



Hospitals in War  
**Health Services for Refugees  
in Host Country Hospitals:  
Croatia (1993-1997)**

Leila J. Richards, MD, MPH†

Hospitals in wartime should be regarded not only as recipients of equipment and supplies, but also as sources of information and expertise that can prove valuable to non-governmental organizations. Host country hospitals should be used as a resource in addressing significant health needs of refugees concentrated in urban areas. Much can be done by enlisting hospitals as partners in an alliance that, while working on wartime needs, could serve as a solid foundation for further collaboration in the post-war period. [M&GS 1999;6:28-35]

**H**ospitals are powerful institutions in wartime. In countries experiencing or emerging from a war they may be the only institutions capable of functioning with little or no government help. As recipients of valuable medicines and equipment donated by the international community, and as hosts to visiting officials and journalists, astute hospital directors become formidable “players” in the country’s wartime political arena. They may attain positions of influence far surpassing their original mandates. The war teaches them to think pragmatically, and they may prove to be more tolerant and accommodating toward refugees than senior government officials.

This article describes the collaboration between an American non-governmental

organization, the International Rescue Committee (IRC), and a group of Croatian hospitals during the recent conflict in the former Yugoslavia. This collaboration made it possible for more than 3,000 Bosnian patients, most of whom were children, to get medical care at Croatian hospitals, polyclinics and rehabilitation centers from October 1993 through February 1997. This project illustrates how host country institutions can address many of the needs of a refugee population in their midst, and demonstrates the role that non-governmental organizations can play as mediators in this process.

### **Early Phases**

The project was originally planned as an alternative to the UN Special Medical Program (often referred to as the UN Medevac Program) that would allow critically ill and war-injured Bosnian children to be evacuated to Croatian hospitals instead of being sent abroad. These children needed specialized medical care that was not available in Bosnian hospitals due to wartime conditions. To expedite their care in Croatia the IRC contracted during the project’s first year with two hospitals affiliated with Zagreb University. These hospitals agreed to accom-

*†LJR served as Medical Project Coordinator for the International Rescue Committee in Croatia from October 1993 through December 1996. At the time of publication she worked as a public health consultant.*

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moderate the children if they were compensated for their care at a reasonable rate. Both refugee children and those evacuated from Bosnia-Herzegovina were included, as were children from all ethnic backgrounds.

In its second year the project expanded to include outpatient services for children, such as physiotherapy and primary dental care, and hospital care and rehabilitation for a number of critically ill adult patients. With a budget of less than \$6 million, the project provided hospital care and support services for approximately the same number of Bosnian patients as the UN Medevac program. During this period 1,463 beneficiaries were included in the Medical Project (Figure 1). The number of patients evacuated from Bosnia-Herzegovina to countries outside the former Yugoslavia through the UN Medevac Program during this period was 1,468<sup>1</sup> [1]. More than a dozen Croatian hospitals, polyclinics, and rehabilitation centers participated in the project. Except for a few patients who were resettled abroad or died in the hospital (see box: *Outcome Data*), all returned to their homes after discharge from the hospital.

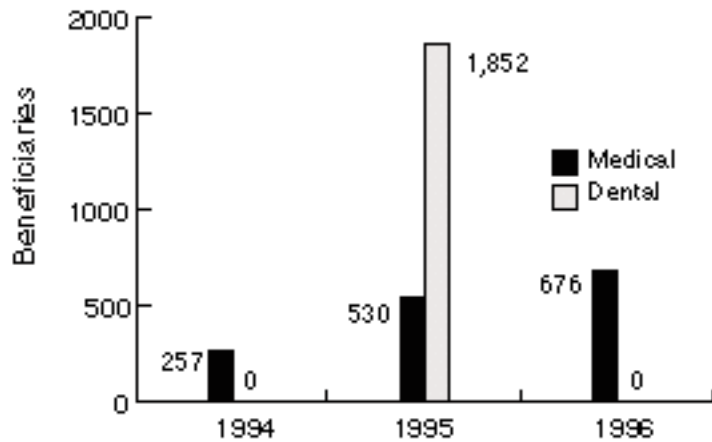
## Background

The war in the former Yugoslavia began in June 1991 when two of its six constituent republics, Croatia and Slovenia, declared their independence. Fighting in Slovenia ended quickly. But cities and towns in Croatia, which had a substantial Serbian minority, were besieged by the Yugoslav National Army in fighting that left 43,000 dead and wounded and drove 250,000 Croats from their homes [2]. When the fighting ended six months later, Serbs held 30% of the country. These Serbs did not want to be part of the new republic of Croatia, and declared their territory "the autonomous region of Krajina." Under the terms of an internationally brokered ceasefire signed early in 1992 this land was divided into "protected areas" and patrolled by UN troops. Nevertheless, clashes erupted intermittently in parts of eastern and central Croatia for the next three years, and Croatia's displaced population did not begin to return to their villages in large numbers until late 1995 after the signing of the Dayton accords.

