According to a later evaluation of the EPP programme in 2005, despite the lack of core capacity activities developed in the meantime, the EPP programme was deemed a success in terms of technical skill and resource transfer and was positively received by the NIPH.

13. The EPP programme’s disease surveillance system was reformed in 2012 and is now compatible with WHO’s 2005 International Health Regulation (IHR 2005), supervised by a “Commission for Surveillance and Response” which indicates priorities and policy.

14. The Kosovo case study serves to show that proper disease surveillance is of paramount importance in a crisis-affected fragile state, but that the very fact that it is a crisis-affected fragile state will make (re)building disease surveillance systems challenging and require the concerted and coordinated efforts of all involved:

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*67 diseases had been monitored under the pre-crisis surveillance system.
“The EPP programme was a concerted effort combining the [NIPH], a multilateral organization, the WHO, and an NGO (the IRC) in rehabilitating public health infrastructure to promote sustainability and governmental ownership of the disease surveillance mechanism. The success of the EPP programme depended on clearly-defined roles and responsibilities, communication among the partners, and especially the early and sustained involvement of the local [NIPH] authorities.”

GLOBAL DISEASE SURVEILLANCE

15. How far have disease surveillance systems come since the Kosovo crisis and how might they be used to improve the disease surveillance situation in crisis-affected fragile states now and in the future?

16. To answer this question, the Study Team spoke to expert representatives of the WHO Regional Office in Europe, Division of Communicable Diseases, Health Security and Environment, and of the NATO DHSC.

17. Below we look at the features of the WHO’s and DHSC’s disease surveillance capacities and discuss how these capacities could be used in the future to improve disease surveillance in crisis-affected fragile states.

The WHO’s Early Warning Alert and Response Network (EWARN)

18. The governing body of WHO, the World Health Assembly, approved the new IHR 2005 on 23 May 2005. This regulation forms the legal framework for collective responsibility for global health security, for international response to potential public health events of international concern, and is the key global instrument for protection against the international spread of disease. It provides clear guidelines about national core capacities required for disease surveillance and outbreak response.

19. During humanitarian emergencies, or in the early recovery phase thereof, the national health surveillance systems may be underperforming, disrupted or non-existent, as was the case in Kosovo. In response to this potential shortfall, EWARN can be set up by WHO, particularly for use in the acute phase of an emergency while the routine systems recover from the effects of the disaster.

20. Although the basic functions and descriptions of the EWARN are well-defined, thanks to the unique nature of each humanitarian emergency, each response needs to be bespoke and so the implementation of the EWARN system needs to be (re)evaluated each time it is applied to meet the specific needs of the emergency. There is no standard way of implementing the system. Under IHR 2005, the WHO—the Health Cluster lead for complex emergency response—will ensure a functioning EWARN by adapting an existing (national) disease surveillance system within seven days, or implement a fully functioning new disease surveillance system within 14 days, incorporating data from all relevant health care activities among the affected population.

21. An EWARN disease surveillance system will generally collate two sets of data:
   a. Indicator-based data collected through routine operations, containing specific disease information and/or syndromes. This system is mostly used to track specific diseases or conditions over time and establishes baseline rates of disease, burden of disease, morbidity and mortality.
   b. Event-based data comprised of the organized and rapid capture of information about events that are a potential risk to public health. This information can be based on rumours and other ad hoc reports transmitted through formal channels (i.e. established routine reporting systems) and informal channels (i.e. media, health workers and nongovernmental organizations reports).
22. The EWARN system can incorporate whatever other health information and disease surveillance systems are available and the information generated by them into the EWARN disease surveillance system, presenting the opportunity to create as comprehensive a picture as possible.

