

Chapter Nine

FORMER YUGOSLAVIA

Why Are the Refugees There?

The civil strife which overtook Bosnia-Herzegovina (BiH) in April 1992 created a large-scale humanitarian disaster. Half of the Bosnian population was forced to relocate, creating economic and social hardships which persist today. More than 1.2 million people were displaced internally, and at least 900,000 more fled to other countries.

Ethnic conflict did not just occur among Muslims, Serbians and Croatians; many areas were subject to factional violence as well.

The Dayton Peace Accord, signed on November 21, 1995, ended the war, but not the displacement of

large numbers of people. The Federal Republic of Yugoslavia (Serbia and Montenegro) hosts 550,000 refugees (Bosnian and Croat Serbs). Of these refugees, 43,000 live in collective centers, and 250,000 receive international humanitarian assistance. Croatia hosts 170,000 Bosnian refugees (30,000 Muslims and the rest Croats). Some 180,000 Croat nationals remain displaced from the 1991 Croatian-Serb war, and 60,000 Serbs remain in a UN-administered area in Eastern Slavonia. Harsh economic conditions and

high unemployment in their "host" countries make life difficult for these refugees, but, so far, most have elected to stay.

Some one million Bosnians were displaced within the borders of the republic when the Dayton Peace Accord was signed; less than half of them have returned home. Although the Dayton Peace Accord

"My son was seven when the war started. He asked me "Why are they shooting at us?" I couldn't answer. I said: "Maybe because we're Muslims." "Only because of that, Mother?"

Angie Ćiric, from Bihac

calls for repatriation of people to their original homes, and UNHCR is responsible for that massive repatriation program, governments who are supposed to receive ethnic minorities remain mostly hostile to the idea. Even donors have not consistently pushed for repatriation. By December 1997, just 35,000 of the 400,000

displaced Bosnians who returned home had settled where their ethnic group constituted a minority. For the average Bosnian, ethnic cleansing has succeeded.

A study conducted by the International Center for Migration and Health (ICMH) highlights the fact that the displaced population tends to be more rural, less well-educated, includes fewer professionals and more widowed people than the non-displaced population. It is not surprising, then, that in December 1996, 74

percent of displaced people reported that they were not employed, compared to 38 percent of those who were not displaced. When talking to Bosnians, men and women, adults and youth, the common plea is for paid work.

Health Services Before, During and After the War

Before the war, Bosnia-Herzegovina had a good health infrastructure and adequate coverage. Infant mortality was 21 per 1000; immunization coverage was around 70 percent; life expectancy was 72.6 years. The total health budget was about \$150 per person, low for Europe, but high for this region. The health system was designed as a tiered referral system, beginning with primary health care clinics (staffed by general practitioners) and moving up to highly-specialized clinical centers. Increasingly, however, patients skipped the first tier and sought more specialized care.

The war destroyed 40 percent of the nation's health infrastructure. Providing health care during the war was difficult, at best. Facilities which were not destroyed or badly damaged often had no heat or medical supplies for long periods of time. More than 12,000 health care professionals either lost their lives or fled the conflict. The doctor-patient ratio went from 2.6 per 1000 in 1991 to 1.1 per 1000 after the war. The war also produced shortages of midwives, nurses, dentists and technicians. Drug production and distribution systems were severely disrupted during the war, resulting in shortages of essential drugs and dependence on NGOs for supplies.

Predictably, most health indicators fell during the war, particularly for young children. Perinatal mortality



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East Mostar. The women's centers run by Stope Nade, which provide RH services, emotional support and training, stayed open throughout the war and served women of all ethnicities.

ty rose from 15.3 per 1000 live births to 38.6 per 1000. The incidence of low birth weight doubled. Some of this was attributed to lack of food—an estimated 200,000 people did not have enough food to maintain their health—and increased consumption of cigarettes. Congenital abnormalities rose dramatically, from 0.37 percent to 3 percent. Increased rates of neural-tube defects also were attributed to nutritional deficiencies. The number of tuberculosis cases also rose. During the war, 156,827 people died, half of them from gunfire and shelling. About 6,000 people died from hypothermia or malnutrition, 474 from

assault and rape, and the rest from unknown causes. Some 30,000 people were tortured; 175,286 were registered as wounded; and 76,626 required hospital treatment.