Once Croatia's independence was internationally recognized in 1992, it was inevitable that Bosnia-Herzegovina would seek its independence as well. When it did so in March 1992, a prolonged and devastating conflict began which within two years left

1. The total program budget, shown in Figure 2, includes activities carried out in Bosnia-Herzegovina as well as in Croatia. Of this amount, the budget for medical care in Croatia was approximately \$5.5 million.

**Figure 1. Number of beneficiaries in medical and dental projects\* in Croatia.**



\* calculated as patients per center

more than 280,000 dead and wounded and 26,000 missing [3]. By late 1993 the fighting and the "ethnic cleansing" of towns and villages had displaced half of Bosnia's population [4,5] and had driven more than 275,000 people into Croatia as refugees [6]. Some were accommodated in collective centers and refugee camps, but the vast majority found shelter with relatives or acquaintances.

The war in Bosnia-Herzegovina turned the country into a mosaic of warring enclaves with shifting front lines. Travel between these areas for the next three years was hazardous and often impossible. International relief agencies travelling in UN convoys delivered medicines and supplies to hospitals, but the major hospitals were cut off from each other, short of staff, and often under siege.

## Organization and Evolution of the Medical Project

The plight of children in this setting was brought to world attention in the summer of 1993 by the case of Irma Hadzimiratevic, a five-year-old Bosnian child who contracted meningitis after sustaining spinal injuries during a mortar attack. The hospital caring for her in Sarajevo, which had been under siege for more than a year, could not offer the specialized care the child needed. Although Irma's situation was hardly unique, her case created a wave of international sympathy, and she was subsequently evacuated to a hospital in London.

Popular concern about the situation of children like Irma generated political pressures that led to the rapid expansion of the UN Medevac Program in the fall of 1993 [7]. The program, which was administered by the International Organization for Migration (IOM) in conjunction with UNHCR, matched critically ill and injured Bosnian patients with

## Outcome Data

It was not possible to keep long term outcome data on patients following their final discharge from the project. Data that follows, therefore, is necessarily incomplete.

**Mortality:** To our knowledge 10 deaths occurred in children and three in adults accepted to the IRC's Medical Project between October 1993 and March 1997. These numbers include two children with leukemia who died en route to Zagreb from west Bosnia and two children who died in the US after having been resettled, on medical grounds, with their families.

The remaining six deaths occurred in children with leukemia or solid tumors. They include those who died in the hospital and those whose families chose to take them home when their condition was known to be terminal.

Of the three adults who died, two had malignancies (Ewing's sarcoma and Hodgkins' disease) and one died from complications following neurosurgery in Zagreb for a postpartum cerebral hemorrhage. (The death followed a heroic rescue that involved carrying the patient out of Sarajevo by tunnel on a stretcher).

**Resettlement:** Five children were resettled abroad with their families for medical reasons after having been hospitalized in Croatia. As noted above, two of them died—one while awaiting a bone marrow transplant for treatment of Burkitt's lymphoma and one who had sustained extensive burns.

The remaining three children had war-related injuries and needed long term rehabilitation. One child had lost both legs (one necessitating a hip disarticulation) and was resettled, with the help of the IRC, near a Shriner's rehabilitation hospital in the US. The other two were resettled on the initiative of their families.

All remaining children were discharged to the care of their families in Croatia or Bosnia-Herzegovina.

offers of hospital beds in more than 30 countries. Prospective patients were screened by a panel of international doctors in Sarajevo, and those accepted into the program were flown abroad for care. (A few patients were also sent abroad through privately organized evacuations.) The Special Medical Program was also carried out on a more modest scale in Croatia and Serbia (known as the Federal Republic of Yugoslavia) for country nationals needing urgent medical care outside of their national borders.

