

**ASSISTANCE FOR VICTIMS OF ATROCITIES  
IN CROATIA AND BOSNIA-HERZEGOVINA**

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# Former Yugoslavia



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Macedonia has proclaimed independent statehood, but has not been formally recognized as a state by the United States.





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# I. EXECUTIVE SUMMARY

## A. Background

This report recommends programs to assist victims of atrocities in Croatia and Bosnia-Herzegovina. It does not chronicle the atrocities that have occurred. The magnitude and nature of the atrocities are horrendous. They include systematic rape and impregnations of women--some of whom have been literally raped to death, rape of men and children, cruel and sadistic treatment of prisoners, murder of children, and intentional mental torture of families as they are forced to watch the rape, murder, and mutilation of family members and friends. These acts are well described elsewhere. It is clear that they have occurred on a massive scale affecting tens of thousands and perhaps hundreds of thousands of people. Atrocities have been committed on all sides, but the vast majority appears to have been committed by the Serbian army and militia.

The team visited refugee camps and communities throughout Croatia and in parts of Southern and Central Bosnia. Although there was no attempt to interview victims, we spoke with ex-prisoners who had been held in concentration camps, women prisoners, women and children who had escaped from Bosnia-Herzegovina, and displaced persons from within Croatia. We also talked with representatives of the international agencies and private voluntary organizations that provide services to refugees and displaced persons in both countries to develop a sense of the types of trauma experienced and of the programs that could best help the victims of these atrocities.

The United States has developed unique expertise in establishing programs to treat the victims of trauma, both from the Vietnam War and from two decades of developing programs for the victims of sexual abuse. Given the immense needs in the former Yugoslavia, the team concluded that the **United States and USAID** can play a key role in helping to address these problems.

The team makes numerous recommendations to assist the victims of trauma described here; however, it is only an end to this war and the endless cycle of such atrocities in the region that will begin to bring real healing to the region. Presently, there are an estimated 800,000 refugees and displaced persons in Croatia, 2,280,000 in Bosnia-Herzegovina, 560,000 in Serbia, 80,000 in Montenegro, 70,000 in Slovenia, and 30,000 in Macedonia, almost

all of whom require some type of assistance <sup>1</sup>.

At least three characteristics distinguish former Yugoslavia from many other disaster situations: 1) Croatia and Bosnia-Herzegovina are well-developed countries with a highly educated and sophisticated population, 2) the region has an extensive telecommunication and transportation network, and 3) local services, particularly in health, are so developed that creating parallel systems would be quite counter-productive.

**The core of the program would concentrate in five related areas:**

- o Reunification of families and displaced children, IRC
- o Local NGO programs to assist trauma victims including victims of torture and rape through an umbrella grant to a U.S. NGO, -IRC, ADR, DELPHI INT.
- o Training and upgrading the skills of medical professionals and social workers dealing with the victims of trauma, CRS
- o Hospital partnerships centered around the treatment of physical and mental trauma, UH
- o Emergency medical supplies. PROJECT HOPE (DH & RH)

Specific programmatic suggestions are listed below. The estimated budget for these programs is \$17 million over three years (\$6.25, \$5.0, and \$6.0 million in FY1993, FY1994, and FY1995 respectively). In FY1993 these funds could be provided as follows: \$4.5 million from Europe Bureau funds, \$.5 million from the Women in Development matching funds, and \$.75 from the Agency's R&D Displaced Children and Orphans earmarked fund.

## **B. Program Considerations**

1. Location - At the present time, what is feasible differs markedly in Croatia and Bosnia-Herzegovina. The team primarily recommended programs that would be based in Croatia to assist refugees and displaced persons living there. They also gave preference to interventions that could be easily duplicated or expanded to Bosnia-Herzegovina when the security situation permits. Assistance for Bosnia-Herzegovina will be targeted to groups based in Croatia who are able to deliver to Bosnia-Herzegovina emergency humanitarian assistance -- primarily food

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<sup>1</sup> These estimates are taken from the Department of Humanitarian Affairs, United Nations, Geneva. March 11, 1993.

and medicine. The team also recognized that regular government services that have been made available to refugees and displaced persons should be subsidized to lessen the extra burden of the Croatian people.

2. Development Assistance Concerns in Croatia - Assisting the people and government of Croatia to cope with the large number of displaced and refugee populations brings forth a number of concerns: a) Will assistance to social services in Croatia free up government resources to wage war? b) Will money spent on strengthening the Croatian services, such as health and education, reach the refugee population? c) How long will the Bosnian refugees be forced to remain in Croatia? d) Should services available to refugees in Croatia be expanded rather than concentrating on ending the war in Bosnia or finding permanent homes for refugee resettlement? and e) Has Croatia violated human rights standards that must be met under U.S. law before some forms of assistance can be offered?

3. Vehicles for Providing Services - Some of the concerns outlined above can be avoided by giving support to the non-governmental sector, which is fast emerging in Croatia. Support to NGOs is also part of A.I.D.'s long-term strategy to strengthen democracy and pluralism in Croatian society. Thus, humanitarian assistance in this context can be congruent with long-term development goals.

4. Most Vulnerable Groups - Attention should be focused on the most vulnerable groups: unaccompanied minors, victims of rape and torture, female headed households, traumatized caretakers and the elderly.

5. Treatment of Trauma - A clear understanding of the nature of severe trauma caused by the atrocities endured in Bosnia such as rape, torture, and ethnic cleansing is necessary to design effective programs.

Severe trauma can impair and even destroy the coping mechanisms of individuals, communities, and nations when inflicted in a state of captivity and helplessness. In the former Yugoslavia, this has happened in a number of ways including: holding people in concentration camps, torture, rape and other bodily violations, deprivation of physical needs (such as sleep and nourishment), and forcing people to witness or conduct violence against others, such as the rape, mutilation, or murder of family members, and against their own moral values.

Fortunately, the harm done to the human condition by violence does not have to be the "end of the story". The key to the initial stage of recovery is for the violence to be "in the past". This is most certainly not the case in Bosnia-Herzegovina -- nor is it fully achieved among refugees who do not know where

they will be able to settle permanently. In general, healing depends on establishing a safe environment and trusting relationships with family, friends, and care givers in the context of a supportive social system while allowing the individuals control over their own lives. Fostering the use of culturally appropriate coping mechanisms is especially useful at this stage. This recovery stage is being facilitated in Croatia today through the strong sense of community within the refugee population, local NGOs, and the formal health care system.

Later, when relationships are reestablished and the threat of violence is minimized, people can safely enter into the next phase of recovery. In this phase, they consciously recall the past and feelings associated with those memories and mourn the losses they have been forced to endure. Croatia's existing health care system has many psychologists, psychiatrists, nurses, and social workers who can provide the culturally appropriate therapy, both to individuals and groups, to facilitate this grieving process. The final stage of recovery, referred to as "reconnection and commonality," occurs when people reach a point in which they no longer see themselves as simply victims and can expand their view of themselves and their world beyond the confines of their violent pasts.

## C. Findings and Recommendations

### CHILDREN

1. Displaced Children - There are an estimated 40,000 orphans and displaced children from the war. The most important need these children have is to be reunited with their families. Children separated from their families are not only in Croatia where they are usually with members of extended families, but also in Hungary, Libya, Malaysia, Germany, Serbia, and Bosnia-Herzegovina to mention only a few.

Unaccompanied children need to be reunited with their parents within and outside of former Yugoslavia. One local effort involves two national non-governmental organizations: Our Children of Croatia and Merhamet. These organizations, in turn, could be linked to an international non-governmental organization (possibly the International Rescue Committee) and to other organizations working inside Bosnia (Our Children of Bosnia, Children's Embassy, etc.). As soon as possible, the project headquarters could be moved to Sarajevo and expanded to assist children in Bosnia-Herzegovina and other parts of the former Yugoslavia. The program should be coordinated with ICRC which is also working on tracing activities. Although the program is inspired by the plight of children, it would reunite all members of the families, including parents and the elderly.

2. Newborns of Rape - The team documented less than 25 births that had occurred as a result of rape in Croatia. These babies are being cared for in NGO facilities. It is impossible to know the exact number of such infants born to date in Croatia. It is clear that most women have aborted when possible and that most infants from rape will be born in the April-May 1993 time frame. The team concluded that the situation needs monitoring closely as most infants from rape will be born later in the year and in areas of Bosnia-Herzegovina that the team did not visit.

3. Adoption - Croatian adoption law complies with international standards. Infants born of Croatian mothers, who have been raped, may be placed for adoption after six months. The law also requires a six month wait for abandoned children while the parent(s) is searched for and/or the abandoning parent(s) changes her/his mind. In Croatia, abandoned newborns thus far were reportedly born to Bosnia-Herzegovina refugee women. The Bosnian Government has notified the Croatian Government that it considers these children Bosnian and therefore not eligible for adoption through the Croatian process. Bosnia-Herzegovina also expects Croatia to deliver the children to Bosnia-Herzegovina for care within two years of birth. Bosnia-Herzegovina has also suspended all adoption for the duration of the war. UNCHR is contracting with Child Protection International to study and recommend solutions to these issues.

The Croatian Government states that there are many prospective adoptive parents waiting in Croatia to adopt babies of rape, regardless of ethnic and religious origin, i.e.: Croatian, Bosnian, or Serbian. The Government has no plans to identify babies of rape from the general population and does not anticipate a large number of these children.

### Recommendations

1. Initiate a program to reunite displaced children and families. This tracing program would begin in Croatia and a number of other countries and expand to Bosnia-Herzegovina when possible. It would include family reunification services, stipends for displaced and refugee families in especially dire circumstances, schooling for children and continuing education programs for single mothers. (Cost in FY1993 - \$.75 million to come from the Displaced Children and Orphans earmark.)

2. Establish a focused, dedicated monitoring system within Croatia, Bosnia, and Serbia which will pro-actively search for and monitor reports of abandoned newborns and adoptions outside of legal channels.

## **TRAUMA VICTIMS**

A range of social and mental health services is needed, from media messages that educate the general population to intensive counseling, medication, and inpatient tertiary care for the extremely traumatized.

1. Extent of Traumatization: Everyone has experienced trauma to some extent. Different levels of service are needed to address different degrees of traumatization. Low level trauma can be addressed by increased awareness through media, education, and general community support. Trained mental health professionals in government organizations or NGOs are needed to provide services to people who have been more seriously traumatized. Extraordinarily traumatized individuals should be referred to specialized medical, psychological, and psychiatric services.

2. Service Providers: A wide range of groups offer general assistance to trauma victims including the Croatia Government, international relief organizations, and NGOs. There is also a growing number of NGOs who offer or could offer more specialized services to trauma victims including International Rescue Committee (IRC), Suncokret, the Women's Center for War Victims, Autonomous Women's Center, Caritas, the Zagreb Women's Lobby, Trejnevka, the International Federation of the Red Cross (IFRC), local Catholic parishes and priests, the imams, Merhamet, and the University of Zagreb. Some, such as Suncokret, Caritas, and IRC, offer integrated services for women and children.

3. Professional Expertise: Many highly trained professionals lack training in the treatment of post-traumatic stress, war trauma and/or sexual violence. At the general societal and cultural level, there was a widespread "conspiracy of silence" on domestic and sexual violence.

4. Appropriate Modalities: Any treatment modality employed for the treatment of sexual violence and war-related trauma should protect the confidentiality. Programs singling out rape victims are inappropriate and are likely to traumatize the victim further. A family and community perspective versus a particular focus on women is needed to address trauma. Men and children should be involved through education, schools, media, and social service programs. Issues of honor, shame and the way different economic and social groups within the society frame the experience of sexual trauma need to be addressed.

5. Retraumatization: Various groups, including the press, embassies, non-governmental organizations, women's groups, etc., have gathered evidence on women's rapes. The inappropriate

manner in which such evidence has sometimes been gathered has further traumatized women.

6. Enforced Idleness: There are social and psychological costs for refugees and displaced who have nothing to do. They need some means of employment (even if unpaid) and children need to continue their schooling at all levels.

7. Vicarious Traumatization: The mental health of relief workers is at risk in the former Yugoslavia. They are coping with very stressful and traumatic events, large scale victimization, and severely traumatized individuals. Most also work in personally dangerous situations. The stress can sometimes be so great that it jeopardizes the work of these relief workers and their judgement in providing relief to refugees and displaced.

### Recommendations

1. Program to assist trauma victims through an umbrella grant to a knowledgeable and locally experienced U.S. PVO. This PVO will assist local groups (emerging PVOs) with funding, training, and other technical assistance. Such groups could include local women's groups, non-governmental organizations, and uniquely competent individuals. There are many PVOs like Suncokret, the Women's Center for War Victims, Autonomous Women's Center, and Trejnevka that are doing outstanding work and have proposals worthy of consideration.

2. A program to train and strengthen the skills of health professionals dealing trauma should be developed. In some cases, more long-term participant training of trainers may be useful. Local professionals would benefit from more specialized training in the treatment of sexual and war related violence and the ensuing trauma.

3. Assess the status of family law as it relates to sexual abuse and organize a workshop to increase understanding through AID's regional CEELI project.

4. If funding permits, support educational programs, in formal classrooms and radio programming to assist with trauma education and to reunite separated families throughout Croatia and Bosnia-Herzegovina.

5. Develop a model interview protocol and guidelines with the WID Office, State Humanitarian Affairs, and others to protect the best interest of women and other trauma victims being interviewed. These protocols should protect the women's identity, outline the boundaries of inquiry, provide for informed consent, and include a follow-up plan in case that such an interview is traumatic. The guidelines should be distributed to

the press corps, government and documentation teams, and humanitarian relief organizations and used in any war crimes trials. The enforcement of these guidelines may be considered part of UNHCR's and Human Rights Groups' protection function.

6. Assist to Establish models of trauma care - a number of American and international NGO are working to set up models of trauma care which includes training components for local health professionals. If funding permits, assistance to these groups should be considered.

#### HEALTH CARE

1. Croatia - Although the health care system is excellent and staffed by dedicated professionals, the war has exacted a heavy price. Buildings and equipment have been destroyed, government funding is inadequate to meet the demands of over 700,000 refugees and displaced persons, medical staff are exhausted and underpaid, and medicines and equipment in some areas are in short supply. Without more funding, the health care system at some point will deteriorate.

2. Bosnia-Herzegovina - Hospitals and clinics continue to operate in many areas in spite of the war. Provision of emergency medical supplies to facilities that are still operating is of paramount need. ICRC, UNHCR, WHO, and a number of PVO's that have on-going communications with areas throughout B-H continue -- at great risk -- to supply many of these hospitals and clinics with medicines whenever possible.

3. Expired Donated Medicines - Large numbers of expired medicines have been donated. In one case, a medicine had expired in 1968. Donated medicines are often inappropriate or so mixed together in small batches as to be almost useless. Care must be given to providing needed medicines and supplies in sufficient quantities to be distributed efficiently.

4. Bosnian Muslim Access to Services - Earlier this year the government of Croatia felt it could no longer afford to continue to offer health care beyond emergency services and vaccinations to refugees. In response to protests from the international community and assistance from UNHCR, the government reversed this policy, but there are still reports that Muslims are either put at the end of the line or not admitted at all. The team saw examples of wounded Muslims who were denied entrance to hospitals in Zagreb but also toured the Zagreb Children's Hospital where equal care is given to all religious and ethnic groups alike.

#### Recommendations

Given the excellent nature of the present system, A.I.D.

should focus its efforts and expenditures on strengthening the present primary and secondary health care system rather than creating expensive parallel systems. Since refugees and displaced persons to some degree use the existing Croatian national health care system and therefore deplete its resources, health care assistance should not target refugees exclusively. In turn, assistance should be contingent on the equal availability of services for refugees (Bosnian Muslims and Serbs) as for Croats.

1. Emergency Medical Supplies (\$1.3 million) - provide \$1.3 million in additional medicines and supplies to Croatia and B-H. These medicines should be made available to PVO's distributing them to Bosnia-Herzegovina, to meet the needs of refugees and displaced persons, and to help meet gaps in the existing Croatian medical care system. A professional pharmacist and/or doctor should identify pharmaceutical gaps, such as the lack of proper drugs to treat trauma victims, cancer drugs noted in the children's hospital, the anesthesia in B-H, and medicines for children.

2. Hospital Partnerships- We recommend establishing a hospital partnership program in Croatia. This program should include at least three hospital partnerships in different parts of Croatia. Candidate areas would include Zagreb, Karlovac, Osijek, and Split. The partnerships would be centered around trauma--both physical and mental--and where possible, would include outreach programs into Bosnia-Herzegovina. The partnership facilities would be located in areas with large numbers of refugees and displaced persons so that the partnerships could work with local authorities to meet the needs of refugees and displaced persons, particularly trauma victims.

## **PROSTHETICS**

In Croatia, local capacity and international programs already operating appear to be handling the present need for prosthetics. The greater need, however, is among the people in Bosnia-Herzegovina. The team therefore recommends monitoring the situation and being prepared to access the need in Bosnia-Herzegovina when possible.

## **ECONOMIC DEVELOPMENT**

1. Overall Situation - The economic situation of Croatia is rapidly deteriorating. Production has fallen, unemployment is high, hard currency savings are rapidly being depleted, and price escalation borders on hyper-inflation. Reports of inadequate agricultural inputs (seeds, tools, and fertilizer) in areas of Croatia occupied by Serbia for the coming season have been reported.

2. Relationships between Bosnians and local Croatians are likely to become increasingly strained over time as the cost of providing for refugees and economic disruption grows.

3. Recovery - Increased economic assistance to Croatia could help lay the foundations for rapid recovery after the termination of the war. Such economic recovery will be essential to the mental and physical well being of the war-affected population.

### Recommendations

1. Agricultural inputs - Immediately conduct an agricultural assessment in Croatia and provide needed agricultural inputs by reprogramming IRC winterization funds and/or through other A.I.D. funding.

2. Increased SEED Funding - In consultation with Croatia Country Team and the AID Rep, we recommend that the level of development assistance to Croatia be reexamined to increase assistance significantly consistent with human rights requirements.

### **STAFFING**

To administer these programs, additional staffing is essential in Croatia. We recommend a three month TDYer be assigned to Croatia immediately and, subject to consultations with the Embassy in Zagreb, that one or two PSCs be hired to assist with these programs.