The NATO Deployment Health Surveillance Capability (DHSC)

Background – EpiNATO

23. During the deployment of NATO forces in Bosnia-Herzegovina in 1995, the lack of disease surveillance capacity was deemed a missing NATO capability that would be required during future peace keeping missions. As a consequence, the NATO Epidemiological System (EpiNATO) was developed in 1996 and was improved in 2012–2013 (EpiNATO-2). This latter version has been implemented in KFOR since March 2013.

24. The EpiNATO system is used to monitor and report, on a weekly basis, any incidences of disease or injury of deployed NATO troops and feeds into NATO's wider DHSC (described below) to allow for analysis and dissemination. EpiNATO allows health trends to be followed, and public health policy and strategy efficiency to be assessed. The EpiNATO system does not replace the national health surveillance system where it is being applied, but it rather complements it, providing direct information from NATO medical treatment facilities to NATO HQs.

25. However, as far as EpiNATO's outbreak detection capacities go, the system can only detect outbreaks of diseases several days after the onset which can, in some cases, already be too late to take the most effective action. In addition, EpiNATO does not have the capability to determine whether such outbreaks may be attributed to the use of biological weaponry or to natural causes, a factor of some importance for the security community in determining what action to take.

The Role of the DHSC

26. To address the delay in outbreak detection and the lack of capability to determine the nature of an outbreak, NATO needed a so-called Near-Real-Time disease outbreak detection system which could complement EpiNATO's existing capabilities. The French Near-Real-Time-Surveillance System (Alert et Surveillance en Temps Réel: ASTER) was selected for this purpose as it had already been successfully tested and in use for several years by the French Armed Forces.

27. ASTER provides a web-based service using “syndromic surveillance” for the early detection of outbreaks among military personnel immediately after the first consultation (i.e. not waiting for diagnosis confirmation from further consultations or test results) and so provides a more “real time” health picture, able to detect potential outbreak patterns more swiftly than the EpiNATO system which is based on diagnosis reporting and laboratory analyses.

28. Once implemented, ASTER will complement (i.e. not replace) EpiNATO’s disease and injury surveillance. The DHSC’s combined capabilities under EpiNATO and ASTER, should contribute to reducing the delay in outbreak response which, in turn, could significantly reduce the number of cases and, as a consequence, arrest the outbreak spread.

29. The DHSC, the entity responsible for NATO's health surveillance capability, currently functions as an analysis centre which is designed to collect and process health data generated by NATO medical staff from wherever they have been deployed. The DHSC works closely with NATO Nations, which provide the DHSC with two national complementary capabilities: epidemiological intelligence and outbreak investigation and management capabilities.
30. The DHSC is currently working towards two goals:\(^{188}\)
   - 24/7 health surveillance capabilities for all NATO deployment areas, integrating different aspects of surveillance (i.e. veterinary, laboratory, etc.) into the DHSC capabilities; and
   - Developing a multinational Near-Real-Time Surveillance System to function as a comprehensive interoperable system for NATO.

**Towards a Coordinated and Comprehensive Disease Surveillance System**

31. As the Kosovo case study demonstrates, the EWARN system may face challenges during a crisis and its immediate recovery phase that could prevent it from working optimally. Such challenges might include: unavailable resources, lack of or limited security, or limited infrastructure facilities. In addition, a lack of border control, common in a crisis-affected fragile state, or other security related matters, could facilitate transmission of trans-regional diseases in an already weak health environment while poor relations with neighbouring countries may hamper the health information exchange and could result in cross-border outbreaks going undetected.

32. These challenges, certainly those relating to providing security and stability, could be met by the security community which is uniquely equipped to resolve many of them swiftly and efficiently as well as to assist with providing a significant amount of emergency health care to the civilian population.

33. But the contribution of the security community could be even greater, i.e. beyond that of just providing security and practical assistance where required. The security community is often among the first to arrive on the scene in a crisis-affected fragile state, such as Kosovo and will invariably perform an analysis of the health situation and any possible weaknesses in public health surveillance, both for force protection purposes and as part of maintaining a high level of awareness about the general situation. This data, produced for NATO operations by the DHSC, could be included and integrated into the EWARN system, which is already equipped to be able to integrate multiple sources of health information to produce a more comprehensive overview of the general health picture.