### *War-Injured Children*

The news stories covering Irma's case failed to mention that Bosnian children like her were being cared for at hospitals in neighboring Croatia in a makeshift arrangement that had existed since the war began. War-injured children who had been evacuated from Bosnia by military helicopter were often taken to the Institute for Mother and Child (now known as Children's Hospital) in Zagreb, Croatia's capital. The hospital, which specialized in pediatric trauma, offered a full range of surgical subspecialties, including neurosurgery. The nearby Children's Oncology Unit of Zagreb's University Clinical

Center, which had served as a regional referral center before the war, was treating critically ill Bosnian children with acute leukemia and other hematological disorders. An official at the University Clinical Center estimated that refugee and war-injured Bosnian children occupied 30% percent of its pediatric beds at this time [2]. According to Croatia's Office for Displaced Persons and Refugees, there were approximately 157,000 refugee children in the country in late 1993, and children constituted 56% of the refugee population [8].

The war in Bosnia-Herzegovina put these and many other Croatian hospitals in an awkward position. While Yugoslavia was intact, Croatian and Bosnian hospitals had been closely connected. Their doctors had studied together at the same universities, and their patients had been covered under the same national health insurance plan. Because of Zagreb's geographical proximity to west Bosnia, many of its hospitals and rehabilitation centers had been built to accommodate Bosnian as well as Croatian patients. Croatian hospitals had a total of 1,800 pediatric beds [2]. Pediatric wards in Zagreb's leading hospitals had empty beds to fill, and hospital administrators were willing to accept more Bosnian children. But falling government reimbursements had left hospitals short of revenue to buy supplies, pay salaries, and make needed repairs. Hospital administrators needed some financial support for the cost of their care.

After holding discussions with representatives from UNHCR, the IOM, the Bosnian Embassy, and the Croatian Ministry of Health, the IRC offered to provide this support to two hospitals affiliated with Zagreb University. The conditions under which the support would be given were set out in contracts signed with each hospital. The hospitals would set aside a portion of their beds for Bosnian children, and the IRC would pay the hospitals a flat rate for the care given to the children who occupied these beds. Rates were calculated on the basis of bed-day and were all-inclusive. The hospital agreed to allow IRC doctors to visit the children, review their medical records, and discuss their progress with the children's doctors. The IRC would keep a record of each child admitted to the project, and would help arrange for any followup care the children needed, including rehabilitation and short term foster care. With the endorsement of the Croatian Ministry of Health, the IRC's Medical Project began in October 1993.

This arrangement offered several advantages over the UN Medevac system. Children would be cared for in a familiar environment, close to their families, and could usually

return to their homes as soon as they were discharged. They would be hospitalized under prearranged guidelines, streamlining the admission process for them and for admitting physicians. The project would also serve as a clearinghouse where information about the children's condition and their need for social support services could be conveyed to other organizations. This clearinghouse function was particularly important in the case of unaccompanied children. These included critically injured children evacuated from Bosnian front lines by military helicopter or ambulance, those unable to return to Bosnia on discharge because of fighting near their homes, and children needing a series of operations or hospitalizations. Services that IRC's medical project could offer these children included placement with host families or group homes in Zagreb between hospitalizations, communication with children's families in Bosnia through UNCHR or the ICRC, and arrangement of short-term accommodations in Zagreb for visiting parents.

### *Fostering Multi-ethnic Cooperation*

The IRC's Medical Project also established channels of communication with the Croatian medical community at a time of growing popular resentment against refugees. The flow of Bosnian refugees had strained Croatia's resources and competed with the country's own displaced population for shelter and humanitarian aid. Hostility against refugees, fueled by government propaganda, increased after the Croatian government intervened in the war in Bosnia on behalf of Bosnian Croats fighting in Herzegovina in October 1992. By establishing a presence in Croatian hospitals IRC staff could assure that nationalist sentiments would not compromise the care that Bosnian children were receiving.