### **D. Conclusion**

The vast majority of the victims of the atrocities are in need of assistance as soon as possible. A package of assistance is recommended below for immediate term (0-30 day), near term (30-75 days), and long term (more than 75 days) implementation. These estimates are based on how long the contracting actions will require. The programs are primarily for Croatia with the intent that they serve as models for future efforts to reach the large number of victims in Bosnia-Herzegovina. The team has also proposed other assistance activities in Croatia if additional funding becomes available.

## II. BACKGROUND

No matter how many wars one has witnessed, the brutality and violence that is occurring in the former Yugoslavia is shocking. Unlike many conflict regions, the former Yugoslavia enjoyed a high level of economic development. Prior to the war, many people identified themselves in the most recent census as Yugoslav, not by the various ethnic and religious identities that are now dividing them. The outbreak of the war reminded the international community once again how this century has seen two major wars that began in this region. The brutality of "ethnic cleansing" is also all too reminiscent of the atrocities of World War Two. Everyone has stories to tell of systematic violence against specific ethnic groups and their communities: women raped, children murdered, men castrated, families destroyed, and communities razed to the ground.

In Croatia alone, a country of four and half million people, there are estimated 600,000 to one million refugees and displaced persons. They live primarily in private homes and hotels; those in refugee and displaced person camps hope their status is temporary. Most want to return to their home village to resume their life. If they are able to return, they will have to rebuild from scratch. As one refugee observes, "It will be just like starting over again after the Second World War." Most people hope for peace and are not yet willing to emigrate out of the immediate area, although some are seeking temporary employment in other parts of Europe and beyond.

The religious divisions of the peoples of the former Yugoslavia are often overemphasized as a driving force in the war. The Muslim community should not be confused with fundamentalists of the Middle East. The former Yugoslavia was largely secular. There is no visible difference among Serbs, Croats and Bosnians--all are Western European in outlook, dress, education and orientation.

The purpose of the war is not solely to gain territory, subjugate another group or garner more industrial resources but to identify the other ethnic group and to rid the territory of that group, although it might have resided there for centuries. To many, ethnicity was not a significant factor until the war. Especially in Bosnia-Herzegovina (B-H), people tolerated the other's ethnic identity, intermarried and worked together. Since the war, however, ethnic distinctions and differences have been heightened by war-related experience, access to resources, and religion.

Across all religious and ethnic groups in the three regions, the Serbs, Croats, and Bosnians, particularly those in rural

areas, are patriarchal, with extended families and regional clubs as characteristic forms of community and social networks. Within the patriarchal system, the head of the family is traditionally responsible for protecting the honor and purity of the women. What reinforced and overlaid this in the former Yugoslavia was the local Party organization, which was also predominantly patriarchal. Since the break-up of Yugoslavia, this political reality has become more apparent through the substitution of elections for quotas. Women have far less representation in the new governments. They are best represented in Slovenia (11.3% of representatives were women) and least in Serbia (where only 1.6% were).

Prior to the war, urban-rural differences were apparently more significant than ethnic differences. Sexual attitudes and practices were quickly "modernizing" in urban areas. The nuclear family was becoming increasingly common. In urban areas, cohabitation before marriage was also widely accepted. However, women's groups documented the existence of domestic violence. According to a woman's group, in Belgrade, every fifteen minutes a woman was beaten or molested and in rural areas, rape was the second most frequently reported crime (after arson, stable burning). The former Yugoslavian government did not address this issue in its social programs and what few programs there were, were primarily organized by local women's groups (e.g., telephone hotlines and legal initiatives).

Sexual violence in this war has been used as a deliberate weapon, and women have been the primary target. Rape has become an instrument of war and ethnic cleansing. The purpose appears to be to humiliate the male of the other ethnic group and to uproot entire populations through terror and intimidation. At the same time, deliberate impregnation is frequently pursued. Women are being held and raped past the first trimester in rape/detention camps and then released to humiliate the other side. Given this context and use of rape as a form of "pollution" and humiliation, it is not surprising that some impregnated women reportedly view the foetus as a malignant tumor and have abandoned the newborns. It is also reported that they are having second and third trimester abortions.

Likewise, men are being defiled and humiliated. They are being sexually abused and tortured in other ways to demonstrate their physical weakness. The result, according to one victim, is that they no longer feel like men. He added that he would have preferred if his people had been shot rather than beaten to death with baseball bats, a table leg, fire extinguisher, etc.

Men, women, and children are also having to cope with what has happened to other members of their family who have been tortured. Males bound by their notions of shame and honor, in particular, are having to deal with sisters and wives who have

been sexually violated. In some cases, their anger has been directed at the victim, resulting in battering and even murder.

Villages within Bosnia and particular communities are targeted by different groups during the war. Whole villages are burned out, their people frequently detained in schools, stadiums, and other public buildings. In some cases, the military targets particular houses of a different minority group. One tactic is to blow up the house of someone from another ethnic group by simply putting a candle in the abandoned house and turning on the gas. In both Bosnia and Croatia, the targeted group's houses and places of worship have been expropriated, blown up or targeted in the artillery fire.

The war has taken place in three phases. Each phase has involved different groups and to some extent, is creating different experiences and trauma. During the first phase, which lasted six months, admissions from the war in one hospital in Zagreb were 70% Croatian, 25% Serbian, and 5% Muslim. During this phase, most physical injuries were from air attacks and mortar fire. During the second phase, which lasted a year, the Serbs began their campaign of ethnic cleansing. During this phase, admissions in the same hospital were 80% Muslim, 15% Croatian, and 5% Serbs. It is likely that most of the detention centers and rape camps were established during this phase. Finally, during the present third phase, the conflict is taking place between three armed forces--the Serb JA, the Croatian HVO, the Bosnian army, and militia associated with each group. Atrocities are reported among all three groups and a state of lawlessness prevails. There are sporadic incursions and shelling within Croatia on the eastern front (Osijek and Slavonski Brod), on the Dalmatian Coast (near Zadar), and Karlovac (a town about 40 kilometers from Zagreb and site of a large transit center). Most of the current hospital admissions in Zagreb (primarily Croats and Muslims) are the result of accidents--people who have stepped on land mines or been caught in cross fire.

Bosnia-Herzegovina is now about 70% controlled by Serbs, and that portion of the country is essentially inaccessible to outsiders. Of the remaining area, there are three categories:

- a) front-line areas, where little more than immediate life-saving supplies can be delivered;
- b) isolated pockets, where the only current supply is brought in at night on the backs of horses and people who sneak through the lines, and where air-drops have subsequently taken place; and
- c) the relatively stable areas, where despite sporadic shelling and/or sniper activity, life goes on with an amazing normalcy, and where the residents are anxious to do

spring planting and get their factories back to work.

These are not rigid categories--there are shadings and degrees of difference--and as battle lines and levels of activity change, some areas become more or less stable. One drives through villages in B-H which were almost totally destroyed, and others where there is no apparent sign of war. The shops are reasonably stocked, the gas station is operational, and farmers are tilling the fields.

The volatile conditions in Bosnia-Herzegovina require a degree of flexibility which is not possible under "normal" assistance programming. The degree of development of ex-Yugoslavia means that many requirements can be met locally and very quickly if funds are available and flexible. Response time to urgent needs can be measured in days rather than months. Relatively stable areas are prone to receive large numbers of displaced persons fleeing fighting. Hundreds or thousands of people can arrive with virtually no warning. The NGO community is less hampered by the absolute amount of funding available than it is by the rigidity of funding and the slow response time of the donor agencies--people die while papers are processed.

### III. THE SITUATION OF CIVILIAN VICTIMS

#### A. Defining Trauma and Recovery

Violence tends to breed violence and certainly in the former Yugoslavia, the "beast of war" has been unleashed. As in the story of St. George the Dragon Slayer, the people here have discovered that if you cut off the head of the dragon, nine more grow back in its place. Because of the war, the populations of Croatia and B-H have been subjected to extreme violence. In terms of A.I.D. investment in the region in response to these events, a model for what trauma is and how healing from it occurs may be useful for choosing which projects to fund.

"Stress" is any event or events that cause people to change their usual routines. Stressful events which are "traumatic" not only change daily routines, but they impair and in some cases destroy the coping mechanisms that individuals, communities, and nations typically use to return to "normal life". Diagnoses such as post-traumatic stress disorder, "major depression", anxiety, and "dissociative disorders" describe particular psychological reactions that can occur in anyone given the right combination of traumatic events. Repeated trauma is especially associated with long-term effects which can impair an individual's ability to function in relationship to others. Individuals, of course, comprise communities, societies, and nations. If as a group they have been traumatized, then the ability to "bounce back" without a larger network of support could be greatly impaired.

For repeated trauma to occur, a state of captivity must be established by a perpetrator or perpetrators. In the former Yugoslavia, this has happened in a number of ways including: forcing people into concentration camps and holding whole cities hostage, such as in the case of Sarajevo. Captivity allows the perpetrator to break down the will of the individuals through an assortment of techniques including: isolation from the outside world, torture, rape and other bodily violations, deprivation of such physical needs as sleep and nourishment, forcing people to witness violence against others particularly when rendered helpless to intervene, and making people go against their own values, such as threatening someone with death of a loved one unless he or she tortures someone else.

Fortunately, the harm done to the human condition by violence does not have to be the "end of the story". Much has been written about the recovery from violence including the work done by clinicians in the U.S. Veteran's Administration and by those working with individual victims of such violence as rape and incest. A number of these clinicians, such as Hermann and Courtois, have described the "stages of recovery" people who have

been traumatized go through for healing to occur. Healing may be defined as reaching a state of resolution within oneself and in relationship to others. On a larger scale, the "healing of a nation" might be described as coming to that state collectively within a society and in relationship to the global community. Resolution is a state of understanding that one has been forever changed by the violence that occurred, while integrating these changes into a new definition of self and thus be able to go on with the future without being controlled by the past.

The key to the initial stage of recovery is for the violence to be "in the past". In general, healing depends on establishing safety. If one is living with violence or the threat of violence, recovery cannot proceed. This is the case for many of the refugees in Croatia. For example, in the transit center at Karlovac, shelling and sniper attacks on the town continue threatening the lives of all who live there. A more typical example of on-going trauma is the separation of families, as some members are trapped or fighting in B-H.

Along with the establishment of safety, relationships must be fostered which support the traumatized individuals without controlling them and which provide an atmosphere for trust to develop. Ideally, these relationships should include a network of friends, care givers of various kinds and a supportive social system while allowing the individuals control over their own recovery. Fostering the use of culturally appropriate coping mechanisms is especially useful at this stage. Some of this is already happening in the refugee camps of Croatia. For example, a local NGO called the "Center for Women War Victims" is going into camps, befriending women, inquiring about their basic needs and providing the opportunity for trust to develop within the context of an ongoing relationship.

Later, in the context of supportive relationships and when the threat of violence has been minimized, people can safely enter into the next phase of recovery. At this point, survivors might choose or find themselves recalling the past, along with the feelings associated with these memories, mourning for the losses they have been forced to endure. Croatia's existing health care system has many psychologists, psychiatrists, nurses, and social workers who would be able to provide the therapy, both to individuals and groups, in a culturally appropriate manner to facilitate this grieving process.

Going through this process frees people up to enter into the final stages of recovery which Hermann calls "reconnection and commonality". In this stage, people reach a point in which they no longer see themselves as only victims. They begin to be able to expand their view of themselves and their world beyond the confines of their violent pasts. At this point, "something new" can be created and just as in the story of "St. George the Dragon

Slayer", they discover that it is not cutting off the dragon's head but piercing his heart that releases virtue in the end.

## B. Trauma Victims

As one Croatian woman observes, "We are all victims of this war." Everyone has experienced the loss of the former Yugoslavia, of a stable society and the way of life associated with it, and of families and friends. Many people have also lost their homes, schools, and communities. People have lost their jobs in the tourist areas of Croatia, farmers in Bosnia have lost their lands and livestock, and young people face unemployment and inflation in Zagreb. Students have had their education disrupted. Factories, hospitals, schools, houses, bridges, roads, water stations, etc. in B-H and Croatia have been bombed (although the level of physical destruction is far greater in most parts of Bosnia). People have been forced to adopt ethnic identities and to treat others as ethnically distinct. Almost everyone has seen their usual routines altered in some way by the war.

The various forms of trauma from lesser to more extreme include: (1) economic and social dislocation; (2) separation from family; (3) violence so extreme that can alter the social fabric and personality of the individuals affected. Initial traumatic experiences are being reinforced in individual cases by (4) retraumatization through others or (5) living conditions.

### Economic and social dislocation:

The level of economic and social dislocation varies from the more severe forms of those who have overnight become minorities within enemy-held territories (including Serbs living in Croatia) to those who have lost their jobs in their country of residence due to discrimination. The war has also affected those who may not have experienced the conflict directly, but are sheltering the refugees and displaced, and live in fear of war coming to their communities in B-H or across the border to Croatia, Montenegro, Macedonia, or Kosovo.

More than three million people have become internally displaced or refugees. Among them, some people are especially vulnerable. They include unaccompanied elderly, unaccompanied minors, and female heads of households. Many female heads of households have lost their primary source of income and thus, have no way to care for their children. Some women are "traumatized caretakers" who, because of torture or other war-related trauma, may not be able to nurture their children adequately.

### Separation from family:

Many have also been separated from their families. At both ends of the life cycle, people are especially vulnerable and suffer more from the loss of family. For infants the loss of a primary caretaker can be critical to later development. For the elderly, the effect of dislocation and loss at a point when one is anticipating retired life and does not have endless years left to recover financially and emotionally is especially severe.

### Severe traumatization:

There are also a relatively smaller yet significant number of individuals who have been so extraordinarily traumatized as not to be able to function in daily life. Their situation varies from those who are in war-torn areas of Bosnia and are barely surviving, to those who have reached Croatia, and can and should be treated. For example, among the refugee and displaced population are men, women, and children who have been repeatedly tortured through sexual violence. There are also parents who have seen their children brutally tortured or killed and were helpless to save them. Others have experienced severe trauma because they have witnessed repeated violence to friends and family.

### Retraumatization:

Relief workers, local women's groups, and professional health care workers alike have reported that many refugees, particularly those women who have been sexually violated, are being retraumatized by well meaning outsiders (including journalists, women's groups, and officials) seeking information and documentation about these victims' suffering. The outsiders have not always conducted their interviews with sensitivity to the psychological vulnerability of the refugee victims. In some instances, the outsiders have even placed the refugees at physical risk because they have not maintained sufficient confidentiality. In addition, there has been little effort to provide follow-up care. There have been at least two reported cases of suicides following such interviews. Women have also been pressured to tell their stories by outsiders who say, "you have an obligation to help your people." At the present time, there are no guidelines or structures in place to protect these women and to help them in the healing process.

### Repeated Trauma: Living Conditions

The situation of refugees and displaced from the war varies by location and by living circumstances. Within Bosnia, most are not living in safety. They are living with other families, in public buildings, and as prisoners, in detention centers. In Croatia, most are living in relative safety (except in those

border areas of the country where conflict is reoccurring). The refugees and displaced in Croatia are primarily living in apartments, with local families, and in collective centers in tourist hotels. Some, however, are housed in camps and transit centers. On the Dalmatian coast, for example, relief workers reported that 50% of the refugees are living in private homes and 50% in hotels and camps.

Many of the refugee camps are crowded, with poor sanitation and inadequate lighting, and little privacy. The refugees in the camps are living on a restricted diet and have inadequate hygienic supplies (toothbrushes, soap, and feminine hygienic items). Their mobility is somewhat restricted. More significantly, they can be forcibly moved without notice.

In late February, 1993, relief workers reported that some 2,000 - 3,000 refugees were moved without notice from Reznik Camp to a site in Varazdin. In moving the refugees, the Croatian Government surrounded Reznik with armed guards and police dogs and forced the refugees onto buses. The night before the move, the Government turned off the electricity to prevent people from fleeing. They had little forewarning and were then told the next morning to board the bus for Varazdin. The relief agencies were not allowed in and there was no UNHCR protection officer present. The conditions in the new camp in Varazdin are reported by relief workers to be poorer than those in Reznik. On the Croatian side of the camp, two people live in a nine by twelve room. On the Bosnian side, 18 people live in a nine by twelve room. Many people have lost personal belongings in this move and ties to families and friends in Zagreb. Families have also been separated in the process. The process of moving people from place to place is dehumanizing and potentially retraumatizing.

People living in collective centers in houses, summer camps/hostels, and hotels along the Dalmatian Coast fear being forcibly evicted come the summer tourist season. Last summer, some refugees camped on islands. Although the local villagers have taken people in and hotel owners are receiving money from the government, they have also lost income from tourism. These places will have to be refurbished and repaired once the refugees leave.

The refugees in the collective centers have better living conditions than in the camps and receive food cooked in central kitchens. However, many adults have little to do to occupy their time. An estimated 50% or more of the refugee children are not in primary school due to overcrowding in the local schools. In some cases, the refugees are starting schools themselves. The Bosnian Government is also trying to establish its own schools with its own curriculum.

Elderly people in collective centers who have been separated

from their families live alone in small facilities with nursing care, but with few amenities. In one elderly people's cottage visited, the people spend most of their day lying on cots. Most were elderly women. A few were still wounded. They had no social activities and lacked hygienic supplies (e.g., diapers for incontinence). They reported being lonely and when interviewed, were visibly upset about being away from home and separated from their families.

### C. Children

In this war, civilians are the specific focus and target of violence. The "ethnic cleansing", which continues unabated in Bosnia-Herzegovina, has led to widespread physical and psychological suffering among children in war-affected areas of former Yugoslavia.

Violence and bombardments also have resulted in massive displacements of war-affected populations. At present, there are some three million people from former Yugoslavia who are displaced within their own state (Bosnia-Herzegovina, Croatia), in other Republics of former Yugoslavia, in several European countries (Austria, Hungary, Germany, Italy, Turkey, among others), in the Middle East and Asian countries (Jordan, Kuwait, Libya, Malaysia, and in North America (United States, Canada). About one-half of all these refugees and displaced persons are children under the age of sixteen.

Still it is civilians inside Bosnia who are most at risk at this time. Thousands of families remain trapped in cities and towns where there is little economic activity, few sources of food, and nowhere to escape. None of the camps for displaced people in B-H are able to provide schooling for any of the children, while infants and toddlers are especially vulnerable to the diseases and respiratory infections that result from the lack of food, inadequate sanitation, poor housing, and under-supplied health services.