34. In reality, however, while it might already be technically possible for the DHSC to contribute the health information it gathers to the EWARN system, the security community often cannot share all its information externally due to security protocols and the humanitarian and development community, wishing to safeguard their neutral position, are not always willing or able to work together with the security community.

35. If the security community and the humanitarian and development community could find a way to overcome these barriers to information sharing, the comprehensive health picture that would subsequently be created by converging both systems could be shared among all actors functioning in the crisis-affected fragile state to the benefit of all involved, not least the local population.

**Conclusions**

36. As we have seen from the Kosovo case study, crisis-affected fragile states are vulnerable to the threat of emerging infectious disease outbreaks. In such a case, a well-functioning disease surveillance system is of paramount importance, on the one hand, to manage the risk to public health and on the other hand, to the international response to the crisis in general.
37. This risk of infectious disease outbreaks in the crisis-affected fragile states is one shared by the security community and the humanitarian and development community actors responding to the crisis at hand. Each set of actors requires as comprehensive and accurate a picture of the risk of disease as possible to accomplish their objective(s).

38. And yet the shared risk is currently addressed separately by each community, resulting in different disease surveillance systems that, for the reasons already given, do not (yet) interact with each other. The obvious risk of gaps in disease surveillance information can be detrimental not only to the local population, but also to the actors from the security community and the humanitarian and development community.

39. Information sharing among health actors in the security community, the humanitarian and development community and the host nation seems to be the key to unlocking comprehensive disease surveillance. However, as described above, any information sharing between the security community and the humanitarian community would require policy changes by each: (a) policy amendments in the security community (such as NATO) regarding the sharing of potentially classified information and (b) the humanitarian and development community (such as the Inter-Agency Standing Committee and WHO) to incorporate security community-sourced health information.
INTRODUCTION

1. In the aftermath of the Kosovo Conflict, as KFOR peacekeeping troops moved into the Mitrovica region in October 1999, they discovered a legacy left by decades of pollution from intensive mining and heavy industry, resulting in “one of the most serious lead-related environmental health disasters in the world and history”. The resulting health risks were so severe that UNMIK felt there was no alternative but to close the lead smelter plant until the health risks could be mitigated.  

2. The closure of the smelter had a profound socio-economic impact on the area. The majority of the local population were directly or indirectly employed in the local mining industry. The mine’s closure meant for many the loss of their only source of income. It also meant the loss of one of the few opportunities for both Kosovar Albanians and Kosovar Serbs in the area to interact as many worked together in the plant. The resulting social unrest in an already troubled area meant KFOR found itself having to intervene on more than one occasion.  

3. In fact, the security community took action to try and mitigate the impact of the closure of the plant—such as paying redundant employees compensatory wages, and offering free lead contamination tests. However, many locals perceived the closure of the plant by the security community as interfering in local affairs. Mining related pollution had been going on long before KFOR arrived on the scene and was accepted as an occupational hazard; a part of daily life. Now, suddenly the population was told the pollution posed an unacceptable health risk and their lives and livelihoods were to be disrupted as a result.  

4. But had UNMIK, assisted by KFOR, chosen not to act—i.e. had not closed the lead smelter but just removed the troops from the immediate threat of lead contamination—there were few locals who would have condoned such action.  

5. This narrative sets out the story behind KFOR’s discovery of the lead pollution in the Mitrovica region, the action taken by the security community as a consequence, and the impact thereof on the local population.  