The Medical Project was administered by a team of young Croatian and Bosnian health professionals with overlapping responsibilities: visiting hospitalized children, talking to their doctors and their families, and contacting other aid agencies. This teamwork ensured that both the needs of the refugee community and the realities of the Croatian health system would be addressed when problems arose. (While government regulations required that

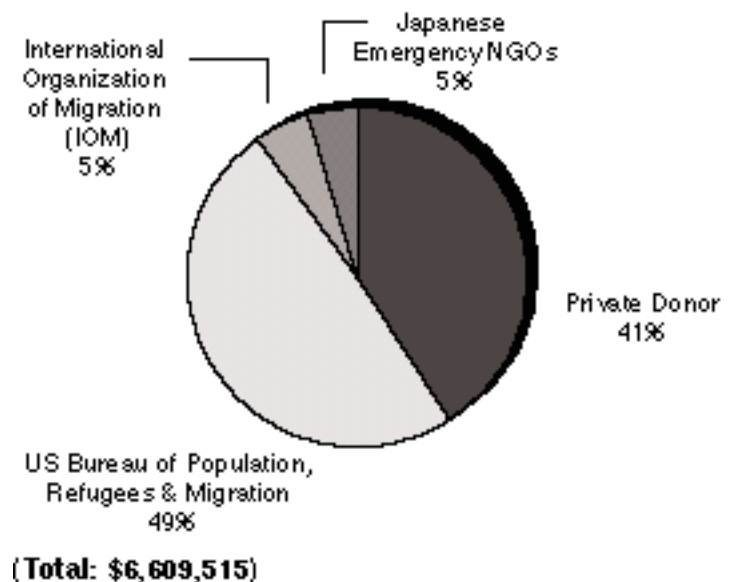
all locally hired staff have Croatian nationality, it was possible to assemble a multi-ethnic team by recruiting refugee medical staff with dual nationality, and by employing a refugee doctor as a part-time "consultant.")

Working on this project demanded a great deal of patience and diplomatic skill. The fact that the first members to join the staff, a Croatian doctor and a Bosnian physiotherapist, did not share the same views about events leading up to the war did not prevent them from collaborating on a project in which both of them believed. The staff later grew to include general practitioners, dentists, school health specialists, a rehabilitation specialist, and a pediatrician. Most remained with the project until loss of funding forced it to close in March 1997.<sup>2</sup> An American physician (the author) served as the project's coordinator and intermediary from 1993 through 1996.

In its first year the Medical Project focused primarily on the care of critically ill and injured children. It was financed entirely through a grant from Theodore Forstmann, an American businessman (Figure 2). Mr. Forstmann's continued support for the project over the next three years provided the flexibility to include a number of related pilot projects, such as sending displaced and refugee children to Croatian summer camps.

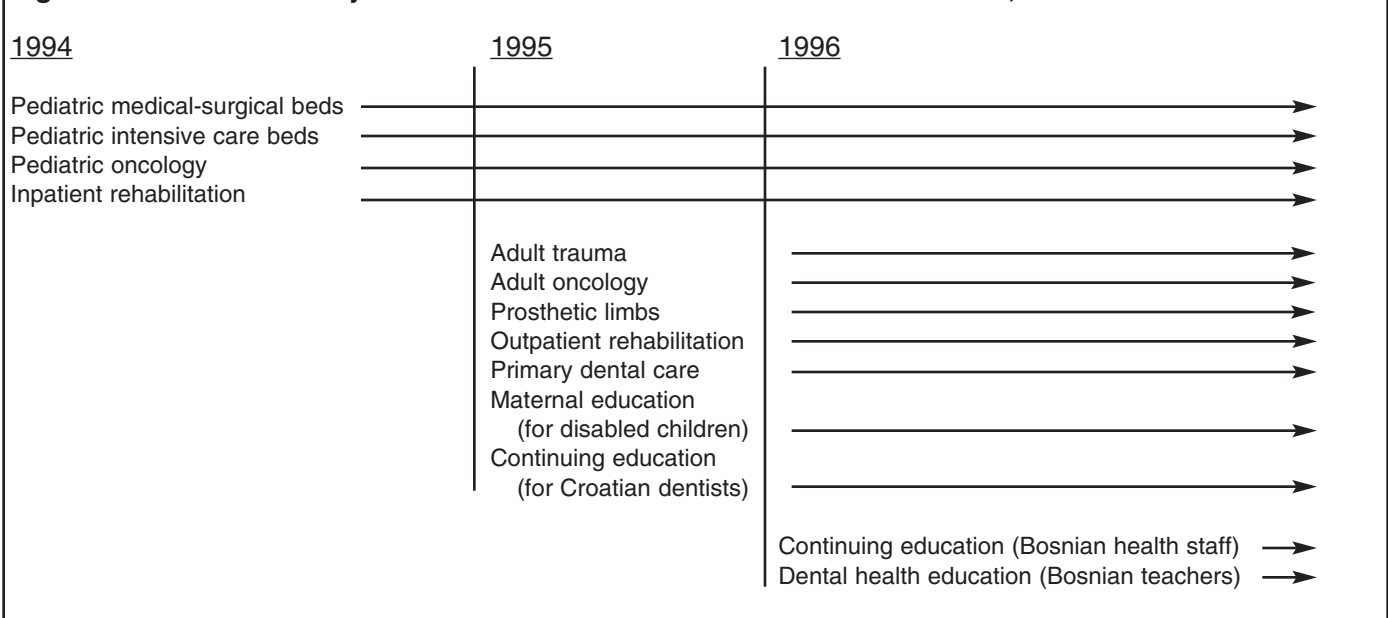
In 1995 additional funding from the Swiss government and the US Bureau of Population, Refugees, and Migration made it possible to add six more Croatian hospitals to the project and, at the donors' request, to include a number of adult patients as well. The Swiss grant, administered through IOM, allowed some Bosnian patients in the UN