Not surprisingly, the health care system remains severely stressed. International donors contribute to the rebuilding of structures; but rebuilding the health care system will take more time. The demands on the health care system are daunting: in addition to the 12,708 classified war invalids, many of whom require long-term rehabilitative care, there is a large backlog of services (such as treatment of cancer patients and children who have not been immunized) that were postponed during the war, and the newly-added burden of treating post-traumatic stress disorder.

Since the war, private clinics have mushroomed around the country. This is partly in response to market forces and partly because many health professionals no longer want to practice within the government's low-paying health system. International donors are encouraging the Ministry of Health to adopt traditional health models, based on a strong primary health care network and tiered referrals—a design that was failing badly even before the war. It will undoubtedly take several years, and a few false starts, for an effective health care system to evolve in BiH.

Reproductive Health During the War

Malnutrition, lack of routine care, trauma, increased smoking and continuous stress took its toll on women, especially in the long term. Fortunately, because of the skill and dedication of medical personnel and the high standard of medical facilities, even during wartime, maternal mortality did not rise.

Numbers of pregnancies, however, declined dramatically, as did the number of pregnancies brought to term. In Sarajevo, for example, the number of deliveries fell from 10,000 per year to only 2,000 per year during the war. By 1993, abortions outnumbered pregnancies two to one. Some contraceptives were available through a few NGOs. USAID shipped 600,000 condoms and 240,000 cycles of pills during the height of the war. Still, since commercial supply channels were interrupted, most women had little access to contraceptives, and little in the way of systematic RH services were available.

Drugs to treat STDs also were in short supply, or were only erratically available. Health professionals complained that they never knew what was coming (in one instance, a large shipment of antimalarials arrived, packaged with “kits” designed for Africa). Still, whatever was available was used. During the war, routine tests and diagnoses of complex medical problems were suspended.

Rape as a Weapon of War, and Its Aftermath

Before the war, Yugoslavia was a socially conservative, male-dominated society with defined gender roles and relatively few opportunities for women to assume leadership, especially in rural areas. The loss of husbands and fathers which so many women sustained, combined with the traumas and violence they experienced, have profoundly affected the society, and jeopardize women's ability to cope with their new circumstances as heads of households.

Even more devastating is the burden of violence carried by so many women in the former Yugoslavia. Rape has always been a part of war; but in few cases has it been so deliberate, dramatic and well-publi-

STOPE NADE—FOOTSTEPS OF HOPE

In May 1993, Marie Stopes International (MSI) began conducting a program of psychological, social and health assistance to refugees, displaced and other war-affected women. At the peak of the war, MSI ran some 67 centers, working with all ethnic groups throughout the former Yugoslavia. Registered locally as Stope Nade in 1995, the program still runs 34 centers that cater especially to young people and provide a wide range of services, including counseling and support for war trauma and rape victims, safe havens in domestic violence cases, RH services, job training, assistance in searching for employment, and social activities. Stope Nade educates wider audiences through radio programs.

When women describe, enthusiastically, the role the center has played in their lives, the word “safe” recurs regularly in their descriptions. During the war, especially in cities under siege, the centers were constantly full because women felt “safer in a group”. Today, whether it is group counseling sessions where older women talk about their losses, learn to trust and stop “feeling so alone,” or boisterous classes where young women learn to sew, use the computer or dress hair—laughing and joking with one another all the time—women report feeling “safe here” and “with people who care.” Stope Nade staff build on this confidence to help young people make sound RH choices and avoid pitfalls—from unsafe sex to sex for money.

Because government health facilities are still not able to meet the demand, the RH program provides gynecological exams and screening tests, such as cervical smears. For the women, these are not just laboratory tests. Women welcome being seen by gynecologists—many of them female—in whom they have confidence. The project doctors spend time with each woman, giving advice and counseling. This helps build women’s self-confidence and convinces them that someone cares about them. Stope Nade sees its RH program as part of therapy for traumatized women.

cized. Yet data on the extent of sexual violence is poor, in part because women are, justifiably, reluctant to come forward. One survey found that among the displaced population, 11 percent of women aged 16-49 said they personally knew of a woman who had been sexually tortured or abused during the war. Others believe that rape was not as widespread as initially reported. Whatever the actual numbers, however, its effects on those subjected to it, especially teenage girls in rape camps, are terrible and long lasting. Catholic Relief Services is working with a small group of rape-camp victims in Sarajevo. These

women suffer severe depression, inability to concentrate and lack of self worth. Many are ostracized from their families, or by husbands unable to accept them back. A few will never recover their sanity. They receive no compensation or special health assistance from the Bosnian Government. Given the hostile or indifferent environment around them, it is not surprising that so few women come forward to tell their stories or to seek help.

