population-based surveys to obtain more accurate data on the prevalence of domestic violence. Population-based surveys also provide insights into the causes and results of violence, and can monitor trends and explore the impact of different interventions. This new-found interest, while positive, leaves substantial room for costly methodological mistakes, breaches of ethical standards, and other actions that may put women at risk of harm.

> **"Each year, 45% of female homicide victims are killed by present or former male partners compared to 8% of male victims. On average, 2 women per week are killed in England and Wales by their partners/expartners."**
> ***Criminal Statistics, UK Home Office***

In recognition of the need for practical and ethical guidance on how to do such research, the Core Technical Team of the WHO Multi-Country Study on Women's Health and Domestic Violence Against Women has developed "Ethical and safety recommendations for research on domestic violence against women". This document emphasises that although research on violence against women by intimate partners raises difficult ethical, safety, and methodological considerations, experience shows that it can be done with full respect for ethical and safety considerations. Moreover, when interviewed in a sensitive and non-judgmental way, in an appropriate setting, many women are willing to discuss their experience of violence.

The WHO report provides information on actions that will help ensure that women are not put at risk during the data-collection process. The report addresses several topics, including: the safety of the respondents and the research team; the need for studies to build on current experience about how to keep under-reporting of abuse to a minimum; measures to ensure confidentiality for women's safety and data quality; and actions to reduce any possible distress caused to the participants by the research. The document also addresses the ethical obligation of researchers and funders to help ensure that their findings are interpreted properly and used to advance the development of policy and relevant interventions. A few specific issues are described briefly below.

The physical safety of respondents and interviewers from potential retaliatory violence by the abuser is of prime importance. For women in an abusive relationship, merely taking part in a study may provoke further violence. Women must be informed of the nature of the questions and given several opportunities to stop the interview or avoid responding to certain questions. Logistical planning and budgeting should include consideration of the respondents' safety and may involve rescheduling of interviews in other settings. All members of the research team, particularly interviewers, will need specialised training and support over and above that normally provided to research staff.

> **"Since 1981, the largest increase in violent crimes has been in incidents of domestic violence."**
> ***British Crime Survey, Home Office***

Active efforts must be made to minimise any possible distress caused by the research. Domestic violence is a sensitive and stigmatised issue, and women are commonly blamed for the violence they experience. Questions need to be asked in a supportive and non-judgmental way. Interviewers need to be aware of the possible reactions and know how to end an interview if necessary. The research team should be able to respond appropriately to the subgroup of women who may need additional help during or after an interview. Appropriate service providers to whom women could be referred should be identified in advance.

It is important to ensure that the research findings are used for advocacy, policy making, and the development of interventions. Too often critical research findings never reach the attention of the policy makers, those people best positioned to use such data, and the public. The use of results is more likely if key players in policy, advocacy, and service-provider groups are involved in the research from the outset as members of an advisory or consultative committee. Researchers also need to be proactive in helping to ensure that their research findings are interpreted appropriately by the lay public and the media, and that particular groups are not stigmatised.

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Assessment of international medical evacuations in Macedonia

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

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

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

The agreed task for MSF was to provide primary health-care services for two camps with a total of 70 000 refugees, and for refugees living among the host population. The IOM insisted that all patients to be considered for evacuation had to be referred from primary and secondary health-care facilities. This meant that irrespective of objections to the IOM's policy, MSF was de facto included in the process of selection for medical evacuation, with major negative consequences to the programmes; the volume of patients is estimated to have increased by 30–40% as a result of evacuation requests. Medical staff frequently spent 2–3 h of every 8 h shift explaining to patients why medical evacuation was not warranted for their condition. One MSF doctor commented "I have never had

people become so sad when I told them they were well." There were several reports of patients (with diabetes, arterial hypertension, or angina pectoris) deciding to stop taking their medications in the hope that they could worsen their condition sufficiently to warrant medical evacuation. The time consumed in dealing with evacuation seekers forced the cancellation of essential skills-building courses for national health staff. This meant lost opportunities for teaching subjects identified as of critical importance, for example, management of insulin-dependent diabetes. But most importantly, it effectively diminished the attention that could be offered to ill people not specifically seeking evacuation.

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

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

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

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

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

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

In Macedonia there was not a clear and consistent application of medical criteria to determine which people should be evacuated for medical reasons, and which could be treated adequately in Macedonia. There was an unevenness in the rates of medical evacuation depending on refugee location, and nothing to suggest that there were important differences in health status from one group of refugees to another. The refugees in camps were given much higher levels of service by the international community than those integrated into the host population. There is circumstantial evidence that non-medical criteria may have had some role in the actual medical evacuations that took place, which seriously tainted the perception of medical-careproviders as fair and impartial. Governments seemed more interested in medical evacuation as an opportunity to generate favourable media images to feed their home audiences than in responding to medical needs among refugees.

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

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

Principles for medical evacuations

- Medical evacuation should not take place when treatment of the quality usually accepted by the refugee in his or her home country is available in the first country of asylum.
- Investment in expanding local health-care capacity in a region with a refugee influx is likely to be more inclusive, more equitable, and more cost-effective in addressing the treatment needs of ill people than medical evacuation could be. Furthermore, the provision of treatment for patients living among their own communities makes it much more likely that they will receive much needed care and support from their social network than if they were evacuated to an unfamiliar third country.
- Criteria for medical evacuation must be clearly defined and universally recognised among all agencies involved in health care.
- Medical evacuation, when provided for refugees, should also be considered for members of the host population with medical problems of the same severity.
- Recognising that care is more than treatment per se, medical evacuees should be accompanied by family members.
- There must be a clear distinction between processes for medical evacuation on strictly medical criteria and other processes for placement in third countries that may be available.

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