MINING AND THE ENVIRONMENTAL IMPACT

A brief history of mining in Mitrovica

6. Mining is woven into Kosovo’s history. The invading Roman and Ottoman empires each fought for control of the richly endowed silver mines. In the Middle Ages, the mines provided a valuable source of income that was used to fund fortresses to keep just such invaders out. These days, Kosovo’s mines, in particular in the Mitrovica region, are dilapidated industrial wrecks; shadows of their former glory when, at their peak in the 1980’s, they were responsible for 70% of Yugoslavia’s mineral wealth and generated employment for over 20,000 workers.  

* The Study Team notes that the security community did not directly cause that social unrest.
7. The Trepça mining complex was once the largest mining facility in Kosovo and one of the largest lead mining facilities in the world.\textsuperscript{193} In the early 1920s, the British \textsuperscript{Trepca mines Ltd. were one of the most prominent enterprises in the former Yugoslavia. It included smelters, factories, offices, hotels, shares in other companies and many other components.} built the core mining facilities which were taken over by the Germans during World War II who used them to extract almost 40% of the lead used for the Nazi war industry.\textsuperscript{194} During its peak, in the years of the Federal Republic of Yugoslavia, the Trepça mining complex was churning out hundreds of tons of minerals a year, including lead, zinc, silver and gold.\textsuperscript{195}

8. The Trepça mining facilities in the Mitrovića area also housed the region’s largest lead and zinc mining, beneficiation, smelting and refining complex. Heavy industry built up in the area over time; local production plants include a lead smelter, fertilizer production plant, refinery, battery factory, zinc electrolysis facility and a sulphuric acid plant.\textsuperscript{196}

9. Proper mining waste disposal was never really considered a priority under the communist regime,\textsuperscript{197} which encouraged a generally passive attitude towards environmental issues resulting in a lack of awareness of the risk of pollution in the Mitrovića region among the population and the International Community in general.\textsuperscript{198} Years of general neglect and poor maintenance following the break-up of Yugoslavia, including failed attempts at privatization, further compounded the environmental situation in the region.\textsuperscript{199}

The Environmental Impact – Pollution

10. One of the most serious, and persistent, causes of lead pollution in the region came from the malfunctioning of the lead roaster complex at the Zveçan lead smelter, which was built in 1967 and functioned so poorly that it emitted as much as 14.8 kg of lead per tonne of crude lead smelted—the modern standard is 0.2 kg.\textsuperscript{200}

11. But perhaps the longest lingering environmental problem in the region is the industrial waste or \textit{tailings} as referred to in the mining industry. Uncontained industrial waste disposals, such as those at the Gornje Polje waste dump, the Zharkov Potok tailings pond, and the various waste piles (or \textit{slag heaps}) located at the Mitrovića site, have been identified as the sources of metal rich dust, one of the main causes of the health risks associated with the area.\textsuperscript{201} The water quality of the local rivers, the Sitnica and Ibar, is considered very poor and both rivers have been classified as “dead”. Besides untreated sewage, the water in these rivers also contains various types of industrial waste including drainage waters. The water in the rivers is so polluted it cannot be used for consumption, irrigation or even industrial purposes without prior treatment.\textsuperscript{202}

12. In summary, Kosovo’s mining industry, while perhaps fruitful economically, has been detrimental to the environment. The population now finds itself saddled with a legacy of longstanding and persistent pollution with little means to clean it up by themselves.

**The Security Community’s Involvement**

Roma Internally Displaced Persons

13. Prior to the Kosovo Conflict breaking out, the Roma in the region had settled in a Southern Mitrovićan neighbourhood referred to as “\textit{Roma Mahala}”.\textsuperscript{†} At the end of 1999, in the wake of the Kosovo Conflict and the start of the region’s administration under UNMIK, the Roma Mahala was destroyed and the inhabitants forced to flee as Kosovar Albanians looted

\textsuperscript{†} The term “mahala” comes from Turkish and means “neighbourhood.” It is used in the Albanian, Serbian, and Romani languages.
and burned Roma homes in a wave of retaliatory violence against those they believed to have been “Serbian collaborators” during the conflict.  