In addition to displacement, many children, mothers and fathers have experienced severe trauma. Mental health services and social outreach programs are non-existent in Bosnia's camps for displaced persons.

Despite courageous efforts of parents and extended family members to continue to care for children in war-affected areas, massive child-parent separations have occurred in both Bosnia and Croatia. Fathers and teenage boys over fifteen years of age who were drafted into armies often have lost contact with their families, while many mothers who remained in endangered communities to care for children and the elderly have been killed, physically abused, raped, and forced to flee. Moreover,

faced with repeated shelling and the threat of a winter without adequate food or protection, thousands of parents in Sarajevo and other war-affected areas, hoping that the separations would be temporary, sent their children to other countries.

Neither UNHCR's or ICRC's general information on refugees or displaced persons contain data on separated or "unaccompanied" children. Some estimates suggest that about 5% of the child-refugee population is without parents or legal adult guardians. Official data suggest the percentage of unaccompanied children may be higher. For example, October 1992 data on displaced persons in Croatia indicated that of 46,051 children under the age of fifteen, almost 20% (9,067) were unaccompanied.

Detailed information on unaccompanied children is sparse. A Unicef project on psychosocial assistance to 420 host families in Zagreb identified 91 unaccompanied children placed in 62 families. Another Unicef study analyzed the conditions of 100 unaccompanied children in collective shelters, hospitals and host families in Zagreb. The children ranged in age from infants to adolescents (13 were 0-3 years-old; 6 were 4-6 years-old; 10 were 7-10 years-old; 24 were 11-14 years-old; and 36 were 15-18 years-old). While before the war, three-fourths of these children lived with both parents and about one-fourth with one parent, over half of them (54%) were placed in host families without the written or verbal consent of either parent.

#### Refugee and Displaced Children in Croatia

Children, their mothers and the elderly, comprise 90% of the 700,000 official displaced persons and refugees in Croatia. In addition, there are another 150,000 estimated non-registered refugees. Children under 18 years old constitute 60% of the total figure.

Most of the registered refugees have been taken into families or put up in hotels and pensions where, at government expense, their obvious needs for food, shelter, clothing, and medicine are, for the most part, being met. Less obvious problems are now beginning to be identified.

Nearly all refugee women and children in Croatia have been separated from their husbands and fathers. Despite ICRC's program to exchange messages between separated family members, the majority of refugee women and children do not know the locations or the welfare of their husbands and fathers.

Many children and their mothers were victims of physical abuse, beatings and rape. In their home villages, they witnessed violence and murder of family members, friends and neighbors, and were robbed of their personal possessions. Severe depression and dysfunction is reported to be on the rise among women, which not

only affects them as individuals, but decreases their capacity as mothers to care for their children as well. Boys and girls over the age of ten also appear to be at increased risk for depressive disorders.

In recent months, several intergovernmental and non-governmental organizations have attempted to respond to the psychological and social needs of refugee children. In October 1992, Unicef began a series of trauma workshops for teachers in primary schools in and around Zagreb that have accepted significant numbers of refugee children. The seminars provided teachers and school-based psychological practitioners with basic information about post-traumatic stress syndrome, art therapy in classrooms, and individual and group treatment programs for especially vulnerable refugee children. The program, funded by Norway, receives technical assistance from The Child Trauma Center in Bergen, Norway and from the Department of Health Psychology in Croatia. Unicef plans to offer more seminars for personnel from 20 additional schools and, eventually, for governmental supervisors from six different regions that have absorbed large numbers of refugees and displaced persons.

An evaluation of the impact of the first seven seminars is still in process. However, Unicef personnel stated that preliminary results indicate that the success of the program so far depends on the pre-existing orientations of individual teachers and school-based psychologists before they were exposed to the training. Those who believe that refugee children are a national priority and respond to them out of humanitarian concern, appear to have put the seminar contents to good use. Others, perhaps even a majority, who are concerned with routine teaching tasks and believe that refugee children should not be in Croatian schools, have not implemented art therapy or treatment programs for refugee children.

It must also be noted at despite government policy, many primary-school aged refugee children are not in formal schools. Local schools have been unable or unwilling to absorb them. Moreover, Muslim refugee children who read only Cyrillic are taught by Muslim refugee teachers in camp-based schools. These children will not benefit from the Unicef program.

One of the most vulnerable groups of refugees are currently residing at the Karlovac transit center outside of Zagreb. Initially established for men and male youth who were tortured and brutalized inside Bosnia and are seeking resettlement to third countries, the transit center now houses about 100 women and children who entered Croatia seeking their husbands-fathers.

At Karlovac, the International Federation of the Red Cross (IFRC) helped establish an emergency medical team of ten doctors to assist the residents in this overcrowded center. The team

also employs a general practitioner who undertakes basic psychological screening. In addition, IFRC employs three social workers who, among other activities, are beginning to establish pre-schools for children.

Recently, IFRC also began outreach work for refugees housed along the coast. In addition to general support, IFRC's coastal project is helping to establish a network of support groups for war victims and will offer training for local practitioners and social workers who work with refugees. Plans are underway to establish a school for Muslim refugee children.

Because of the rapid increase in the number of refugees, the Croatian government, despite the help of UNHCR, has managed only to arrange for the barest necessities in terms of food and medical care. Nonetheless, since the fall of 1991, a number of groups of Croatian volunteers and other individuals who had graduated in the field of psychology and social work began to respond informally to the psychosocial needs of refugees. One of these groups--Suncokret--chose to concentrate on the problems affecting children.

Suncokret, which has linked itself to the Belgium-based International Service Civil International (ISCI), an international organization for volunteer work worldwide, might be described as a budding non-governmental "Peace Corp." Today, over 100 domestic and ex-patriot volunteers (mostly university students) are living and working in a number of camps in Croatia. In addition, about 20 volunteers are working with displaced people near Medjugorgje in Bosnia.

Volunteers have offered many varying and different types of activities for children, ranging from musical and theater workshops, radio projects, sports and other games, to language and other lessons. They have helped to establish schools, recreational programs, and support groups for the children's mothers. Their plans also include preparing mothers and children for the inevitable moves within Croatia, and once the moves occur, to establish small economic enterprises and employment opportunities. They have a day-to-day presence in the camps where they work and seem especially well informed about the refugees' needs.

#### Abandoned Newborns

Consistently the team heard: (1) to the knowledge of government and NGO officials interviewed, very few babies from rape have been born to date and (2) a large percentage of pregnancies from rape are presumed to have been aborted. The team also heard that if there ever will be a significant number of births, they will begin in March or April 1993, nine months after the systematic rape is believed to have begun. For

example, Sister Angelita of Caritas Zagreb stated that 20 abandoned babies are being cared for by nuns in CARITAS homes. In addition, 38 siblings of the abandoned "newborns" were also abandoned and are under Caritas' care. The director of the hospital in Zenica, Bosnia, reported only a single case of a baby being abandoned. He also stated that the rate of abortions is "extremely high" and growing, but that they do not perform abortions after the 20th week.

The number of newborns of rape was reported as five, seven, 20, or "no way of knowing." Three indications that a newborn resulted from rape are: (1) they are abandoned at hospitals at birth, (2) the mother comes from a region "ethnically cleansed", and/or (3) the mother refuses to see the baby. There was no evidence that women coming into hospitals for delivery are interviewed or offered counseling. Health care practitioners may prefer to offer the women anonymity and to avoid adding to their pain, grief, and shame. Many practitioners, due to their overwhelming workload, are also not available to assist traumatized women on a sustained basis, even if the women ask for services.

The number of future newborns expected from rape was reported as "no way of predicting" to "up to 700 in B-H and a few in Croatia." There has been no effort to find the women carrying these babies. It would also be difficult because a large number have been assimilated into host families. The justification in not asking is, again, to protect the dignity of the women. There are also no service providers available to offer help to them if the women are identified.

In Croatia, abandoned infants are cared for in either government or NGO facilities. Those of Croatian mothers may be placed for adoption after six months. The law requires a six-month wait for abandoned children while the parents are searched for and/or the abandoning parent changes her/his mind. Most babies already born are of B-H mothers with refugee status in Croatia. The B-H Government has notified the Croatian Government that it considers them B-H children, not eligible for adoption through the Croatian process, and that they must be delivered to Bosnia for care within two years following birth. The Bosnia Government has also suspended all adoption procedures for the duration of the war. UNCHR has contracted with Child Protection International to study and recommend solutions to the adoption issue.

Merhamet, the Muslim relief organization, has declared that the Muslim community will assume care of all infants of rape born to members of their faith, and that these infants will not be candidates for adoption placement. They assert that those not cared for by birth mothers, should be cared for by foster families or in institutions, if necessary, but "not by adoption."

They do not state whether adoption by Muslim families would be acceptable.

The Croatian Government states that there are many adoptive parents in Croatia willing to adopt babies of rape, regardless of ethnic origin. Further, the Government has no plans for identifying newborns of rape from the general population and does not anticipate large numbers of these babies.

### III. EXISTING SERVICES

#### A. Health Care

Health care in Croatia is primarily provided through a well organized, sophisticated national health care system on a par with most Western European countries. The first director of the World Health Organization, Dr. Stambler, was a Croatian who returned when the communists took over Yugoslavia and implemented the pyramid system he developed for WHO. At the apex of the pyramid are teaching hospitals located in four regional centers (Zagreb, Osijek, Split, and Rijeka) called Clinical Center Hospitals. Below these sophisticated tertiary care teaching facilities are regular city or county hospitals. In addition to these general hospitals, there are specialty hospitals for designated conditions such as tuberculosis or mental health problems.

At the base of the pyramid is a public health system organized around clinics called houses of public health to which patients are referred from local dispensaries or ambulances. Ambulances are usually staffed by two doctors and two nurses and deal with most everyday, common problems.

Medical leaders indicated that Croatia has an adequate number of well trained health professionals in almost all areas. There is a reported surplus of physicians and an adequate number of nurses and paramedical personnel. Leaders of the medical school in Zagreb indicated and the team observed that there was little experience or training in the areas of sexual abuse and that training in these areas was needed. If the war continues, the numbers and type of health professionals will have to be reevaluated in light of the need for long term trauma treatment for many individuals and the possibility that hundreds of thousands of refugees and displaced persons might continue to live and receive health services in Croatia.

The team visited five hospitals and numerous ambulances throughout the country and was very impressed with both the level of care and the sophistication of the medical practitioners. The medical professionals seemed highly dedicated, were working exceedingly long hours under great stress, and were providing excellent care within the constraints they had to operate. This is in spite of receiving low salaries (physicians make between \$100-150 dollars per month) and salaries that have fallen markedly in the last two years as a result of high inflation.

An excellent system that offers universal care to all is not without its problems. The war has exacerbated pre-existing problems in the universal health care system.

- o Funding - the war has resulted in inadequate funding being made available to the health care system to purchase necessary medicines and equipment. The system continues to work primarily because of the dedication of the health professionals and a fairly large infusion of donated medicines and supplies.
- o War damage - Serbian forces have destroyed or damaged a large number of the hospitals and equipment in Croatia and B-H. According to the Croatian Medical Journal<sup>2</sup> and government sources over 30 hospitals have been totally or partially destroyed with damages that amount to over \$750 million.
- o Management - Management techniques and normal cost accounting could be greatly improved. It is not surprising in a system that did not require accounting for costs that methods to make decisions on resource allocation and efficient operations have lagged behind.
- o Referral - Patients access care through their gatekeeper physician who is part of the public health system. Inefficiencies have arisen because each referral of care including follow-up care or tests must come from the primary physician. This evidently leads to large inefficiencies as people run back and forth to get "tickets" and receive results.

Findings:

1. Croatia - although overall the health care system is excellent and manned by dedicated professionals, the war has exacted a heavy price. Buildings and equipment have been destroyed, government funding is inadequate to meet the demands of over 700,000 refugees and displaced person, medical staffs are exhausted and underpaid, and medicines and equipment in some areas are in short supply. Without more funding, the health care system at some point will fall into chaos. It is unlikely that any government that allowed this to happen could survive in Croatia. Given the excellent nature of the present system, it would be expensive and highly inappropriate to establish a parallel system. To the degree possible assistance should seek to shore up and complement the established health care system.

2. B-H - In B-H, hospitals and clinics continue to operate

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<sup>2</sup> Zdravko Lackovic, Jasenka Markeljevic, and Matko Marusic, "Croatian Medicine in 1991 War against Croatia: A Preliminary Report, in the Croatian Medical Journal, War Supplement 2, 1993, page 114.

in many areas in spite of the war. The team visited facilities in Mostar and Zenica and discussed the situation with many PVO groups. Until the war is over, provision of emergency medical supplies to the facilities that are still operating is of paramount need.

IRC and UNHCR have been able to get some medicines to many areas in B-H. There are also a number of PVO's that have on-going communications with areas throughout B-H and continue at great risk to supply these areas with medicines whenever possible. For example, Merhamet has a large warehouse filled with donated medicines that it is constantly sending throughout B-H.

3. Out-of-date Donated Medicines - Large numbers of expired medicines--in one case by over 24 years having expired in 1968--have been donated. Donated medicines are also often either inappropriate or so mixed together in small batches as to be almost useless. Care must be given to providing needed medicines and supplies in sufficient quantities to be effectively distributed.

4. Muslims' Access to Services - Earlier this year the government felt it could no longer afford to continue to offer health care beyond emergency services and vaccinations to refugees. In response to protests from the international community and an infusion of money from UNHCR, the government has reversed this policy, but there are still reports that Muslims are discriminated against and are either put at the end of the line or not admitted at all. The team saw examples of wounded Muslims who were denied entrance to hospitals in Zagreb but also toured the Children's Hospital, where the same loving care was given to Croats, Muslims, and Serbs alike.

5. System-wide assistance - Given that almost all refugees and displaced persons to some degree use the existing Croatian national health care system, and therefore, deplete its resources, health care assistance should not only be targeted towards programs for refugees but also assist the overall system. Such assistance should be contingent on the equal availability of services for refugees (Muslims and Serbs) in addition to Croats.

#### Recommendations:

1. Emergency Medical Supplies (\$2 million) - Either through OFDA or through an on-going contract which the Europe Bureau has with Project Hope, provide \$2 million in additional medicines and supplies to Croatia and B-H. These medicines should be made available to PVO's distributing them to B-H, to meet the needs of refugees and displaced persons, and to help meet gaps in the existing Croatian medical care system. A professional pharmacist and/or doctor should identify needs, such as the lack of cancer drugs at the children's hospital and the

reported lack of anaesthesia in B-H.

2. Hospital Partnerships (\$1.5 million) - We recommend establishing a hospital partnership program in Croatia. This program should include at least three hospital partnerships in different parts of Croatia. Candidate areas would include Zagreb, Karlovac, Osijek, and Split. The partnerships would be centered around trauma --both physical and mental-- and where possible, would include outreach programs into B-H. The partnership facilities would be located in areas with large numbers of refugees and displaced persons, so that the partnerships could work with local authorities to meet the needs of refugees and displaced persons particularly the victims of torture. These programs should also service the larger Croatian population, both because of the burden refugees are placing on the entire system and the fact that care is most likely to reach victims of torture in this manner.

## **B. Trauma Services**

Different levels of social and mental health services are needed to address the different kinds of trauma that have affected individuals, their families and communities. As the pyramid analogy suggests, at the lowest level, services should be directed for the entire population affected by war. Services that will benefit the population's social and mental health include: (1) economic development and increased levels of employment, (2) housing, (3) education and job training, and (4) increased communication and social awareness through the media. At the next level, people need more specialized services to address particular traumatic experiences and the social disruption caused by war. Such services should be offered by local paraprofessionals and relief workers, social workers, psychologists, teachers, nurses, and clerics. The services may be provided through government programs, women's groups, religious groups, social clubs, and other nongovernmental organizations. These people and organizations can assist in re-establishing communities, assisting vulnerable groups, identifying and referring extraordinarily traumatized and/or dysfunctional individuals to intensive health and psychiatric services, organizing support groups, and establishing hotlines. At the highest level of the pyramid, people who have been extraordinarily traumatized or are dysfunctional need specialized medical, psychological, and psychiatric services, which in this context often includes inpatient care and medication.

At the lowest level, the following groups could provide economic, educational, housing, and media services to the general refugee and displaced population as well as the affected local population: the Croatian Government, Caritas, Red Cross, International Rescue Committee, Merhamet, UNHCR, Croatian

American Society, the University of Zagreb, UNICEF, and the European Community. Many private individuals are also giving generously of their own personal resources and time. The media and communication system are sophisticated and programs could be developed for radio and television to assist both refugees and local people adapt to the stresses of war. Programming should be done by local groups but could be assisted by donors. The Croatian Government should be given support to provide for refugee housing and schools.

At the next level, the following groups are just a few of those who could offer more specialized services to trauma victims: International Rescue Committee (IRC), Suncokret, the Women's Center for War Victims, Autonomous Women's Center, Caritas, the Zagreb Women's Lobby, Trejnevka, the International Federation of the Red Cross (IFRC), local Catholic parishes and priests, the imams, Merhamet, and the University of Zagreb. Some, such as Suncokret, Caritas, and IRC, offer integrated services already for women and children. The local Catholic parish in Slavonski Brod is also offering a variety of services which are utilized by the Muslim and Croatian refugee and local population. The priests provide counseling as well as material assistance.

Finally, extraordinarily traumatized and depressed trauma victims will need inpatient care and treatment in local hospitals and at the Vrapce University Hospital of Psychiatry. Training should also be provided for psychiatrists and other medical care providers at the regional levels.

#### Findings:

1. Assistance and Range of Services: The current level of assistance to traumatized victims is insufficient. A range of social and mental health services is needed, from those which reach the entire population to those which involve intensive counseling, medication, and inpatient tertiary care.

2. Professional Expertise: Because of the inattention to rape and other forms of sexual violence in the former Yugoslavia, highly trained professionals do not necessarily have sufficient training in the treatment of post-traumatic stress, war trauma and/or sexual violence. At the general societal and cultural level, there was also a widespread "conspiracy of silence" on domestic and sexual violence.

3. Vulnerable Groups: Special attention must be paid to large numbers of unaccompanied minors, female-headed households, traumatized caretakers and the elderly.