Rape is only one manifestation of sexual and family violence. Several young women describe being pressured during the war, by their own communities, to

have “duty sex” with troops going off to fight. It is difficult to verify how widespread, or how coercive, this practice was. Since the war, domestic violence has become a large problem. Husbands returning from concentration camps, or fighting in the field, often find themselves unemployed and powerless. A reproductive health assessment conducted by IRC in Gorazde, Bosnia-Herzegovina showed that 55 percent of 249 women surveyed knew at least one woman that had been beaten by her husband or boyfriend. Ninety percent of these women knew more than one woman who had been beaten. Alcohol abuse is common, and has often led to wife beating. With the breakup of families and the effects of trauma, it is reported that many teenage girls have gone into formal or, allegedly more common, informal prostitution. Many have sex with peacekeeping troops in exchange for money or presents. However, there is no credible data to determine how widespread this problem is. What *is* clear is that the problem of violence and abusive or exploitative sex will need to be addressed for a long time to come.

Reproductive Health After Dayton/Meeting the Needs of Traumatized Women

It is almost as difficult to obtain a good overall view of reproductive health after the war as it was during the war, since there is so much contradictory information. More data is needed. The ICMH study found family planning to be more common in populations that were not displaced than in those that were, but low in both (33 percent and 13 percent, respectively). Condom use among populations that were not displaced was 37 percent; while among displaced persons, condom use dropped to 28 percent. The most

common female method of contraception, used by 28 percent of the contraceptors, was the IUD. This is surprising given the high costs of IUDs. About a third of Bosnian women who practice contraception use coitus interruptus. Abortion, however, is still the most widely-practiced method of fertility regulation, despite its high cost. But birth-to-abortion ratios have decreased to 1:1 since the war.



Nancy Harris

In Bosnia, older people keep talking about the war. Young people want to listen to music, be with their friends, and to get jobs.

More displaced people use oral contraceptives than those who were not displaced (15 percent versus 7 percent). ICMH suggests that this difference is due to NGO outreach work among displaced persons. USAID, a major donor in contraceptives, shipped 553,200 cycles of oral contraceptives to BiH in 1997 and 550,800 to Croatia. Pills are expensive in Bosnia, and only one type of pill is available.

A joint UNFPA/WHO project in Bosnia-Herzegovina is training health professionals (some 500 have been trained to date), distributing RH materials and restoring the flow of information on RH topics, particularly among youth. Efforts to reduce medical barriers to

contraceptive use (especially restrictive prescription practices) and to supply low-cost contraceptives through pharmacies, clinics and private practitioners are urgently needed.

Information on STDs, sexual behavior and the use of contraceptives among youth is unavailable. A study done in Banja Luka before the war suggested high knowledge but very low practice of contraception, though 65 percent of young people have sex before marriage. There is little reason to believe these numbers decreased during the war. Testimony from young people themselves suggests that they are still sexually active in large numbers, placing them at high risk for STDs and unwanted pregnancies. To meet the needs of youth, large-scale distribution of condoms should be launched through outlets, such as clubs, counseling services, youth clinics, vending machines and perhaps schools. Stope Nade plans to open an adolescent clinic in Bihac.

One offshoot of war may be increased risk of reproductive tract cancers. Stope Nade was funded to help women re-establish normal checkups, including cervical smears and breast exams. Examining more than 5,000 women, the agency found increased dysplasia, discharge and STDs. Some of this can be attributed to

the lack of routine gynecological care. But the Bosnian OB/GYN community is convinced that stress and trauma also play a part.

The increase in the number of women having children since the end of the war can be seen as a good sign. Families are beginning to heal—and to look at life positively. Appropriate emphasis by the donor community, upon which the former Yugoslavia is still so dependent, on all aspects of RH care will contribute to a positive future for the next generation.

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