14. Escaping the violence, around half of the Roma Mahala inhabitants crossed the border into Serbia (proper). The rest fled to the northern (Serbian-majority) areas of Kosovo and settled in (or nearby) makeshift camps in Cesmin Lug and Zitkovac, in the vicinity of the Mitrovica mining and industrial sites. The camps, set up by the Office of UNHCR in October in 1999 as the first waves of Roma IDPs arrived in the area, were only ever meant as a temporary solution to the Roma IDP problem. The UNHCR wished to return the Roma IDPs to a reconstructed Roma Mahala as soon as possible.

15. However, in October 2001, the camps were still populated and UNMIK took over administration of the region and the camps.

**KFOR Detects High-Level Contamination**

16. In mid-1999, KFOR’s Multinational Brigade (MNB) North, under French command, was assigned to the Mitrovica and Zveçan areas. The troops were stationed in and around the mining complex facilities in the area. The KFOR troops were using abandoned warehouses as barracks.

17. In October of the same year, and around the same time as the Roma IDP crisis hit the region, a military medical report issued by the French Service de Santé des Armées indicated a risk of environmental contamination of the site and consequential health risk to the French troops stationed there. The report called for further monitoring of the situation which was duly undertaken between February and June of 2000. The analysis showed high levels of lead contamination, both in the environment and in the soldiers' blood. The level of lead in the atmosphere was, in fact, about 200 times the recognized safe level.

**Zveçan Lead Smelter Shut Down**

18. The French authorities passed the findings of the February–June 2000 analysis on to UNMIK. Based on these findings, on 14 August 2000, UNMIK assumed responsibility for the Zveçan smelter which represented “a major health hazard, which threatened both the local community and the international presence stationed in the area.”

19. A contingent of 900 military personnel from MNB North, UNMIK administrators, and police officers were required to take charge of and close the smelter (Opération Vulcain). Rioting broke out as workers and locals protested against the closure of what they saw as their only source of income for a reason that, prior to the security community arriving and taking control, had not been deemed a problem; in fact, most had not even been aware of there being any problem in the first place.

20. Political tensions increased between UNMIK and the Kosovar Serbian political representatives. Control of the complex had been disputed between the Kosovar Albanians and Kosovar Serbians for some time and both groups saw UNMIK’s assumption of responsibility for the Zveçan smelter as an “environmental excuse” from UN and NATO to occupy Kosovar property.

**Measures to limit exposure**

21. The KFOR troops immediately adopted their own measures to protect themselves as much as possible: food and water were imported and special hygiene measures were implemented in order to limit the assimilation of heavy metals. Shorter rotation times for military personnel deployed in the area was employed as a method to limit exposure to high levels of lead contamination.
22. However, the Roma IDPs, faced with fewer options to limit their exposure to the high lead levels, remained in the camps while a more permanent housing solution was sought for them by UNMIK. UNMIK still intended to return the Roma IDPs to the reconstructed Roma Malhala as soon as possible. But in the meantime, no significant steps were taken to address the health situation in the camps or the contamination of the sites in general.\footnote{218}

23. In the summer of 2004, the WHO, prompted by Roma rights and other human rights organizations, conducted an assessment in the Cesmin Lug and Zitkovac IDP camps.\footnote{219} Based on the findings from this assessment, the WHO alerted UNMIK to the adverse effects of lead contamination on Roma IDP health, stressing the need to close the camps.\footnote{220}

24. By March 2005, several international organizations, local institutions and NGOs* began to work together to coordinate and organize the relocation of the affected Roma IDPs into a safer camp site. The former military camp at Osterode, abandoned by the KFOR troops in late 2005, was identified as a suitable site and the Roma IDPs were encouraged to move there.\footnote{221} In March and April 2006 the inhabitants of the Zitkovac and Kablare camps voluntarily moved to the Osterode camp and the two former camps were demolished.\footnote{222}