4. Housing Conditions: There are different constraints in delivering services in camps versus hotels and private homes. In

general, the psychic costs of camp life are high and material conditions are worse than in the hotels. Yet, with tourism so important to the Croatian economy, refugees will eventually have to vacate the hotels.

5. Appropriate Modalities: Any treatment modality employed for the treatment of sexual violence and war related trauma should protect the confidentiality of the person being treated vis-a-vis others and their community. Rape shelters and specialized treatment of rape are likely to stigmatize the rape victim further and will not address the issues of secondary trauma.

6. Secondary Victims: A family and community perspective versus a particular focus on women is needed to address trauma. There is a need to work with men and children on this issue through education, schools, media, and social service programs. Issues of honor, shame and the way different economic and social groups within the society frame the experience of sexual trauma need to be addressed.

7. Vicarious Traumatization: The mental and social health of relief workers is at risk. Especially for those workers who must deal with large-scale victimization and severely traumatized individuals and/or must work in personally dangerous situations, the stress may be so great so as to jeopardize their work and their judgement.

8. Enforced Idleness: There are social and psychological costs for refugees and displaced who have nothing to do. They need to find some means of employment (even if unpaid) and teenagers and children need to be able to continue their schooling.

#### WID Findings:

1. Retraumatization: Various groups, including the press, embassies, nongovernmental organizations, women's groups, etc. have gathered evidence on women's rapes. The manner in which such evidence has been gathered may have put individuals at social and psychological risk.

2. War Crimes: Rape is a war crime and has been used as a deliberate tactic in this war. Victims of the war are the primary objective and weapon, not a consequence of the war. War tribunals are valuable for allowing the victims to recognize the political and military nature of their trauma.

3. Sexually Transmitted Diseases: Little is reported and there is almost no screening being undertaken in potentially high risk groups (e.g., soldiers and sexually assaulted victims).

4. Women's Health Care: Women may not be availing themselves of all health services because of overcrowding and long lines, limited access to safe abortion and family planning, and problems of confidentiality.

5. Women's Status: In the transitional political and economic state, women report that they are losing ground in terms of employment and legal protection.

### Recommendations

(1) An umbrella grant - to a knowledgeable and locally experienced U.S. PVO to provide funding, training, and other technical assistance to local women's groups, nongovernmental organizations, and uniquely competent individuals

(2) Short and long-term participant training - for psycho-social and mental health service providers

(3) Strengthening the Current Delivery System: From a public health perspective, A.I.D. should focus most of its efforts and expenditures towards strengthening the current primary and secondary level service delivery system (as outlined on the pyramid).

(4) Hospital Partnerships: Through its hospital partnerships and participant training programs, A.I.D. should provide assistance at the tertiary level to strengthen psychiatric services for trauma victims. More specialized training in the treatment of sexual and war-related violence and the ensuing trauma is needed. There is a need to key into the common myths around sexual violence and to understand the patterning of violence in individual lives and in the society as a whole. Social and mental health programs should respect and incorporate the local professional capacity. Study tours for professionals and paraprofessionals to the U.S. should be hosted that foster cooperation between the two and offer models of professional and lay person collaboration in U.S. mental health programs.

(5) Housing Program: A.I.D. with other donors should consider providing assistance to the Croatian Government to develop a housing program for refugees and displaced persons.

(6) NGO Support: NGOs that address the social and physical needs of these vulnerable groups, through hotlines, women's support groups, specialized medical care, or educational programs should be supported. Programs that are able to integrate both women's and children's needs should be given priority.

(7) Stigmatization of Rape Victims: In developing trauma programs, victims should be accessed through their communities and care should be taken not to single out women. Programs

should be developed at all three levels to address the different degrees of trauma.

(8) Causes of Violence: A.I.D. should support NGO, women's groups, and local university researchers in the efforts to understand the nature of this violence and to develop programs to address its causes and effects.

(9) Vicarious Traumatization of Relief Workers: In any of the programs that A.I.D. funds, a component of the program should address this issue through, for example, mandatory leaves, debriefing meetings, peer consultations, and professional training opportunities.

(10) Education and Training: A.I.D. should consider supporting Bosnian and Croatian government efforts to provide more primary schooling (and/or encourage other donor support in this area). A.I.D. should also encourage other donors to provide scholarships for refugee university students to complete their education. Finally, NGO programs to support women's microenterprises should be considered.

(11) Assist to Establish models of trauma care - a number of American and international NGO are working to set up models of trauma care which includes training components for local health professionals. If funding permits, assistance to these groups should be considered.

#### WID Recommendations

(1) Interview Protocols: Human Rights Groups, the State Department Bureau of Humanitarian Affairs, Interaction, and/or the Office of Women in Development should develop protocols and guidelines designed to protect the best interest of the women and other trauma victims interviewed in these situations. These protocols should protect the women's identity, outline the boundaries of inquiry, provide for informed consent, and include a follow-up plan in the case that such an interview is traumatic. The guidelines should be distributed to the press corps, government and documentation teams, and the humanitarian aid organizations. The enforcement of these guidelines may be considered part of UNHCR's and Human Rights Groups' protection function.

(2) War Crimes Tribunal: For symbolic reasons, to acknowledge the need for retribution and accountability, to restore peace and to promote psychological healing of individuals and their communities, the international community should establish an impartial and nonpartisan War Crimes Tribunal.

(3) STD Diagnosis and Treatment: Education, screening, and treatment need to be more readily available to all sectors of the

population (refugee, displaced, and local) through prenatal care, family planning clinics, and hospitals with confidentiality assured. A.I.D. should consider supporting assessments to ascertain the extent of the problem.

(4) Women's Health Care: The quality of health care as it affects women's health should be further investigated and considered in the development of health assistance programs which A.I.D. funds.

(5) Women's Status: There is a need to support women's groups and nongovernmental organizations which address women's economic and social status through A.I.D.'s emergency and development assistance programming.

### C. Psychiatric services

The current medical infrastructure in Croatia includes many psychiatrists. In conversations with psychiatrists and other faculty of the medical school at Zagreb, a number of needs were voiced.

The clinicians interviewed identified a lack of experience in working with rape survivors and victims of violence before the war. As in the United States until ten or so years ago, incest and rape were vastly under-reported--"nobody talked about it". They expressed a desire for training from the United States regarding this area of need. Workshops and other seminars taught by people experienced in cross-cultural psychiatry, the psychotherapy of trauma survivors and the management of psychotropic medications for people with severe post-traumatic symptoms would be very useful for this particular professional community in Croatia.

Additionally, providing books and journals addressing the treatment of post-traumatic stress disorders would be quite helpful. A large body of such literature has been written by clinicians in the United States and other countries and journals, such as the Journal of Traumatic Stress, are widely available. The Croatian clinicians, however, do not have the funds to purchase these materials and donations for a library of this sort-perhaps to be housed at the medical school in Zagreb- would be appreciated.

Another area that needs funding is research on the psychological effects of the war. Physicians have already been gathering data on refugees' acute psychological disturbances. Following up these findings over time will not only aid these individuals but will be an important contribution to the world medical community regarding the treatment of victims of violence.

The psychiatrists in Croatia are eager to understand and treat the numerous people affected by this war. They need books, specific training, and money for research in order to enhance their expertise in this area.

#### D. Prosthetic Services

Pre-war Yugoslavia had a modern European prosthetic industry located in Belgrade, Zagreb and Sarajevo. The current problem area is Central Bosnia where an estimated 500-1000 known war amputees had no access to prosthetic assistance until the recent arrival of Handicap International (HI) in January 1993. Located in an annex building of the main hospital in Zenica, HI began seeing patients in early February, and they are planning a trip very shortly to Sarajevo to assess the status of the former prosthetic facility and its staff.

The head of orthopedic surgery at the Zenica hospital, the International Rescue Committee (IRC) registered nurse at Mostar and the HI staff said that many of the field amputations were poorly done and required further surgery which was difficult to schedule given the emergency-only status of the hospital. Field medical stations utilize whatever local doctors are available. Thus, gynecologists and general practitioners who have never performed surgery are doing amputations.

HI has a French physical therapist coordinator and a French prosthetist on-site. A local orthopedic workshop owner is being trained as a prosthetic technician, and additional local staff is being recruited. All patients are being fitted with prefabricated provisional prostheses imported from France (both above-knee and below-knee). The current capacity is 20 patients per week, and the waiting room was filled when the team visited. Current funding will allow 500 patients to be fitted, and there is no funding to permit the fitting of permanent prostheses. At this time, the HI staff knows of one pediatric case. Clients thus far have been overwhelmingly young men. It must be stressed that HI has only been operational a few weeks, and they are only dealing with the immediately known cases -- the true extent of demand is unknown. Transport and communication difficulties make their outreach limited. The HI team knows of 100 cases in Tuzla (in the extreme northeastern part of Muslim-controlled Bosnia). They hope to get into Tuzla to assess the situation and decide on their approach to these patients. The HI facility at Zenica has space for housing 10 patients from outside the immediate area. They have not seen demand for orthotics, nor are they equipped to deal with orthotics. There is also no capability to treat hip disarticulation or upper extremity amputations. While land mines are used, the prevalence does not approach the levels seen in other war zones, and the problem is not widespread among farmers

and children as it has been in other wars.

HI, the head of orthopedic surgery and the IRC nurse all mentioned the urgent need for external fixators. The surgeon claimed that half of the amputations he performed could have been avoided if the equipment he previously had used were available.

Carole Nerland, the HI coordinator, was hopeful that a second phase proposal which she was already preparing would include local production of permanent prostheses and the training of a local staff. Local metal and plastics are available and there is some hope that the previous employees of the Sarajevo prosthetics facility can be located. The team assured her of USAID interest in seeing any follow-on proposal.

## **E. Children's Protection Services**

Former Yugoslavian Laws, known as The 1978 Act on Family and Marriage Relations, and The Act on Social Protection are under revision. Prior to the war it is reported that services were acceptable by international standards. War-time conditions, particularly the large number of displaced persons and refugees, are placing strains on the existing system.

Services have been and continue to be delivered through district Ministry of Labor and Social Protection (MOLSP) Offices, supervised by 17 district offices throughout Croatia, and administered by the central government. District offices have social protection teams including child and family welfare social workers, health professionals psychologists, and psychiatric care givers. Referrals are made by the individual seeker of services, from health, educational, or by law enforcement officials. In the case of child protection, they can be made by any citizen. Referral for child protection is legally mandated, not voluntary.

District social centers have the added responsibility for providing services to 700,000 victims of war within their jurisdiction. The consequence is that centers are severely overloaded with people needing traditional and now war-related services. Existing staff need help. However, funds are lacking to hire additional staff, although many trained individuals are currently unemployed.

### Findings

MOLSP officials report that child protection staff are not able to offer adequate services to children, such as helping families remain intact, to accept return of a child, processing a child from a center into a foster family and/or into adoption, because of the high volume of referrals requiring crisis intervention. There is concern that the situation is out of control and without added funding for staff, non-war related clients will soon be victims of the war-generated crisis.

Because of staff shortages, children, who should return to parental care, move into foster family care or into the adoption process, are remaining in the impersonal care of centers. Conversely, children in dangerous situations at home are remaining there when they should be moved into safer, out-of-family care. Family stresses generated by the war increase the caseloads and the entire child protection system is backed up. Staffing relief is needed.

#### (1) Childcare Centers

- MOLSP operates centers in the 17 regions of Croatia.

- Child/staff ratios are 10/1 which is 50% below recognized minimum standards for age 0-6 years old children who require more intensive personalized care.
- Funds are available for minimum care (food, shelter clothing, health service, minimum staff, etc).
- Centers are keeping some children longer than necessary because service center staff are not able to devote time to return home, faster family placement, or adoption. This poses a threat to normal psycho-social development and the ability to assure future adult responsibilities.
- Some overseas groups are providing toys and clothing to make environment more pleasant.
- Many foreigners seeking to adopt children from the centers. They must go through the central government.

### (2) Foster Family Care

On February 19, 1993 MOLSP held 1,910 children in foster family care. Prior to the war there were usually about 3000 in care. Numbers are down because of the loss of territory to Serbian occupation, social center preoccupation with refugees, foster families withdrawing because of poor support services from social center staff, and poor foster care payment (currently \$30 per month to cover total care expenses. CARITAS Zagreb stated that it costs at least \$60 per month to sustain a child in family care.

### (3) Adoption

MOLSCP is responsible for all adoption in the country. No-governmental adoption agencies tend to be viewed with suspicion.

A child may become available for adoption if parents, or surviving parent surrenders parental rights to the state, or if for reasons of abandonment, neglect or abuse, parental rights are permanently terminated.

When a child becomes available for adoption, the district social center responsible for that child is responsible for funding an adoption family within its own jurisdiction. If none is found, the child is referred to the regional MOLSC office which makes the need known to the district office within the region. If no family is found, the need is referred to the central MOLSP office in Zagreb, which makes the child known to all MOLSC regional offices and subsequently, if necessary, reviews foreign adoption applicants for a family. Foreign adoption occurs between five and ten times annually. It usually involves physically or mentally challenged children.

Parts of the former Yugoslavia have a long tradition of adoption for children of similar ethnic heritage. It is reportedly inconceivable that a child would be adopted across

ethnic lines. The Croatian Government (GOC) is taking a strong position that this standard will be adhered except in only the most unusual exception, which demonstrates the child's best interest. GOC officials seemed offended by the number of persons, organizations and governmental representatives coming wanting to adopt children. Many shroud their adoption agenda with offers of various kinds of assistance, which is seen as particularly offensive. A Croatian government official reports that domestic adoptions have increased since the war started--seemingly generated by an extra spirit of generosity.

GOC officials do not expect that infants born of rape will be difficult to place. They have Croatian families ready to adopt these children, in any case.

The Government of Bosnia and Herzegovina (GBH) has declared a moratorium on adoption for the duration of the war. Muslim representatives from B-H state that babies of rape born to Muslim mothers will be cared for by the Muslim community if birth mothers are not willing to keep them. Koranic scholars have said that raped Muslim women are heroines of the war, of special grace, and to be honored and protected appropriately; as are their offspring.

Infants of rape born to B-H mothers in Croatia are declared by GBH to be B-H citizens and therefore cannot be adopted through Croatian proceedings. UNHCR is seeking a special consultant to look into the matter. In the meantime the reported "up to 20" of such known babies to date remain in care in Croatia. In the press of wartime priorities, neither government appears ready to invest significant time or resources into the matter.

### Recommendations

(1) Community Social Services: Provision of community based social services to victims of war through existing GOC structures and evolving Croatian NGOs is needed. Except for special war victims services, GOC and the former Yugoslavia have a tradition of providing acceptable social services (general welfare, counseling and psychological-psychiatric services, health services, special education, child protective, foster care, and adoption services) to its citizens.

(2) Training: The need for rapid infusion of feeds and specialized training for serving victims of war, thereby allowing the existing structure to resume services to its non-DPR clientele is critical.

(3) PVO Umbrella Grant: a grant to an NGO who would sub-grant to GOC agencies and/or local NGO's is needed. Funds received will help extend immediate care and will help develop the GOC and NGO capacity to offer direct and preventative

services to its citizens. This will also serve as a model and a training venue for export to B-H and other countries in need.

(4) MOLSC Model: The model used by MOLSC would be the base for developing services to war victims. A system for serving war victims will include components for conflict resolution and ethnic healing, as well as community building, family and community economic issues, single parenting, etc. Individuals and/or families would be brought into services through self referral, referral by other professionals, schools, law enforcement, DPR Camp staff, home visitors, and multiple other ways. Some services would be individual while others would be done in group setting. Volunteers, and essentially, DPRs would be actively engaged in service delivery.

(5) Duration of Funding: Funding for the duration of the war plus at least 5 years past war would be necessary. Social workers and other human services professionals, including physicians, are paid \$100 per month. Using that figure plus a average of 33% cost for support services for each worker the figure of \$133 per month would need to be used for staff calculations.

(6) Revision of Laws: MOLSC representatives would like assistance in securing model family welfare laws, and child welfare including adoption laws and regulations. The GOC is reviewing similar issues A.I.D. may pass this request on to: the American Public Welfare Association, the Child Welfare League of America, DHHS Children's Bureau, and the National Committee for Adoption. These materials should be addressed to:

Ms. Helena Ujevia, Professional Counsellor  
Socijalne Skirbi  
Baruna Trenica 6  
41000 Zagreb  
Croatia.

Recommendations for Reunification:

1. Reuniting children and families - One of the most basic and urgent needs is to reunite unaccompanied children with their parents as soon as possible. Where reunification is not possible, other appropriate and legally prescribed placements should be sought. Vesna Bosniak, a senior program officer currently on leave from Unicef, has developed a plan of action aimed at supporting and reuniting unaccompanied children with their parents within and outside of former Yugoslavia. Initial efforts would involve two national non-governmental organizations: Our Children of Croatia and Merhamet. These organizations, in turn, would be linked an international non-governmental organization (possibly the International Rescue Committee) and to other organizations working inside Bosnia (Our

Children of Bosnia, Children's Embassy, etc.). If/when possible, the project headquarters would be moved to Sarajevo.

(2) Non-governmental organizations promoting grassroots social networks and support groups within refugee communities in Croatia should be supported. Suncokret is a child-focused, non-governmental organization that is developing social outreach programs that appear to be responding to the scale and scope of the problems facing refugees. Their effort would benefit from funds for transportation and stipends for domestic volunteers. Many more university students would like to become involved in Suncokret's effort; however, most students cannot afford to pay their own way over an extended period of time. There also may be opportunities for American volunteers. IFRC also has social outreach programs for war-affected women and children in coastal areas which should be considered.

(3) Coordination - There is a need to identify, coordinate and support Croatian professionals capable of providing relevant technical assistance to grassroots organizations working with refugees and displaced persons. There are a number of professionals, including university-based psychologists, social workers, and psychiatrists, who are offering technical assistance and training for the staffs of various organizations working with refugees and displaced people in Croatia. There appears, however, to be a discrepancy between what these professional have offered, on the one hand, and what field-based staff, on the other hand, believe they need. An independent assessment of needs and resources would be useful. The assessment could also examine the feasibility of creating a structure to serve as a clearinghouse to collect relevant information, offer training seminars, and develop action-based research efforts.