25. However, in April 2008, results from studies undertaken by the Republic of Serbia Institute for Public Health and Protection still found high levels of lead contamination in the Roma IDP’s blood lead levels at the Osterode camp. The situation for the Roma IDPs had not improved much.\footnote{223}

\section*{Radioactive Waste}

26. In addition to the lead contamination found in the environment, KFOR troops also discovered three barrels of low-level radioactive material in a mine, as well as stocks of nitrogen and ammoniac leaking into the soil. These contaminants were found abandoned in the Trepca industrial park after the withdrawal of Serbian forces in 1999. One Trepca official† reported that repeated requests were made to various international and national actors such as UNMIK, KFOR, the MOH, and the Kosovar Ministry of Environment, to safely remove the hazardous materials. However, these requests were not answered and we understand that, to this day, no clean-up operation has taken place.\footnote{224}

27. While those in charge of the mine have the authority to deal with the problem, they do not have the financial means or capacity to do so. The international community, and in particular the security community do have the means to clear up the contamination, but they cannot act as the matter is deemed “out of their field of responsibility”.\footnote{225}

28. This example of how a health threat such as low-level radioactive waste is left in situ and untreated for over a decade serves to illustrate that, without proper coordination between those who can and want to act, no action can be taken. It is perhaps also indicative of the relationship between the security community and the rest of the international community when it comes to dealing with the health system of a crisis-affected fragile state. While the security community has the means and the will to act, their hands are often tied at the international and national political level as to how much they are actually allowed to do.

\footnote{* Including the Kosovar Ministry of Health, UNMIK, UNHCR, WHO, UNICEF, OSCE, Danish Refugee Council, Norwegian Church Aid, CARITAS Kosovo, Internal Displacement Monitoring Centre, Refugees International.}

\footnote{† The Director of Department for Development and Environmental Protection.}
THE IMPACT OF POLLUTION

The Impact on Health

29. The pollution in Kosovo is considered one of the main challenges to its future. There are severe health problems throughout the whole country, undermining an already difficult situation for the population. The incidence of respiratory diseases is highly correlated to the atmospheric pollution from nearby lignite-fuelled power plants. According to UNICEF, respiratory diseases in Kosovo are among the main causes for the highest infant mortality rate in the Balkan area.

30. Observers from different vantage points in society repeatedly noted that the industrial pollution surrounding Mitrovića, while a problem, does not represent a proverbial "tinderbox," ready to ignite. Ongoing and chronic lead poisoning has not produced, to date, the sort of social unrest that implicates security forces directly. Rather, it is just another feature of a tough situation. In addition to the extent of the contamination and the effects on population, public health officials noted that the situation in Mitrovića is not considered "the most important thing", either by Kosovar or Serbian sides. A certain scepticism and resistance from the population has arisen; before the security community got involved, lead was considered to be primarily an "occupational hazard", suddenly now it is an urgent health risk. A general lack of awareness of the potential health consequences for the community living close to the mining and processing sites compounded by controversial messages on the environmental situation since the end of the war have only made matters worse.

31. In reality, as confirmed in the WHO Risk Assessment Report of 2004, the health security threat related to lead exposure was of "unprecedented seriousness". In the Mitrovića and Zveçan area elevated blood lead levels were confirmed, far above the safety threshold, about 32% and about 46% respectively. 25% of them are children aged 2–3 years. More remarkably, 100 of the 160 (about 63%) Roma children living in the IDP camps were qualified as "medical emergencies owing to severe acute and chronic lead poisoning".

32. Ethnic tensions remain strong in the area, and the associated difficulties in access to health care for minority groups are an ongoing problem. For example, Kosovar Serbs from northern Mitrovića avoid secondary and tertiary care in Kosovar Albanian dominated Pristina and often go to Belgrade instead—a four-hour drive—causing substantial treatment delays.

33. One official noted that health and environmental clean-up issues have stalled since 2008, when Kosovo’s declaration of independence antagonized Serbia. One Kosovar Albanian official reported that the Kosovar Serbians are instructed to have no contact with Kosovar Albanians in this field: “We try to pass messages to them via the EU who [sic] is mediating”, he said. He went on to explain “The political issues that divide Serbia and Kosovo (and the north and south parts of Mitrovića) could play out on a different stage while environmental clean-up and profound public health response could provide a local “bridge to cooperation... [Those issues] are common ground.”

The Economic Impact of Pollution

34. To provide some idea of the economic impact lead contamination has on population health, we refer the reader to the World Bank-commissioned Country Environmental Analysis of Kosovo. This study investigated the state of the Kosovar environment and the key

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*The lignite deposit near the capital Pristina is one of the largest in Europe and are still being used in the major thermal energy-power plants in the area to provide electricity to the whole country.*
environmental issues, and gave an estimation of these issues’ health and economic costs (based on 2010 data).\textsuperscript{237} According to this study, the estimated total economic costs due to health effects of air pollution in Kosovo (the cost of treating mortality and illnesses) is EUR98 million annually, or 2.3\% of GDP.\textsuperscript{238} In particular, the average loss of IQ\textsuperscript{*} \textsuperscript{239}, directly related to lead contamination in the children, has an estimated cost of between EUR68 million annually, or 1.62\% of GDP in average.\textsuperscript{240} These figures serve to show the economic magnitude of this problem in the region.

35. Closing the Zevçan smelter had also had a direct economic impact on the region. Unemployment in the Mitroviça area rose to 77\%,\textsuperscript{241} greater than the average Kosovar rate—over the 30\%, already one of the highest in Europe—\textsuperscript{242} and is considered today one of the main causes of insecurity and destabilization in Kosovo.\textsuperscript{243}

36. In an effort to mitigate the economic impact of closing the smelter to the local population, UNMIK guaranteed the payment of regular salaries to the 3000 workers who would be affected by the closure,\textsuperscript{244} and emphasized the fact that their control of the smelter would be “until air pollution control mechanisms are installed and the affected population tested.”\textsuperscript{245}

CONCLUSIONS

Taking the past and the future into consideration – Long-Term Impacts

37. In this case, KFOR troops detected a serious health threat, not only to themselves, but also to those working and living in the region. Terminating the source of that health risk—i.e. closing down the lead smelter—was, perhaps, the obvious action for the security community,

\footnote{This estimate rises dramatically in Mitrovica municipality, where IQ loss reaches the 8–10 points for children, compared with the 1.5–4 points Kosovar average loss.}
i.e. UNMIK and KFOR in this case, to take. But doing so had further reaching consequences for the local population than just the obvious and immediate health benefits; consequences founded in the region’s past, and its future; consequences that probably should have been taken into consideration at the time action was taken.

38. In terms of the region’s past, the shut-down of the lead smelter, which had formed the core of the region’s socio-economic culture for decades, impacted the population to a greater degree than could have potentially been anticipated by the security community at the time. Rising unemployment, and the loss of opportunity to work together, potentially widened the already present divide between the two ethnic groups and contributed to rising tensions in the region.

39. In terms of the region’s future, without a clear “end state” planned for their actions (and perhaps also the means and motivation to execute it), after the closure of the lead smelter in 2000, the security community’s response to the situation has been reactive rather than proactive; taking action when and where it was required but not planning ahead further than that. As a result, the longer term prospects of the local population in terms of the economic, social and, indeed, health related consequences, have not changed much since.

40. However, it is perhaps, even with the benefit of hindsight, difficult to determine whether the action taken by the security community in this case was, strictly speaking: wrong or right. The alternative to taking action, not taking any action at all, was probably not a realistic option in this case. Indeed, not taking any action could have, arguably, been more harmful than taking the wrong action. Had KFOR simply removed its troops from harm’s way and left the local population to unwittingly continue working and living in heavily polluted surroundings, then who is to say what might have happened? Speculating, it is very likely that KFOR would have been accused of only acting in its own health interests, disregarding the local population’s interests.