(4) Information Center: A focused, dedicated system should be established within Croatia, Bosnia, and Serbia which will proactively search for and monitor reports of abandoned newborns, as well as any reports of newborn adoption's outside of legal channels. One institution should be the central repository for this information and charged with the responsibility for monitoring the location, disposition and permanent planning for each infant. A.I.D. funds, if necessary, should be made available to assist in the start-up and first two year's maintenance of this "center." This center could be placed with: Children of Croatia, Children of Bosnia, ICRC or UNHCR.

## **F. Economic Assistance**

The economic impact of the war varies regionally within different sectors of the population. The tourism industry is particularly hard hit, but plants and factories in the east have also been destroyed.

Many of the displaced and refugee households in the former Yugoslavia are female-headed due to the war. While in-kind assistance for food and shelter is available, many are seeking new ways to supplement their marginal existence, despite the legal and economic constraints on employment.

Over the long term, the problem of how to make a living will become more serious. It is realistic to assume that women who have fled war zones will not see their husbands and fathers again. If current, tragic trends continue, the majority of Bosnian refugees will not be able to return home due to territorial occupation by rival ethnic groups. Thus, it is conceivable that many rural, refugee women will be put in a position of supporting their children in urban areas in foreign countries. Their past working lives have not prepared them for this change.

The price of defending Croatian territory and losing one-third of it and the price of hosting huge numbers of refugees in Croatia is borne by all who reside there. Rampant inflation has lowered everyone's standard of living drastically. Should war break out again or a new influx of refugees flood into the country, the breaking point of the average citizen might very well be reached.

#### Recommendations

(1) Provision of Seeds: A.I.D. through OFDA should provide seeds to boost local production. In addition, assistance for social services should be targeted to the areas most in need, ie, war-affected areas and areas with high concentrations of displaced people and refugees.

(2) Microenterprise development: A.I.D. should support NGO efforts to encourage microenterprise, especially for female heads of households. Assistance should encourage local procurement and build on efforts of IRC and other organizations, which are actively pursuing a strategy to maximize local procurement.

(3) Education and Training: Efforts to offer job skills training or continuing educational opportunities to the displaced and refugee population would be a wise investment. If peace and stability are restored to B-H so that the refugees can return home, the investment will benefit Bosnian society as a whole.

(4) SEED-funded economic assistance: SEED-funded economic assistance, which is primarily technical assistance and training, and therefor will not be diverted to the military should be provided. A.I.D. should work with other donors to create employment opportunities.

## V. PROGRAMMATIC FRAMEWORK

The team focused on the psycho-social needs of the refugee and displaced person population in Croatia and B-H, to assess the scale and severity of the situation of displaced and abandoned children, and to learn about local organizations' response to these needs. The team was impressed by Croatian society's ability to care and host a displaced persons and refugee population equivalent to one quarter of its base population.

For the most part, the team found that at this point, the basic material needs of the refugees and displaced are being met. Thus, we had the luxury of focusing on longer term issues, including the psychological welfare of the war survivors and the economic future of the displaced and the refugees. Given the precarious state of the Croatian economy, we also recognized that the situation for refugees, displaced, and the local population is rapidly deteriorating.

The conceptual paradigm for our assistance lies in our understanding of how people recover from trauma. As long as material needs are met, the focus turns to creating as normal a lifestyle as possible: reunifying families, getting children back into the classroom, allowing the adult displaced and refugee population to take on responsibility for caring for each other or helping adults prepare for an uncertain future through enterprise or continuing education. The immediate focus of our assistance would be to support efforts that allow people to resume a semblance of normal life.

While these social and economic foundations fall into place, preparations can begin to support trauma survivors in their psychological and emotional recovery. As daily life stabilizes, troubled individuals will discover that they are unable to ignore their grief, anger, or fear. It is at this point that they will seek or need help from others in coming to terms with the violence and loss that they have experienced. Thus, the longer term goal of the proposed assistance is to prepare and support the local network of professional and lay people who will help others in their healing process.

### Emergency Relief versus Care and Maintenance

Physical and psychological safety are prerequisites for recovery from trauma. Since the conditions in Bosnia are such that safety cannot be assured, international relief organizations are necessarily focusing their efforts on providing the requirements for basic survival. The civilians trapped in Bosnia, struggling for survival, need more than food, medicines, and fuel. They need protection and peace.

While the refugees and displaced people in Croatia face an uncertain future as well, they are physically safe and living in "care and maintenance" situations. They can be reached with development assistance aimed at addressing economic, social and psychological insecurities and mitigating the trauma of individuals, families, and their communities.

Therefore, recognizing that the greatest needs are in Bosnia but beyond the reach of development assistance, the bulk of analysis and recommendations in this report focus on the displaced and refugee situation in Croatia, existing efforts to assist this community, and areas of need. It is our hope that peace and civility will be restored in Bosnia so that the refugees that we assist in Croatia eventually can return home. The skills that they learn and the programs that they initiate in Croatia to help trauma victims should prove to be transferable.

### Developing Local Capacity

While foreign experts in the treatment of trauma can play a valuable role by offering their insights and lessons learned to their peers in the former Yugoslavia, the problems which the violence created will confront the peoples of the former Yugoslavia for the next generation. It is therefore imperative that the mental health community in countries such as Croatia begin to prepare for the long road ahead.

Since the suffering has been so widespread throughout the civilian population--not to mention the state of mental health of the military, it is obvious to those concerned that the job of supporting the traumatized is too big for the professional community to handle on its own. Two hurdles need to be overcome to achieve a meaningful and effective deprofessionalization of care.

One aspect is that while overworked psychiatrists acknowledged the need for deprofessionalization freely in their discussions with us, they do not appear to be totally comfortable with the concept of paraprofessional involvement. Therefore, A.I.D. assistance should strive to bring local professionals and local volunteer lay people together to strengthen and to complement each other's efforts.

Another aspect of the professional-paraprofessional disconnect is that the professionals are typically part of the state medical system while the paraprofessionals belong to the nascent NGO community in Croatia. Due to the state-dominated nature of the former system, the Croatian public health authorities are not yet comfortable with the concept of NGOs being involved in social services. A.I.D. sponsorship of committed, responsible NGOs--while a risk because they are new and struggling--may lend NGOs greater credibility. This

ultimately furthers the U.S. Government's goals of fostering the emergence of pluralized, democratic societies in the successor states of the former Yugoslavia.

#### Dedicated Managerial Support

For A.I.D.'s promotion of local NGOs to succeed, it is imperative that any financial assistance be coupled with organizational and technical assistance. Many of the NGOs are making the transition from spontaneous, volunteer efforts to more disciplined organizations with defined missions.

An A.I.D. officer or personal service contractor should be assigned to the field in order to monitor the progress of the local NGOs. On-site monitoring will be key in promoting those NGOs that are flourishing and intervening early with struggling NGOs--when directed organizational support or guidance can be decisive.

#### Development Assistance to former Yugoslavian Republics

The example of Croatia demonstrated to the team that while the primary suffering is occurring in Bosnia, an increasing strain is being put on other countries which accept the refugees. In Croatia, for instance, relationships between Bosnians and Croats are likely to become increasingly strained over time, as the refugee population grows and its prospects for returning home dim.

The U.S. is planning to provide SEED-funded economic development assistance to Croatia, in the form of technical assistance and training to emerging and privatizing businesses and government institutions that support market-driven economic growth. In addition, the donor community should continue to strengthen the capacity of the Croatian government to provide health, education, training, and housing to the war-affected population. Relief agencies and NGOs should be encouraged to work with and strengthen the current system rather than create parallel structures.

# ANNEXES

## **Annex 1: Displaced Children and Orphans Fund Report**

### **A. Unaccompanied Children**

It is recommended that approximately \$500,000 - \$750,000 from the FY 1993 DCOF be awarded to an existing local NGO to: a) support an international data base and tracing network, which would also provide specified social services to the children as well as their host families. This network will also collaborate with other, more generalized programs and systems which are managed by such organizations as the IOM, UNHCR and ICRC; and b) provide simple, basic support to a wide network of local, community-based NGOs which will extend throughout Croatia, Bosnia and hopefully Serbia. Within the former republics, this program would be incorporated under a network of existing local organizations known as "Our Children", and will also tie in with "SUNCOKRET" a community based volunteer program which currently operates in Croatia and is expanding activities into Bosnia.

### **B. Abandoned Newborns:**

It is recommended that a dedicated system to search out and monitor reports of newborns being born and abandoned throughout ex-Yugoslavia be established as soon as possible. The system should also attempt, if possible, to monitor reports of newborns being offered for adoption outside any legal system which might take effect in the future. (At the present time, no legal adoptions are allowed in either Croatia or Bosnia-Herzegovina.)

### **III Phase II interventions with additional OFDA or special DA funding, to NGOs through an "Umbrella Sub Grant mechanism:**

- 1) Seed, feed and possibly fertilizer for both family vegetable "Victory" gardens as well as large scale food crop and livestock production.
- 2) Provision of supplemental infant formula and milk
- 3) Support for school re-opening
- 4) Support for "Host families"
- 5) Cottage industry development

### **IV Encourage NGOs to continue current primary reliance on local produced material and products.**

## **V Health**

- 1) Possible support for immunization program, depending on effectiveness of WHO and UNICEF vaccine procurement and distribution scheme.
- 2) Assistance in rationalizing pharmaceutical procurement, distribution and use at the hospital and "ambulance" levels.
- 3) Specialized training for surgeons, doctors and medical/health staff in combat techniques and procedures.
- 4) Assistance in early identification of epidemics and support for preventative measures, especially with respect to water supply and sanitation interventions.
- 5) Physical rehabilitation of hospitals and clinics, and provision of basic equipment and expendable materials, drugs and supplies.

## **Displaced Children in Bosnia-Herzegovina**

70% of Bosnia-Herzegovina is under the control of the Serbs, most of which is not currently accessible to regular shipments of food, clothing and medicines. Places such as Zepa, Srebrenica, Gorazde and Cerska in far Eastern Bosnia would fall into this category. Within the remaining 30% of Bosnia-Herzegovina which is not under Serb control, there are three categories of security:

- A) Areas that are on or close to the front lines (which change on a daily basis) to which only basic survival supplies are delivered on an extremely erratic and undependable basis.
- B) Isolated pockets, where the only current supply is brought in at night on the backs of horses and people who sneak through the lines, and where air-drops have since taken place; and
- C) Relatively stable areas, where despite sporadic shelling and/or sniper activity, life goes on with an amazing normalcy, and where the residents are anxious to do spring planting and get their factories back to work.

These Category C areas are to a greater or lesser degree "stabilized" and UNHCR and international NGOs have established bases of operations in "hub" cities or towns. For Central and Eastern Bosnia, these "hubs" include Vitez, Zenica, Tuzla, Jablanica and even Mostar. In certain respects, Sarajevo falls into this category.

There are an estimated 1,500,000 displaced persons in Bosnia-Herzegovina, most of whom fled their villages and cities and have settled in "safe havens" in Category C areas. Approximately 60% of them are children under the age of 18. Approximately 85% of these displaced persons are residing in private homes, with the rest in "collection centers" such as schools, other public facilities or hotels. Few if any cases have been reported of young unaccompanied children, as all are either with their mothers, extended family or concerned countrymen.

All of these people depend to a great extent on the generosity of their host families and distributed goods and services from the international and national NGOs for basic survival needs. It should be noted that host families are not ordinarily eligible for humanitarian assistance at this point.

### **Phase One Activities**

Numerous NGOs, both "national" as well as international are operating humanitarian assistance programs in B-H, mainly

distributing food, winterization materials such as clothing, plastic sheeting and other shelter materials, solid fuel, cooking/heating stoves and medical supplies and medicines.

Some NGOs are importing goods, others are both importing as well as providing funds for locally produced or available goods such as wood, coal, stoves, etc. IRC is currently producing thirteen local products which have immediate application for the humanitarian effort and are distributed through their own and other NGO distribution networks. These include bunk beds, wood battens, solid fuel stoves with ovens, mattresses, winter shoes, children's clothing, trash receptacles, plastic sheeting, electric heaters, nails, mobile kitchens and various wood projects for repairs and maintenance.

UNHCR is the largest provider of food, shelter material including plastic sheeting, and medicine (primarily consisting of the WHO kits), and maintains warehouses which serve Central and Eastern Bosnia in Split, Metkovic, Zenica, Tuzla, Jablanica, Mostar and Sarajevo. After UNHCR, the International Rescue Committee (IRC) has the largest operation in the area. They and other NGOs provide distribution from the UNHCR and IRC warehouses to down-line distribution points. IRC also has assumed responsibility for facilitating the coordination and collaboration of other NGOs, and contracts through them and provides certain goods and services through them. They are apparently highly regarded by most if not all the NGOs with whom they work.

#### Phase Two Assistance:

Most international NGO field staff and representatives of governmental organizations and local NGO groups agree that there is great need for more of the basic (Phase I) assistance. In addition, Phase II assistance is needed and can be provided Category C areas. Phase II assistance would include modest, low level interventions in the areas of health, nutrition, education, water supply and sanitation and additional cottage industry development.

## Findings:

### Health

The health status in Bosnia ranges from "critical" in the isolated enclaves, to "endangered" at the front line areas, to "deteriorating" in the relatively accessible, stable areas. On the assumption that the isolated enclaves can only be reached with emergency medicine by airdrop or packhorses, attention should be focused on what upgrading and increased supply is needed and viable in the front line and relatively stable (Category C) areas.

In the front line areas, the need for intensive, very short courses on war-related "triage" medicine seems evident. Handicap International, for example, is attempting to set up a course in conjunction with the ICRC for field amputations. The amputations are now (understandably) being performed by whatever medical personnel are available, including general practitioners and gynecologists who have never performed surgery. The result has been stumps which must be reformed before prostheses can be fitted---and since only emergency surgery is being performed, this cannot occur. Because of the very high level of specialization and sophistication of the medical profession in the former Yugoslavia, it must be clear that the suggested training is not a "Third World Upgrade" but rather a colloquium among professionals to exchange techniques and experiences in war-related medicine.

In the relatively secure areas such as the main hospital in Zenice (the only functioning hospital in central and eastern Bosnia) the needs are for material, equipment, repairs, and a wider range of supplies and pharmaceutical. While WHO, UNICEF, MSF, MDM and PSF are all supplying some material and pharmaceutical, there are serious shortages and gaps in coverage. The Zenica Hospital, for example, has large stocks of basic drugs found in the WHO "Hospital Kits", but shortages of bandages, gauze, saline solution, alcohol, plasma, X-ray film, vaccines, external fixators and specialized drugs. The irony that virtually everything is manufactured in nearby Croatia and/or Slovenia makes the shortages even more frustrating. The ability to supply these items is constrained not by the lack of knowledge of what is needed nor by the lack of transport, but by two factors which could be overcome relatively cheaply and easily.

A) A medical logistics system which could canvass needs in the hospital, health centers and sub-stations, and seek out nearby sources. One major A.I.D. collaborating agency, Management Sciences for Health's "Drug Management Program" as well as the U.S. military have this capability, and also the experience to deal with delivery scheduling, warehousing and

control in wartime situations such as this.

B) Funding flexibility to procure items locally (in ex-Yugoslavia) and arrange for expeditious transport is necessary. The need for additional funding may not be great---the issues are the need for flexibility to react quickly to daily, changing needs and an ability to order directly without cumbersome procurement requirements.

The larger equipment needs and repair requirements may be harder to solve, but an experienced medical logistician on the ground would be better able to assess and establish priority needs from the current long lists.

At the present time, less than 40% of new-born newborns are being vaccinated in hospitals. Fewer are being vaccinated outside. UNICEF, MSF, PSF and others are actively engaged in an attempt to improve immunization coverage. While this will be impossible in the insecure areas, this situation should be monitored closely.

One special complication further draining meager supplies of vaccine is the fact that most medical records have been lost or destroyed and as a result areas such as Mostar are approaching the problem from the perspective that all children are assumed to have not been immunized.

Similarly, as the winter ends it can be anticipated that vector-borne diseases will emerge from areas where water supply and sanitation systems have been destroyed, nutritional status is low, and where normal preventive measures are impossible. This will be especially true in over-crowded collection centers where outlets and facilities are tremendously over-burdened.

## Nutrition

While nutritional status is impossible to monitor accurately, doctors and health personnel agree that certainly in the inaccessible areas as well as in many accessible pockets, maternal and infant malnutrition are serious problems.

The high incidence of mortality in infants under 7 days has been attributed to low birth weights, mothers' inability to produce milk (partially, if not primarily as a result of stress and trauma) and maternal malnutrition. In some difficult areas there are unsubstantiated reports that no newborns have survived at all in the past three months.

A number of NGOs are already providing nutritional supplementation and baby formula and are seeking additional funds for expanding this activity.

Besides the importation and/or local procurement of infant formula and supplemental foods (such as protein biscuits), the most important intervention would be the revitalization of local grain, vegetable, tuber and legume production and animal husbandry, through what is referred to as a major "seed and feed" program.

The spring planting begins in March for many of the vegetables as well as the oats and barley crops, and there is a critical if not emergency need for seeds, animal feed, fertilizers and planting tools. Most of this can be procured locally in Croatia or Slovenia.

### Education

From a number of perspectives, one of the greatest needs in Bosnia is to get the children back to the classroom. The children need organized activity and challenges to get their minds off the tragedy and trauma which they have witnessed and experienced. The mothers, especially those who have been traumatized, are primarily, if not exclusively, concerned about the health and welfare of their children. They need to know that there is hope and opportunity for their children and they themselves need the time, freedom and opportunity to become engaged in some sort of productive endeavor, both for therapeutic as well as economic reasons. Until their children are engaged, they cannot proceed with their own healing and lives.

Many of the NGOs are trying to support school re-opening by providing funds for structural rehabilitation, furnishings, materials, books, etc. There are many available teachers who are willing and anxious to resume teaching. There appear to be two major constraints, however. The first is some disagreement in some areas as to the new curriculum. This could probably be resolved on a case by case basis, however, if everything else were in place. The second obstacle is the presence of displaced families residing in many of the school facilities. NGOs are reluctant to push authorities to move any faster on removing people until and unless adequate alternative shelter is found.

Therefore, in some cases, NGOs are interested in supporting the construction of temporary shelters for either the displaced people or for temporary classrooms.

### Water Supply and Sanitation

Municipal water supply systems have been damaged or destroyed. Many collection centers have inadequate facilities for the number of inhabitants they house.

Some NGOs are interested in providing modest, temporary facilities by funding local construction and procurement of

materials and outlets.