Mitrovića’s present: Rehabilitation – Stabilization

41. The cost of the pollution to Kosovo, in real economic terms, is estimated at about 5.3% of GDP. The cost relating to health issues is an estimated 2.3% GDP annually (2010 data) on top of that. Kosovo’s economy would undoubtedly benefit from rehabilitation by (a) not having to bear these costs annually and (b) benefitting from increased productivity of the population and the economic perks of the extraction of minerals.

42. Those interviewed by the Study Team have also suggested that resolving the environmental and health issues in the region would promote unity among Mitrovićan Serbs and Albanians: with both ethnic groups working together towards a common goal. Doing so would almost certainly increase stability in the area, something that is of importance to the security community, and indeed the wider international community in general. But the financial and practical means to do so need to be found outside of Mitrovića, indeed, outside of Kosovo.

43. Without the assistance of the international community, including the security community, in rehabilitating and consequently stabilizing the region, the risk is that Mitrovića will remain caught in a vicious cycle of poor health, economic decline and ethnic tension.
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## ANNEX A:
### GLOSSARY OF ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ASTER</td>
<td>Alért et Surveillance en Temps Réel (Near-Real Time Surveillance System)</td>
</tr>
<tr>
<td>DHSC</td>
<td>Deployable Health Surveillance Capability (NATO)</td>
</tr>
<tr>
<td>EpiNATO</td>
<td>NATO Epidemiological System</td>
</tr>
<tr>
<td>EPP</td>
<td>Epidemic Prevention and Preparedness (program)</td>
</tr>
<tr>
<td>EULEX</td>
<td>European Union Rule of Law Mission in Kosovo</td>
</tr>
<tr>
<td>EWARN</td>
<td>Early Warning Alert and Response Network</td>
</tr>
<tr>
<td>H1N1</td>
<td>Hemagglutinin Type 1 and Neuraminidase Type 1 (aka swine flu)</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HIS</td>
<td>Health Information System</td>
</tr>
<tr>
<td>HSS</td>
<td>Health Surveillance System</td>
</tr>
<tr>
<td>ICG</td>
<td>International Crisis Group</td>
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<tr>
<td>ICJ</td>
<td>International Court of Justice</td>
</tr>
<tr>
<td>ICRC</td>
<td>International Committee of the Red Cross</td>
</tr>
<tr>
<td>IDP</td>
<td>Internally Displaced Person</td>
</tr>
<tr>
<td>IHR</td>
<td>International Health Regulation</td>
</tr>
<tr>
<td>IO</td>
<td>International Organization(s)</td>
</tr>
<tr>
<td>IRC</td>
<td>International Rescue Committee</td>
</tr>
<tr>
<td>JALLC</td>
<td>NATO Joint Analysis and Lessons Learned Centre</td>
</tr>
<tr>
<td>KFOR</td>
<td>Kosovo Forces</td>
</tr>
<tr>
<td>MNB</td>
<td>Multinational Brigade</td>
</tr>
<tr>
<td>MNTF</td>
<td>Multinational Task Force</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NIPH</td>
<td>National Institute of Public Health</td>
</tr>
<tr>
<td>OCHA</td>
<td>Office for the Coordination of the Humanitarian Affairs</td>
</tr>
<tr>
<td>OSCE</td>
<td>Office of Security and Cooperation in Europe</td>
</tr>
<tr>
<td>PISG</td>
<td>Provisional Institution of Self-Government</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UNMIK</td>
<td>United Nations Interim Administration Mission in Kosovo</td>
</tr>
<tr>
<td>UNSCR</td>
<td>United Nations Security Council Resolution</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>UXO</td>
<td>Unexploded Ordnance</td>
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</tbody>
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