### Cottage Industry Development

Underlying many of the above stated needs is the fact that most of them can and should be addressed by the provision of goods which can be procured and/or produced locally. The list of thirteen products currently being procured and distributed by IRC which is mentioned above is only an illustrative sample. Central Bosnia had been a very active industrial center. There are innumerable factories, large and small, which are being retooled to produce new and appropriate goods. For example, a large, undamaged aircraft factory in otherwise devastated Mostar is producing wood burning stoves which IRC has ordered. (Since all warring factions are hopeful of "taking over" Mostar, including an outstanding contract with Boeing Aircraft, and since it is not producing planes or weapons, no one apparently is inclined to bomb this particular facility.)

Similarly, clothing, bedding for shelters and hospitals, blankets, agricultural tools, furniture, etc. are all needed and could be contracted for by NGOs with small cottage industries, cooperatives, individual contractors, etc. Funding of these activities not only addresses the humanitarian needs of the refugees, but also addresses the critical economic needs of the host "safe haven" communities, which is a separate and growing problem. The added pressures on these communities of supporting refugees is straining their own resources and threatening the chances for maintaining a peaceful co-existence.

## **Recommendations for USG Assistance to Bosnia**

### **Displaced Children and Orphans:**

The status of displaced children and orphans in Bosnia can only be viewed in the context of the overall displaced and refugee population. In this context, the most appropriate interventions to address their needs appear to fall primarily within the existing emergency relief program.

There are, however, two priority exceptions which could be addressed with a modest amount of funds from the "Displaced Children and Orphans Fund" (DCOF):

#### **Unaccompanied Children**

It is estimated that there are at least 50,000 unaccompanied children in Croatia, Bosnia-Herzegovina, and at least 20 other countries. Immediate assistance is needed to ensure proper documentation and tracing of displaced children and families, within and outside the new national borders. The establishment of such a system will provide for the protection of these children, the eventual reunification of families and other appropriate long-term placement arrangements for orphans.

It is recommended that approximately \$500,000 - \$750,000 from the FY 1993 DCOF be awarded to an existing local NGO to: a) support an international database and tracing network, which would also provide specified social services to the children as well as their host families. This network will also collaborate with other, more generalized programs and systems which are managed by such organizations as UNICEF, UNHCR and ICRC; and b) provide simple, basic support to a wide network of local, community-based NGOs which will extend throughout Croatia, Bosnia and hopefully Serbia. Within the former republics, this program would be incorporated under a network of existing local organizations known as "Our Children", and will also tie in with "SUNCOKRET" a community-based volunteer program which currently operates in Croatia and is expanding activities into Bosnia.

#### **Abandoned Newborns**

It is recommended that a dedicated system to search out and monitor reports of newborns abandoned throughout ex-Yugoslavia be established as soon as possible. The system should also attempt, if possible, to monitor reports of newborns being offered for adoption outside any legal system which might take effect in the future. (At the present time, no legal adoptions of newborns of Bosnian citizenship are allowed in either Croatia or Bosnia-Herzegovina.)

One institution should be charged with this responsibility for monitoring the location and disposition of all of these newborns.

DCOF funds should be made available as soon as possible, if special funding is necessary, to assist in the establishment and first years' maintenance of this center. One possible entity for assuming this role is the Documentation and Tracing program, mentioned above. The ICRC traditionally assumes this responsibility, but an adequate system does not yet appear to be established.

#### Assistance for Civilian Amputees

The status of civilian victims requiring prosthetic and rehabilitation assistance is not a high priority at this point in Bosnia. However, Handicapped International is operational and modest AID support under the Leahy "War Victims Fund" might be considered.

#### III. General USAID Assistance

The situation in Central and parts of eastern and southern Bosnia (including areas served by NGO and UNHCR operations centers in Jablanica, Zenica/Vitez, Tuzla and Mostar) should continue to be assisted by Phase I and Phase II international humanitarian assistance, with a major continue. USG assistance should continue to be provided through the existing OFDA/DART mechanism, with major reliance on the extensive network which the IRC has established. It does not appear to be a situation where normal USAID program assistance would be appropriate unless special, rapid turn-around procedures which would allow for maximum funding flexibility could be authorized.

#### IV. Priority Needs

The most immediate priority is amend or otherwise modify the existing grant to IRC to enable them to reprogram funds currently authorized for "winterization" assistance, and allow IRC to reprogram those funds for the procurement of seed, animal feed and possibly fertilizer for the present planting season. General line-item flexibility is required for this program if it is to be effective.

Other equally high priorities are:

- 1) Ensure that all grants to IRC are provided with the maximum level of line-item flexibility to allow for field-based decision-making. Windows of opportunity for meaningful interventions, in many cases are short and cannot be anticipated months in advance.

- 2) Jointly, with IRC, assess the implications of providing significant additional types and levels of funding through the establishment of an "NGO Umbrella Management Unit" with that organization. These include implications regarding:
  - a) "Management burden" vis a vis accounting, procurement and other administrative capabilities in IRC's central and field offices
  - b) Maintenance of IRC's current excellent record in serving, collaborating and coordinating with other international NGOs in Croatia and Bosnia. This will be especially relevant if the new role will include additional significant decision-making regarding the awarding of subgrants;
- 3) Support the following Phase II interventions with additional OFDA or special DA funding, to NGOs through an "Umbrella Subgrant mechanism":
  - a) Seed, feed and possibly fertilizer for both family vegetable "Victory" gardens as well as large-scale food crop and livestock production.
  - b) Provision of supplemental infant formula and milk
  - c) Support for school re-opening
  - d) Support for "host families"
  - e) Cottage industry development
- 4) Encourage NGOs to continue current primary reliance on locally produced materials and products.
- 5) Provide necessary support (if requested) for NGO coordinating committees and economic development committees such as those currently existing in Split and Mostar.
- 6) Encourage at least one US health/medical NGO to get involved in Bosnia. One potential candidate might be the International Medical Corps (IMC) which has performed one assessment already and has a representative due in Mostar to conduct a follow-up review in March. Priority needs appear to be:
  - a) Possible support for immunization program, depending on effectiveness of WHO and UNICEF vaccine procurement and distribution scheme.
  - b) Assistance in rationalizing pharmaceutical procurement, distribution and use at the hospital

and "ambulance" levels.

- c) Specialized training for surgeons, doctors and medical/health staff in combat techniques and procedures.
- d) Assistance in early identification of epidemics and support for preventative measures, especially with respect to water supply and sanitation interventions.
- e) Physical rehabilitation of hospitals and clinics, and provision of basic equipment and expendable materials, drugs and supplies.

## Annex 2: Trip Reports

### Bosnia-Herzegovina (Feinberg)

Team members Feinberg and Chapnick travelled to various sites in Bosnia-Herzegovina between Tuesday, February 16 through Friday, February 19. Prior to leaving Washington, the team had been informed by various sources that while the area of greatest need with respect to displaced children and orphans and civilian amputees was certainly in B-H, it would be unlikely that we would be able to travel within B-H on such a short mission, and that we should concentrate on developing programmatic interventions in Croatia,, serving both Croatian displaced persons and Bosnian refugees, with a view towards eventual expansion or replication in B-H proper, when conditions improve and permit.

Additionally, we left with an impression that very little humanitarian assistance in Bosnia proper would be possible beyond the "Phase I" importation of material for shelter (including clothing, stoves and fuel for heating and cooking and plastic sheeting for windows), food and medicines.

In Zagreb, those impressions were modified considerably by recommendations from the U.S. Embassy and the DART Team, all of whom strongly urged us to try to get into Bosnia and assess from our perspective what additional Phase I and possibly Phase II interventions might be appropriate, especially from the perspective of children and civilian amputees.

#### Chronological Account:

After speaking with John Fawcett Director of IRC/Bosnia, based in Split on Monday, February 15, and conferring with AID Representative Mike Zak and Team leader Ross Anthony in the Embassy, it was agreed that we should depart that afternoon for Split in order to catch a ride with a British jeep that was going in to the town of Vitez, just south of Zenica. (The U.S. Embassy was closed that day, and it was agreed that we should proceed to Split immediately. Otherwise we would not be able to find transport and have adequate time to make a meaningful assessment in Bosnia.)

We arrived in Split in the late afternoon and that night had the opportunity to meet with John Fawcett, who is just finishing up a highly praised tour as IRC Director for Bosnia, and Ms. Marie Blacque-Belder, the AICF Coordinator in Split. They provided valuable perspectives on the nature of need in Bosnia, the coverage currently provided by the NGOs, and names and directions to help us track down the key NGO players in the various sites in Bosnia.

We met and immediately departed from Split with the Director of the British assistance group, Bosnian Disaster Appeal (BDA), Harry Orde-Powlett at 7:00 the following morning. The route which we needed to take from Split to Vitez was approximately 200 kilometers, and took us east and then north from Split, though the mountains and circling from south east, clockwise around Sarajevo to Vitez, which is about 80 kilometers northwest of Sarajevo. We arrived in Vitez at about 4:30 in the afternoon with one quick stop for coffee on the way and numerous "traffic jams" on the mountain roads..

We basically followed the UNPROFOR route known as "Circle" through Brnaze to the town of Tomislavgrad. From there we headed south on the "Square" route to Jablanica, then turned off onto "Pacman" going over relatively high and snow and ice-covered dirt roads where traffic (as is usual) was held up for three hours or so by trucks getting stuck on the turns. Once through the mountains, we proceeded to Konjik which is about a mile from the front where Serbs and Moslems are fighting and which was our closest proximity to Sarajevo. We then headed north through Tarcin, Kresevo, Kiseljak and Busovaca before arriving at Vitez.

We were very fortunate in being able to spend about four hours talking with IRC staff about their programs and activities, as almost all of the IRC/Bosnia field officers were in Vitez for a meeting and a farewell party for one of their Australian Field Officers, one of three young, bright, ex-Australian Special Forces soldiers and one Kurdish Iraqi who joined IRC/Ex-Yugoslavia after having worked with IRC in Iraq with the Kurds after the Gulf War. IRC/Vitez has approximately 30 local staff and 6 expatriates serving a very large and hazardous portion of central and eastern Bosnia, including Sarajevo and Tuzla.

(I had an opportunity to speak with Nancy Green, the IRC/Jablanica Field Officer for an hour or so at one of the "traffic jams" between Jablanica and Konjic, and we later met for half a day with the two new staffers in the Mostar, so in all, we had good discussions with all of their expatriate and a good number of their local field staff in Bosnia.)

We were very impressed with the whole IRC team, their youth and professionalism, enthusiasm, dedication, courage and hard work under extremely difficult conditions. (And, from the party, their ability to have a good time together!! They are definitely a close-knit group!!)

On Wednesday morning, after spending the night at the BDA Staff house we were accompanied by IRC/Vitez local staff to Zenica, about a half hour north of Vitez, where we met with the director of the central hospital, representatives of AICF, Solidarite, Handicapped International and UNHCR, and the presidents of two children's groups known as "Our Children" and "First Childrens

Embassy".

We returned to Vitez just after dark and then returned back to Zenica Thursday morning to catch a ride down to Metkovitch with an ODA/UNHCR truck convoy. This was the last convoy allowed on the road after Mrs. Ogata's total suspension of UNHCR relief assistance in Bosnia. The convoy consisted of ten DAF-Layland 3000 flat-bed trucks and a lead car, returning empty after dropping off food and clothing in Zenica. The trip to Mektovich, which covered approximately another 250 kilometers took about 7 hours, and took us down the "Lada" route to Modrinje, where we picked up "Skoda" as far as Busovaca. From there we picked up "Pacman" and retraced our path down as far as Jablanica. After Jablanica, we headed south on "Garnet" and then apparently wended our way across the mountains following the same route we had followed in from Split.

We arrived at the UNHCR warehouse and truck depot in Metkovic, Croatia, at about 8:00 PM and were able to sleep on couches in the rooms of the ODA drivers as all hotel rooms in town were taken.

The next morning we hooked up with a jeep driven by Vinnie Gamberale, the IRC Field Operations Officer based in Sarajevo whom we had earlier met in Vitez. He was representing IRC at the weekly meeting of NGOs operating in Mostar, Bosnia, about 45 minutes northeast of Metkovic. John Fawcett had organized the Mostar NGOs along the lines of the Split-based organization and it appears to be a very effective mechanism for getting NGOs together to disseminate information, discuss security and operational issues of mutual interest and to facilitate the informational dissemination process, especially concerning UNHCR, IRC and other funding and program matters. It started in Split and has now been replicated in Zenica and Mostar and will soon begin in Sarajevo.

After the meetings, we were able to discuss the Mostar program, and especially the plans for public health, with Pat and Mike, the newly arrived IRC/Mostar field officers. They both were in Somalia until recently, with the International Medical Corps. Pat is an RN and Mike is a medical logistics type.

We left Mostar and returned to Metkovic where we stopped to get some gear for IRC before heading on to Split, where we arrived at about 8:00 PM. We had a brief discussion with George Adams, the new IRC/Bosnia director who has just arrived from Peshawar. We also had an hour or so with Vinnie and Jason Aplon who heads up the Humanitarian Assistance Coordination and Operations Office in Split.

We returned to Zagreb on the early morning Croatian Airlines flight on Saturday.

## Interviews

Wednesday, Feb. 10:

Dinner with DART Team and Terry Peel

Thursday, February 11:

USAID/Zagreb: Mike Zak

USEmbassy: Ronna Pazbral - Security Briefing

USEmbassy: Tom Mittnacht:

USEmbassy: Laura Faux-Gable

USEmbassy: Ann Sides:

UNICEF/Bosnia: Alexandra Zhivkovic/UNICEF/Bosnia

Friday, February 12

USEmbassy: Ronald Neitzke, Charge d'Affair

CARITAS/Zagreb: Sister Angelita/CARITAS/Zagreb

UNHCR: Marie de la Soudiere/UNHCR

Saturday, February 13

DART Team (Joe Bracken and Rene )

Sunday, February 14

IRC/Croatia: Tom Yates/IRC

DART: Joe Bracken

Visit to Reznik Camp

Monday, February 15 (Zagreb and Split)

UNICEF/NY: Vesna Borsnjak

IRC/Bosnia/Split: John Fawcett/IRC/Split

ACIF: Marie Blacque-Bender/ACIF/Split

Tuesday, February 16 (Split to Vitez)

BDA-Harry Orde-

IRC/Vitez: Mike Stievater, Field Coordinator and staff

Wednesday, February 17 (Vitez and Zenica, Bosnia)

ACIF/Zenica: Alix Destrenau (nurse)

SIZ: Irsam Omerspahic, Director

(Public infrastructure and facilities construction company)

Solidarite/Zenica: Antoine Peigney, Coordinator

UNHCR/Zenica: Roisin Sheridan, Social Services Coordinator

Handicap International/Zenica: Carole Nerland,

P.T./Administrator

Zenica Central Hospital: Dr. Muhamed Vejzagic, Director

First Children's Embassy: President and staff

Nasa Djeca/Zenica ("Our Children"): Vera Polic, President

Thursday, February 18 (Vitez to Zenica to Metkovic)

IRC/Vitez: David Robison, Field Officer

UNHCR/Zenica: Kim

## Karlovac (Witterholt)

I visited Karlovac on 2/18/93 along with A.I.D. team leader C. Ross Anthony, Ph.D. Karlovac is a town on the south-western border of Bosnia and Croatia. It is close to the front and shelling of the town occurs on a regular basis. The night before we arrived, a local dairy had been hit and destroyed with unconfirmed reports of three people being killed, and we heard gun shots being fired in the distance shortly before we left Karlovac that same night.

On 10/1/92, a transit center was opened to facilitate the movement of refugees into areas of asylum. These refugees were primarily those who had been held in concentration camps. Most were from the North-Central region of Bosnia. Their cultural identities included Bosnian Muslims and ethnic Croats. Many had been held in the prison camp at Omarska, described by the IRC manager of the transit center as a "killing machine". An estimated 5000 refugees have been through the center since it opened and approximately 2000 refugees were being held there at the time of our visit with 10 to 30 more arriving daily.

The facility is divided into two camps, one primarily for women and children, many of whom have husbands who had already been sent to refugee camps in other countries such as Germany, and the other camp being for men. In both camps however, particularly the one in which the men are housed, their wives and children-if alive and having been able to escape the fighting-reside as well. Food is catered in from a local hotel. People live crowded into rooms lined with bunk beds. Complaints of the boredom and uncertainty of camp life are universal. Although this facility was initially intended for short stays, many of the people have been waiting for three months or more to be moved on. We met with refugees in both camps, some of the physicians staffing the clinic at the Men's camp, and camp administrators.

The men were eager to tell of their experiences, both in Karlovac and of when they were held in concentration camps. Most told of surviving torture while in prison. They described the concentration camps as "always noisy-all night long-screams-sounds of beatings-gun shots..." They told me they craved "quiet-peace and quiet". The current facility is crowded and noisy. This, along with the gunfire and shelling from the front does not provide for a calm atmosphere.

One man we spoke with was a 32 year old man from Bosnia who acted as the spokesperson for a group of men we visited with. He has a wife and 3 children, all girls ages 7, 8 and 10. They are currently living in Austria where he says "they are safe". He tells us: "I can't sleep at night-I wake up all night..." He has nightmares "over and over again" of the prison camp where he was held for 6 months. "I lost 32 kilos in that camp...I cannot

rest...I saw so many beatings...so many deaths. In the camps we ate once a day-1/8th loaf of bread and a plate of water. We had 30 seconds to eat. They beat us at each meal. They would make us lie down on the tarmac then walk on our backs. They slapped us and beat us..." He and the other men reported that the smallest number of prisoners were killed by gunshot. Most of the murders were committed by beatings and stabbings.

He and the other men endorsed symptoms which included: hypervigilance, increased startle response, decreased energy, moments of numbing and social withdrawal, intrusive memories and thoughts of the violence, poor appetites, decreased sleep and nightmares. From a psychological point of view, such symptoms would fit the criteria for illnesses such as post-traumatic stress disorder and major depression.

The men ended their story with this plea from their spokesperson: "Tell the world-in the name of all of us ex-detainees and refugees not to believe those war criminals. Tell Mr. Clinton...something must finally be done."

In the women's camp, the stories were similar. The children had been allowed to decorate the walls of the camp with paint. The walls in the dining room were covered with brightly colored hand prints and murals-many depicting scenes from the war. Women and children were crowded into rooms lined with bunkbeds. They did their best to make the rooms a home and offered us coffee as we sat on one of the beds. The women we met with had been kept at this site "for 3 months while our husbands have been sent to Germany..." One woman wept as she cried out: "we are all kept here like hostages." All of the women we spoke to had been in concentration camps. The spokesperson for the group told us:"We are all at the end of our rope...waiting for the Germans to reunite us with our men...with the shooting going on here we are frightened. We will need a lot of time to come back to what we were. We need rest. We are still in a state of confusion. We can't believe what we've been through. We are not able to be calm. The children feel they are in jail. They cannot tell the difference between this and the prison camp. When the shells go off here, the children remember. They run in terror to the shelter-hearts racing-panic-you should see the way they run. Since May we have been barely able to undress-all the places we've been...all the moving on..."

As in the men's camp, symptoms of nightmares, sleeplessness, anxiety, and intrusive thoughts were endorsed. The children were described as also having restless sleep. The bomb shelter adjacent to the camp reportedly only holds 200 people. Approximately 500 women and children are housed at this facility.

Later, I met with the physicians on duty at the men's camp. They listed the primary complaints as those of nightmares,

startle, flashbacks, panic and social withdrawal. They also had a lot of colds and the flu had recently spread through the camp. They had identified two cases of tuberculosis among the inhabitants. Psychosomatic complaints were common especially after a weekend of shelling, and many had chronic musculoskeletal pain particularly in the areas of their body where they had been beaten.

The physicians were trying to help the refugees with their most pressing symptoms such as nightmares and sleeplessness. They said they had few effective medications at their disposal for these complaints, primarily relying on sedative-hypnotics such as nitrozapam and fluzapam. They reported that they had not found these to be very effective. The physician allowed me to search through the boxes of medicines that had been sent to the camps. The staff in the clinic had worked hard to put these in some sort of order in the only medicine cabinet which they had available to them. The psychotropic medications I found included the antidepressants fluoxetine and amitriptyline; the neuroleptics chlorpromazine, loxipine, and haloperidol; the antihistamine hydroxyzine and the sedative-hypnotics chlorazepate, nitrazepam, flurazepam and diazepam. In general, even among these, supplies were inconsistent and in small quantities. The physician and I discussed medications which have been found useful by clinicians treating traumatized patients in the United States including trazedone, fluoxetine, and clonazepam. Of these, they only had fluoxetine and that in insufficient quantities to adequately treat the refugees who might benefit from this type of medication.

In summary, 2000 refugees are living in the facilities at Karlovac. They continue to be traumatized by shelling, overcrowded conditions, lack of privacy, and uncertainty about their future. Physicians are available 24 hours a day and work very hard to make people as comfortable as possible given the limited resources at their disposal. Likewise, the IRC staff is doing all they can to help these refugees under harsh conditions.

Some problems that may be able to be addressed include contacting a representative from the German government who might be able to visit the camp and clarify for the refugees what the hold up is. A bomb shelter that is adequate to hold all the women and children is needed. Specific medications in sufficient quantities may be useful to ameliorate some of the symptoms people describe. Ultimately, however, certainty about their future and an end to the violence will be necessary for these highly traumatized people to begin to re-gain their lives.

## Rijeka (Stratos)

Joe Bracken of the OFDA team, Neil Boothby and Kathryn Stratos traveled to Rijeka, a resort town on the Dalmatian coast, on February 18, 1993. Ladislav Jercic, the regional chairman of the Rijeka area, briefed us on the refugee situation in his area. Jercic explained that many of the Croatian displaced population had been able to return to the southern areas of Croatia. Of the refugee population (ie, Bosnian) 90% is Muslim.

On the subject of displaced children, Jercic said that while there was one building for orphans, the displacement of children was not a major problem. Almost always the children came with someone to care for them. Schooling is more problematic. Children in primary school age receive at least some schooling. A supplementary program has been developed for Muslim children, some of whom are familiar with the Cyrillic rather than the Latin alphabet.

Keeping hospitals supplied with medicines and anesthesia is, however, a major problem. Caritas fills some of the local hospital's requests. Only registered refugees can receive routine care. This became a problem as refugees arriving between July 14, 1992 and January 1993 were not registered by the GOC. Rijeka is now in the process of re-registering the refugee population.

Currently an estimated 24,000 refugees and 10,000 displaced people live in the Rijeka region. Monthly estimates are sent to Zagreb. The GOC pays an estimated 1,000 DM/month per refugee family, while the average salary of government officials is 150 DM/month.

One of Jercic's staffers, Sterpin Walther, explained that the hotels currently occupied by refugees need to be vacated in time for the tourist season. Some people may be moved to a former military base further inland. Forty-nine buildings are currently used for group housing purposes (rather than the home setting). One of the residents is appointed to be in charge of maintaining discipline in each building.

We subsequently moved on to Opatija, a smaller town in the Rijeka region. Usually, 30,000 people live in Opatija. Currently, an additional 18,600 refugees and displaced persons reside here. Schools financed by the Italians have been opened for Bosnian children. Many of the Bosnian high school students audit classes in the Opatija schools. While this gives them a place to go to during the day, they will not receive academic credit for their attendance. Those who wish to attend university will eventually have to make these years up.

We proceeded to visit two camps in Opatija. One was outside

the town. The buildings, one-story dormitory style, had originally been built to house (Bosnian) construction workers. Since the late summer and early fall, it houses Bosnian women and children, with a smattering of adolescents. Their husbands were less fortunate in terms of their safety--they had stayed behind in Bosnia to fight the war. Nevertheless, it was clear from our conversation that their flight from Bosnia had often been precipitated by violence that they themselves had witnessed and experienced.

We spoke with the women in the one-room schoolhouse. While we arrived on a day that was a school holiday, the mothers assured us that the children received 3-4 hours of schooling a day. They themselves struggled with the lack of things to do to fill their empty days of waiting. Even the cooking is done by the organizers of the camps, thus leaving them with even less to do to fill out their day. What we saw of the food, however, appeared to be good quality and balanced (including some vegetables).

Routine medical care is provided for by two doctors who visit the camp once every two weeks. This was deemed adequate. A problem, according to one mother, was the lack of dental care, toothbrushes and toothpaste.

The second camp that we visited was actually a very attractive hotel in downtown Opatija that overlooks the Mediterranean Sea. It housed some of the 3,000 people from Vukovar, a Croatian city that was heavily bombed and destroyed and remains in Serb-controlled territory in eastern Croatia. Many of its dwellers were elderly.

It was perhaps indicative of the high standard at which these people of Vukovar were living that they brushed aside our questions regarding their housing and living conditions. They preferred to do their utmost to engage Joe Bracken, the Serbo-Croatian speaker among us and a representative of the U.S. mission in Zagreb, in a heated debate on U.S. and European foreign policy towards the war.

Having extricated Bracken from an increasingly uncomfortable discussion in which little could be said, we lunched in the hotel dining room, which overlooked the water. The tables were covered in table cloths and the hotel staff served us, as it serves the displaced people of Vukovar, a hearty lunch. While we ate our chocolate cake and looked out over the sea, we listened to the stories of the two women from Vukovar who joined us at our table. They spoke of the huge number of deaths (the massacre of 200 soldiers after the city's fall), the destruction of their city through repeated bombardment, and the chaos which resulted--leaving them and members of their families all in different places. Our guide's husband is fighting in the Croatian Army.

Her son, unlike his Bosnian peers, is able to continue his studies in Zagreb. She remains in Opatija, working for the municipal government on a volunteer basis in administering aid to fellow refugees.

The same day in which we visited the lovely, little town of Opatija and its lost and frustrated residents, others in our group visited the concentration camp survivors residing in the Karlovac transit camp. As we compared notes that evening, I could not help but be struck with the strangeness of the day and the irony of the grief and brutality which hid just below the surface--despite the prettiness of the surface human society had created.

## Slavonski Brod (Long)

From February 22-23, Jane McClung (Ph.D., clinical psychologist) and I travelled with an International Rescue Committee (IRC) team to Slavonski Brod in eastern Croatia. The IRC team included two drivers, Josip and Tomaslav, and Catherine (nicknamed CJ), a nurse/social worker, who was travelling to the region to work with local medical experts in helping to set up psychosocial services.

We left late in the afternoon of the 22nd and travelled over back roads through the mountains since the main highway to Slavonski Brod and the East, in general, passes through Serb-controlled territory. Although CJ believed that the expatriates could probably pass unharmed, she was worried that Tomaslav and Josip, both Croatians, could be taken captive. Tomaslav had already spent several months in a Serb prison/detention camp and had no desire to repeat the experience.

The back route adds an extra hour and half to two hours to the journey and means that eastern Croatia is further cut off from Zagreb. Travelling in the evening through snow and unpaved mountain roads took us about five hours. We also stopped for an hour for dinner along the way which meant we arrived in Slavonski Brod at midnight, after the 11:00 curfew.

The countryside on route was rolling and pastoral. We passed through several small town centers which looked like small towns in New England with a main street consisting of a few shops, municipal building or two, church, local bar/restaurant, and town square. It was difficult to believe that there was a war nearby. However, there were few people about after dusk except for the occasional odd cyclist. It could be that the region, being rural, generally retires early. But, we had a hard time finding a place open to eat. At one of the restaurants where we stopped, the proprietor and his wife sat alone at the bar in a large room with 1960's style globe lighting. In better times, it clearly would have had several regulars.

On the final pass, we drove over mountainous, unpaved and snowy roads. It was probably better that the roads were not paved because our vehicle had better traction on the hairpin turns with sheer drops on each side. The area was thickly forested and we met no one along the way. Some parts of the road were logged and road construction was in process. It was past 11:00 and the few houses that we saw nearing the bottom of the mountain were dark.

Nearing Slavonski Brod, we headed to the Brodvin Hotel, which is located in the main part of the downtown near the river. The river separates Slavonski Brod from the Serb-controlled town of Bosninski Brod which is directly across on the opposite bank.

The two towns used to flow together until the Serb forces bombed the main bridge connecting the two towns (as they bombed other bridges in that region connecting the two federations). Josip informed me that last time they had been in Slavonski Brod, they had stayed with the local doctor because there was still shelling near and around the hotel. I sensed his concern that we were close to the front again.

The dimly lit and completely deserted streets did little to dispel the ominous feeling as we parked and walked among bombed out buildings. A bank directly across from the hotel was boarded up and the windows of the tourist agency blown out. Tourism was evidently not a thriving industry (if it ever was). The front half of the Brodvin Hotel was boarded up and seemed to be missing. Later, the hotel owner told me that just last July and August, 200 bombs had been dropped in the immediate area around the hotel. I wondered why he was willing to rebuild again so soon.

Inside the hotel looked like a construction zone as well. The proprietor gave us rooms in the back. We had gotten inside none too soon, because as we headed up to the second floor, we heard machine gun fire. It was probably across the river, but the first round sounded close by. Josip, Tomaslav, and I stopped in our tracks; CJ and Jane at first not hearing kept us heading on to our rooms. Later that hour, we heard a second round further in the distance. "When the bars close, they often shoot off a few rounds then," CJ informed us.

Jane and I shared a room which had a few mementos from the war last summer. Over my bed was a shrapnel hole and Jane unearthed shards of glass on hers. The hotel was still recovering and I think we were the only guests that night. The heating was turned down during the night and the two small blankets did not suffice to keep a side from being exposed to the cold. The bath water the next morning was also tepid. The smell of fresh paint and turpentine permeated the air as the painters and carpenters arrived early the next morning. The maids also arrived early and talked to the painters who were drinking slivovitz while they worked. After showering, I found a plug for my American hair dryer behind the hotel reception counter. The proprietor clearly wasn't giving up and was doing everything to regain and maintain the appearance of normalcy.

CJ and I headed out on the main street to the river before breakfast. We photographed several pictures of the blown out shop windows and apartment buildings along the way. We noticed that the thin plastic sheeting on the apartment buildings could not protect the occupants from the cold and CJ wondered whether she could commandeer UNHCR's heavier sheeting for the next trip. The buildings, many from the late 19th century or early 20th, were stately and had withstood the bombing well. Their windows

were all blown out and there were some cracks on the walls, but except for those that had been directly hit, they were fairly intact.

A bomb had left a large crater in the middle of the road. Several of the cars parked on the main street had also been splattered with machine gun or artillery fire. In one shop with busted out windows, pieces of the mannequin were strewn across the floor. The distinct impression was that most of the store owners were not yet starting to rebuild on the main street, although people were living in the two nearby high rise apartment buildings. Where else had they to go?

After taking a few photos of Bosninski Brod, we headed back. Later, we realized that only a few people went near the water front -- a few cars, an occasional shepherd, and two soldiers. CJ pointed out a member of the special forces (in black uniform) crossing a street and wondered what they were doing there. Later, we heard that the Serbs are building up again on the Eastern front. We also realized that it was not a good idea to stand near the river and take photographs of the other side. Two men who took our same route edged along the walls and looked out at the other side from behind a wall.

The hotel served breakfast but no coffee to several people's dismay. The maid, quite oblivious to the wintry draft created, vigorously washed the magnificently tall French windows all during breakfast. (This is not a service economy although people were very hospitable.) There were two or three other groups having breakfast in the hotel. Later, I discovered that the third floor housed the European Community's and journalists' offices. In the dining room, there were also a few soldiers. A new clientele -- which probably explained the Proprietor's willingness to rebuild so soon.

After breakfast, we headed to the hospital. There we met with Dr. Darko Kraljic, a surgeon. (I'll leave out the striptease routine, Darko's erotic art, and the slivovitz -- suffice it to say there was a lot of joking and merriment while we waited for Darko to change from his emergency clothes to jeans.) CJ had worked it out with Darko and the Hospital Medical Coordinator that IRC would hire Darko part-time and he would help them establish a social and mental health program for the community. She also hoped that the hospital would be willing to provide a room for the services in the hospital itself, but Darko advised her that there was not sufficient space nor would it be appropriate. There were also no more phone lines in and it was already very difficult to reach anyone at the hospital (as we discovered in trying to call Darko beforehand).

The hospital itself was stately and impressive. It

consisted of a few old and several new buildings around a central courtyard. The effects of siege were evident. The hospital windows were taped and boarded and the buildings scaffolded and sandbagged. Darko told us that it had been hit during the shelling. Nevertheless, all the buildings were intact. The hospital's wings housed: gynecology, surgery, internal medicine, pediatrics, pharmacy, morgue, etc. In the center of the courtyard, there was a library which had once contained the most recent medical journals from around the world. The hospital management, however, had canceled all subscriptions to save on costs and Darko informed us that the hospital was currently one million in debt--a fact he attributed to the increased caseload from the refugees and the war. In peacetime, the hospital served the town of Slavonski Brod of some 100,000 people. Since the fighting began, they had treated 7,300 casualties--primarily civilian--1,000 of whom had died. Since the war, the service area had expanded substantially to take in cases from Bosnia and the expanded local refugee population.

The night before Darko himself had treated two casualties from the shelling. He described how victims from the Bosnian side were brought in from as far as seven hours away. They came in private cars designated as ambulances and were rowed across the river. "They only bring us the worst cases," he reported, "And after that trip, we often can't save them." He added they saw on average one to two war casualties a night. The hospital had no capacity to do more than minimal prosthetics and Darko told us that they had just flown two children to Germany. (Why not Zagreb -- I am not sure.)

Darko took us to the pharmacy where the pharmacist showed us his stocks of donated medicines, which came primarily from the EC. A large number were out of date, he informed us, so out of date that he had assigned someone to sort through them. The expiration date on some penicillin, for example, was 1975. Both Darko and the pharmacist spoke of the need for bandages and more up to date x-ray equipment and ambulances (the current ones are 12 years old) for the war casualties. Prior to the war, the hospital had quite sophisticated equipment (e.g., the ability to laproscopic surgery), but was not prepared for this new kind of trauma case (or the magnitude). CJ then delivered a load of pop tarts to the pediatric ward -- one of the donations from America.

Darko recommended that CJ rent a room from his aunt (or some relative) for the center, which they had just renovated from the shelling and which, he thought, would now be out of range of fire. He then led the group through town to a parish, where a local priest had organized a food distribution and social service program for the refugees. When we arrived at the parish, a crowd of people was lined up at the gate pushing to get in. Several slipped through the door as a guard opened the gates for our van. Inside, people were lining up for sacks of potatoes. The parish

had a church and small kitchen where they were also preparing a hot meal.

At the parish, CJ interviewed three refugees: (1) an older woman from Bosninski Brod, who had been a social worker in a refinery, (2) an Catholic Priest also from Bosnia, and (3) an older man, who had been a farmer in Bosnia. All three, I would guess, were in their late 40's or early 50's. CJ with Darko translating asked them primarily about how and why they had left.

The social worker said she had been separated from her daughter who had only escaped several months later from Banja Luka. In Bosninski Brod, the social worker had dealt with workers' problems, such as alcoholism, financial problems, and firings. Her husband had worked for the railway. When the conflict began, her daughter was attending university in Bosnia but could not now get acceptance into a Croatian university. The social worker also reported that Serbs were probably living in her house. She had heard that they had rounded people up in Bosninski Brod, put them in the sports stadium, and tortured them. She herself had hid and said she was fortunate to be living so close by so as to escape easily. She thought the refugee's current needs were: (1) to be registered (to be counted so as to receive services) and (2) for psychological and social services. As Muslim, she believed that many people, Christians and Muslims alike, preferred to talk about their problems to the Parish priest we were visiting. She also thought women would probably be willing to get together and talk in groups, but that the teachers would not like it. The teachers, she explained, were not pleased that the refugees crowded their schools. "The Priest is the only one who understands," Darko translated for her. However, she had also organized a group of people from her former work place, who had worked in the refinery together.

She asked her daughter to join us so her daughter could assist in the translation. The daughter, university age, was reluctant to speak. The mother seemed to want the daughter nearby and during the interview, was most visibly upset when describing being separated from and worried about her daughter. Overall, the social worker spoke matter of factly and I could easily imagine her organizing a group of fellow workers.

The priest described how he had led his parish across the border. His town decided to leave when refugees arrived and describe the Serb advancement. They had also listened to the radio. He reported that the Serbs had completely overrun the town. There were no living Muslims or Croats in the area, more than 80% of the buildings had been destroyed, and no water. On a clear day, the townspeople could look across from the hills to where their town had been. Of the 1,885 people in his parish, 32 had been killed by the shelling, 31 of whom had fought on the front line. They had 17 orphans -- most of whom had been sent to

Zagreb and a few were in Rijeka. Those sent to Zagreb were sent primarily through family connections. When questioned, he noted that their evacuation was not organized. "The brave stayed longer, those less brave left earlier," he explained. The priest had personally led many people out. He himself had lived in a "very old Catholic monastery" which was destroyed by the shelling. When the tanks and army approached, he saw no reason to stay.

Later, after the interview, the priest described how he is organizing a humanitarian program for orphans and others in his parish to provide food, clothes, etc., with money (\$40,000?) from a Croatian American doctor in Chicago. He asked us whether we thought the Americans would be willing to stop the Serb advancement and he encouraged U.S. military involvement.

The third person interviewed, the farmer, had a wife, five children, and elderly mother -- all of whom he sent out earlier. Of his equipment, he had only succeeded in taking out a tractor, which he drove across the border. He was now unemployed and observed, "I can't use the tractor without a field to plow!" His family is living with relatives. His oldest son volunteers for Caritas, his youngest has just finished primary school, two daughters are married, and one son is working on the coast. The farmer saw a need for a program for teachers -- a school working with refugee children -- and he personally needed land to earn a living again. As he explained (and Darko translated), "We are rising our view to heaven, expecting God and the foreign governments that something will be settled on a higher level." "Nothing will be settled here!" both he and the Priest observe. "Help us politically," the Priest added vehemently.

Following the interviews, CJ arranged to meet with the social worker the next day. We then drove through the town past bombed-out factories and houses. The worst damage was near the waterfront and bridge. Several places had been hit when the Serbian forces were trying to destroy the bridge. A water pump station had been badly hit and there were several abandoned houses. Darko pointed out one house where four children hiding in the cellar had died. Further in town, the townspeople seeking revenge had blown up the Orthodox Church. Darko, however, reported that Serbs could live in the village, although as elsewhere, they have probably lost their jobs and livelihood.

Our final visit was to some abandoned military barracks which housed a few deserters from the Bosnian army and their families. The barracks were in poor condition but had running water, electricity, and heating. Several children were unwell and at least one of the deserters had been wounded. However, disability is not grounds for leaving the army. "You fight until you are dead," Darko explained. He pointed out that at least the plumbing was working (since he was still working on getting his

own going again).

After an extended lunch at a country inn, Jane and I returned to Zagreb with Tomaslav. On the return trip, we skirted the mountain passes and with Tomaslav at the wheel, made it back in under four hours.

## **Split to Markaska (McClung)**

Two members of the team, Lynellyn Long and I, spent two days in Split, a mid-sized city on the Dalmatian coast that is about an hour's trip by air from Zagreb. The major purpose of the trip was to visit the refugee accommodations that typify this part of the Croatia and to consult with relief workers and other professionals who are working in this region.

One characteristic of this region that struck me almost immediately upon arrival was the jarring contrast between the sunny, scenic beauty of this area and the ugly, cold reality of poverty and the emotional burdens that both Croatians and Bosnians are carrying here. A couple of scenes that I witnessed illustrate this odd contradiction:

\*sitting in a tourist apartment that overlooks the Adriatic listening to an emotionally overtaxed relief worker relate with fright in her voice that she believes there is growing resentment toward relief workers and her fears of assault;

\*watching Bosnian refugee kids wiling away the hours they would normally spend in school building sandcastles on the beach;

\*making a brief stop at an elegantly simple ninth century church before rushing off to visit a cavernous warehouse filled with food for the camps, much of it unusable;

\*careening down the stunningly scenic coastal road with a man who had been a communist bureaucrat for 30 years who was advocating the 1960's theory of "make love, not war" as his solution to the Bosnian crisis;

\*hitching a ride with a young man in a tiny Serbian-made car whose car radio had been torn out and side window shattered (irreplaceable because he couldn't get needed Serbian auto parts) who stated that he had recently opened a shop that sells gold jewelry to tourists.

In interviews with employees of the International Rescue Committee, the World Health Organization, UNHCR, the coordinator for relief efforts in Markaska, the mayor of Markaska, and Bosnian refugees, we came away with a series of impressions that significantly influenced my understanding of the situation in this area of Croatia and of the former Yugoslavia as a whole.

In an interview with Romeo Jercic, an employee of the International Rescue Committee in Split who oversees the IRC's efforts on the Dalmatian Coast (which stretches from Dubrovnik in the South to the more northerly city of Zadar), we got an overview of the local situation. Romeo was extremely helpful to

us overall, in that he arranged for us to meet a number of local people who could give us their direct impression as well.

About half of the refugees there are housed in hotels and camps while the other half are staying in private homes. At the present time, the Croatian government is financially supporting the hotels and camps. Since this is an area that normally has a relatively small year-round population that swells significantly during the tourist season, the area has been able to accommodate large numbers of refugees. In the town of Markaska, for example, which has a year-round population of about 21,000 people, they have accepted about 25,000 refugees. Although their housing, sanitation, educational and other basic services have been significantly strained by this level of use, so far the government and the local people have managed with considerable grace.

The most serious problem waiting in the wings is the fact that this region depends almost exclusively on its tourist industry to drive the economy. Eighty-five percent of the local population in Markaska, for example, gets its income from tourism. Since 1991, there has been virtually no tourism, and as the Mayor of Markaska observed "For the 1993 season, we don't hope--maybe 1994."

In place of the tourist income has been the economic drain of needful Bosnian refugees. As a consequence, there is a quiet but growing recognition that the refugees will have to leave their living quarters in hotels, pensions, etc. if this region is going to survive economically. Indeed, we did observe what seemed like the beginning of tensions between the local Croatian population and their Bosnian "guests", with fairly frequent observations being made about how different the two groups are. At the same time, however, no one we spoke with was able to speak persuasively about an attractive housing alternative for the Bosnian refugees or displaced Croatians in this area.

In addition, it was apparent from some of the accommodations that there is a chance for the local population to develop resentments simply because it could seem that refugees are actually in better physical circumstances than the local people. The food distribution/relief manager in Markaska reported, for example, that while international relief organizations were providing Christmas gifts for refugee children over the holidays, many local Croatians were able, due to loss of income themselves, to purchase gifts for their own children.

Similarly, when the Bosnian refugee leader at a local hotel was asked if it might be a good idea to start some supportive groups for the residents of the hotel, he emphatically stated no, no doubt partly due to his rather patriarchal attitude toward his "flock", but also, we realized, perhaps due to the fact that the

residents included both Bosnian refugee women and Croatian displaced persons and his fear that more open discussions of the situation could lead to conflict among the residents.

In an interview with Johanna Larusdottir, M.D., the Medical Coordinator for WHO in Split, she referred to the "new but growing problem of getting medical care for Bosnian refugees." There has been a suggestion that the Bosnian doctors in the region be paid to provide such medical care, but again this may be too politically sensitive in terms of alienating the Croatian hosts, as they themselves are also having difficulty receiving adequate medical care. Dr. Larusdottir referred to a Bosnian doctor, Dr. Karlovach, who lives on the off-shore island of Vis, who is attempting to organize Bosnian medical services (Phone: 058-711-273). He seemed to us to be an important contact whom we did not have sufficient time to follow up with.

Yet another aspect of this problem of potentially volatile tension between Bosnian refugees and their Croatian hosts was elucidated by Isabella de la Cruz, a representative of UNHCR in Split. She observed that there a growing number of Croatian inhabitants (colloquially given the unfortunate name "destitutes"), who were economically marginal prior to the war and now, because of the failing economy, are quite poor. This group would normally qualify for government assistance, but apparently do not meet the war-time criteria that the government has imposed (apparently as an attempt to avoid being bankrupted). At the present time, this group of people is quite difficult to identify because they are unregistered with the government. Unofficially they are being taken care of by Caritas, a Catholic relief agency, and the Red Cross. Isabella made a plea to us to consider this group when thinking of funding plans.

It was also in the Split area that we got a direct taste of how ethnic cleansing and the war has affected the elderly. We visited a refugee camp in Markaska that housed about 50 elderly women (and one mentally and physically disabled middle-aged man) in two dormitory-style rooms that were set apart from the larger camp facilities. This camp has previously been a Yugoslavian-style "Y-camp," so the building themselves were simple but quite adequate. However, the area housing the elderly women was very crowded, with beds lined up right next to each other. When we arrived, these women were mostly sitting on their beds staring vacantly. A number perked up at our entry, however, smiling and graciously beckoning us in. The nurse reported to us that many of these women were from Vukovar, a city of 45,000 in Eastern Croatia that was virtually leveled during the first phase of Serbian aggression. All of the inhabitants here were "unaccompanied," meaning that their families has either been unable or unwilling to locate them, and all were in need of 24-hour semiskilled nursing care, which is being provided at the camp.

As I was standing with the interpreter, a petite woman dressed in traditional Slavic garb (black headscarf, gray dress, black stockings, sturdy shoes) approached us and said through the interpreter that she was 87 years old, had lived in Vukovar all her life, and that she wanted me to help her to be able to go home. Since my own parents are in their eighties, I was heart-torn trying to imagine what it must be like for her in the last stage of life, when she is supposed to be enjoying the fruits of her work and the delights of grandchildren, to be facing the devastating loss of literally everything she has known.

Two other aspects of the refugee situation in this region that were stressed over and over again by relief workers and the refugees themselves were the enforced idleness that is endemic here and the related fact that the educational system for Bosnian children is not in place yet. The Bosnian refugees have very little to do, as they cannot get work papers and even if they could, there are no jobs available in this socially overburdened and financially stagnant economy. Further, most of the refugees are either single mothers or elderly men and women, many with rural backgrounds, so they are not particularly well-prepared or able to enter the workforce. There was much talk of providing knitting wool for the women, at least to allow them to spend their empty hours somewhat more productively. However, the larger questions of how or if this refugee community can be integrated into the Croatian economy remains fundamentally unanswered.

Isabella de la Cruz, the local UNHCR rep. outlined a beginning plan to deal with some of the refugee issues. She advocates sending in teams of Croatians and Bosnian social workers to begin organizing refugees in the camps so that they can take a more active role in helping themselves. With more input and activity from them on the psycho-social issues surrounding them, she hopes this would help to reduce potential tensions between the refugee and Croatian population.

Similarly, there is a strong need to develop schools for the refugees. The consensus at this point appears to be that Bosnian children should have their own school, partly because the local Croatian schools are full to bursting with Croatian children, partly because the Bosnian curriculum differs from the Croatian in some fundamental ways (particularly regarding the teaching of history and culture--one worker described the Bosnian curriculum as "more Yugoslav"), and partly, I believe, because neither group is ready yet to tackle the possibility that the Bosnians are going to be living permanently in Croatia. Many people we interviewed felt that there were enough Bosnian teachers around to staff the schools, but that there is a need for physical facilities and provision of supplies, and also a need for leadership and organization around this important project.

As we flew back to Zagreb from Split, I couldn't help but feel a bit relieved to be going to a city where the war and its very real consequences are somewhat more distant and where the contradictions seem a bit less dissonant. At the same time, however, I felt grateful for these two days on the coast, as they allowed me to view faces of this war that I hadn't noticed in the hotel corridors or offices of Zagreb, and thus deepened my understanding of the complexity that is the former Yugoslavia.

#### Interviews (Long and McClung)

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Dr. Louisa Chan, Medical Coordinator, International Committee of the Red Cross (ICRC), Dure Salaja 8, 41000 Zagreb. Tel: (041) 612-444; 633-511/136. Fax: (041) 538-299.

Miro Beslich, Priest, Svecenik in Bijelom, Brdr, Kod Dervente, or Kumicicevie 16, 55000 Slavonski Brod.

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41-273-804

41-276-494

off: 41-277-314

**Help the Children**

Blanka El Kahlifa Segovic

41-214-165

**Merhamet--The Red Crescent-Zagreb**

Izet Aganovic, MD, Pres., Faruk Redjefepic

41000 Zagreb, Tomasiceva 12

41-412-079

611-214

**FRIDAY THE 12th**

**Ann B. Sides, Consul-Second Secretary      41-444-800      (BT)**  
Embassy of the U.S.A.  
41000 Zagreb, Andrije Hebranga 2

**Marie de la Soudiere      41-613-266      (BT, RA)**  
UNHCR, Women & Children ex-Yugoslavia  
41000 Zagreb, Kupska 2  
Fax: 530-109

**SATURDAY**

**Laura Faux-Gable**  
FSO Interviewer of Torture Victims  
A.I.D./Budapest

**SUNDAY**

**Tom Yates**  
International Rescue Committee  
, 'President'  
Reznik Refugee Camp

**Tom Bracken**  
OFDA DART Team

**MONDAY**

**Ivica Kostovic, MD, DSc      41-466-909      (RA/SW/BT)**  
Dean, Univ of Zagreb, School of Medicine  
41000 Zagreb, Salata #3b  
Fax: 466-739, 466-724

**Vlado Jukic, PhD      41-233-043      (RA/SW/BT)**  
Project Coordinator, Pscyh Aid  
Rebro University Hospital  
41000 Zagreb, Kispaticeva

**Jadranka Bosnar, social worker      41-277-314      (BT)**

Caritas-Zagreb  
Kapitol 31

S. Anđelita Sokić  
Croatian Caritas  
41000 Zagreb, Kaptol 1  
Fax: 276-020

41-276-494 (BT)

Vesna Borziak  
On-Leave from UNICEF

41-422-002 (LF/BC/KS)  
or 433-543 (w)

Nina Kadić  
Trednjevka

41 503 531 (RA/LL/JM)

Dr. Lang  
(mobile vans)

(RA)

Dr. Aganović  
Merhamet

(RA/SW/BT)

TUESDAY THE 16th

Dr. Georges el Hayek  
International Federation of Red Cross  
41000 Zagreb, Dure Salaja 6, 3e

41-610-155 (RA/NB/KS)

Herr Raimar Wigger  
Komitee Cap Anamur-Deutsche Notärzte  
41000 Zagreb, Praska 5  
Fax: 42286

41-424-274 (RA/NB/KS)

Mr. McDermott, Director  
Irena Bezić, Psychologist  
UNICEF  
41000 Zagreb, Svaska 41, 16e

41-610-900 (NB/KS/SW)

Serifa Halilović  
BiH Women's Group

41-228-713 (KS)

call: Dr. Azra

41-226-464

Dr. Mladen Havelka  
Social Welfare/Psychiatry  
41000 Zagreb, Mlinarska 38  
Fax: 434-181

41-278-355

(NB/KS/SW)

and Prof. Arpad Barath, PhD  
Professor of Health Psychology & Education

and Vashinka Despot Lucanin, M.A.

**WEDNESDAY**

Vesna Borziak  
On-Leave from UNICEF

41 422 002

(BT/NB)

or 433 543 (w)

Durda Knezevic  
Center for Women War Victims  
41000 Zagreb, Siloviceva 23

41-422-495

(NB/JM/KS/SW)

434-738

...  
Autonomous Women's House

Dragica Kozaric-Kovacic, MD  
Vrapce University  
41000 Zagreb, Bolnicka 32

41-156-211

(JM/KS/SW)

and Ana Marusic, MD, PhD  
School of Medicine, Univ of Zagreb  
Salata 11, PO Box 916

41-156-211

**THURSDAY THE 18th**

Ladislav Jercic, Regional Chair, Rijeka  
Sterpin Walther

**FRIDAY THE 19th**

Prof. dr. Adalbert Rebic, Director  
GOC Office for Displaced Persons & Refugees  
41000 Zagreb, ul. Republike Austrije 14  
Fax: 172-109

41-171-153

(BT,RA)

and Maja Kurent, MD, MA, Counselor  
Visnja Majsec-Sobota, Counselor  
41000 Zagreb, Brace Oreski 14

173-699

Helena Ujevic, Professional Counselor 41-  
GOC, Ministry of Labor and Social Care  
(in charge of child protection)

(BT)

Spiljar 41-  
Kareta  
41000 Zagreb, Vlaska 70A, 3e

## BUDGET SUMMARY OF RECOMMENDATIONS

### ASSISTANCE FOR VICTIMS OF ATROCITIES IN EX-YUGOSLAVIA

(In millions of dollars)

FY1993

#### I. Children

##### Immediate (0-30 days)

- ✓ 1. Reunification of displaced children and families - tracing program (PVO/Soros/ICRC) .75

#### II. Trauma Victims (Rape, torture, etc.)

##### Immediate (0-30 days)

- \* ✓ 1. Program to assist the victims of atrocities - PVO Support through Umbrella Grant (IRC) 1.25
- 2. Speed up placement of and reuniting of refugees being settled in USA (INS) 0.0

##### Intermediate (30-75 days)

- ✓ 3. CEELI - advising on family law 0.0
- 4. Develop a Program to train and enhance the skills of medical professionals dealing with trauma victims 1.0
- 5. Participant Training - make available to trauma specialists .25

##### Longer Run (more than 75 days)

- 6. Additional services for trauma witnesses at war crimes trials 0.0

#### III. Health

##### Immediate (0-30 days)

- ✓ 1. Project Hope - emergency medical supplies for trauma patients and for transport to B-H. 1.5

FY1993

Intermediate (30-75 days)

2. Hospital Partnerships in 3 locations with a medical focus on physical and mental trauma with special emphasis on rape victims. .5

**IV. Other**

Immediate (0-30 days)

1. Revise IRC grant to allow winterization funds to be used for agricultural inputs (seeds, tools, and fertilizer) 0.0
2. Conduct assessment of agricultural input needs in Croatia and B-H and provide needed inputs.

Longer Run (more than 75 days)

4. Economic Development Assistance:  
SEED funding for Croatia<sup>3</sup>  
*PROGRAMMING MISSION.*

Totals 5.25

Presently Available Funds

WID Matching Funds .50  
R&D DCOF Earmark .75  
EUR (SEED Funds) 5.25

**IF ADDITIONAL FUNDING IS AVAILABLE**

1. Radio station to help with family reunification and transmittal of information on trauma and rape.
2. Assistance for program to provide mental and other health service and training, perhaps using mobile vans.
3. More emergency medicines and supplies.
4. Increase funding to hospital partnerships to purchase more purchase equipment or repair damaged equipment.
5. Assist with getting refugees into schools.

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<sup>3</sup>Funded separately under regional SEED projects.