**Figure 2. Source of funds for IRC Medical Project, 1993-1996.**



2. After supporting a wide range of health services within the Medical Project for three years, the US Bureau of Population, Refugees, and Migration chose not to renew its funding in 1997. At that time the Croatian portion of the Medical Project was winding down, but the decision had not been anticipated. No reason was given for the cutoff in funding at the time.

**Figure 3. IRC Medical Project: Subsidized Health and Educational Services, 1994-1996**



Medevac Program to be treated in Croatian hospitals for the first time instead of being sent abroad. Funding from the Japanese government led to a second IRC project that supported primary dental care for more than 1,800 refugee schoolchildren at seven Zagreb polyclinics. This dental program was carried out in conjunction with a school-based health education program that targeted both Croatian and refugee children attending Zagreb primary schools.

By this time the advantages of working with the Croatian health system were becoming more apparent. Bosnian hospitals, short of specialized staff and preoccupied with the needs of the war wounded [7], could not adequately address the needs of other vulnerable patients such as children and the disabled, and many of these patients spilled over into Croatia as "medical refugees." There was a growing awareness that Bosnian refugees living in Croatia would be using the country's health services for the foreseeable future. Moreover, the shortcomings of the UN Special Medical Program had become apparent: the limited number of available beds abroad, long delays in placing patients, the stresses caused by family separations, particularly when children were involved, and the unwillingness of many adult patients to return to Bosnia once their treatment was finished [2].

As the war in Bosnia-Herzegovina gradually subsided in 1995, travel between the two countries became easier. In the months preceding the signing of the Dayton accords in November 1995 staff from the Medical Project traveled to hospitals and rehabilitation centers in Bosnia-Herzegovina to meet with doctors and to determine how

the project could serve their needs. At times they arranged for senior Croatian doctors to accompany them on these visits.

Medical Project initiatives during the postwar period grew out of these visits (Figure 3). While the project continued providing services through the Croatian health system that were not available in Bosnia-Herzegovina, its focus changed to outpatient services and brief hospitalizations for specific procedures. For example, from 1995 to 1997 Bosnian doctors referred 90 children with developmental disorders to a pediatric rehabilitation center in Zagreb for evaluation and physiotherapy. At the center the children's mothers also learned how to care for them at home. Twelve child amputees were referred to another center to be fitted for prosthetic limbs that were not available in Bosnia. In a part of western Bosnia where a single ophthalmologist served a population of more than 250,000, a backlog of patients needing reconstructive eye surgery and prosthetic eyes was referred to a Zagreb eye clinic for treatment.

At the same time, the Medical Project gradually "transplanted" its support to a number of hospitals and primary schools in western and central Bosnia. Contracts were signed with three Bosnian pediatric clinics, a school-based dental program was launched in west Bosnia, and hospitals received donations of surgical supplies, laboratory reagents, medical textbooks, and rehabilitation equipment.

Bosnian doctors also wanted to update their clinical knowledge and skills. Hospitals and rehabilitation centers in Bosnia-Herzegovina had lost much of their specialized staff to military service and the refugee

exodus [9], and newly trained staff wanted to learn about the techniques and resources available at larger referral centers. Using their contacts with hospitals in Croatia and Bosnia-Herzegovina, the Medical Project staff organized educational seminars in both countries for Bosnian pediatricians, oncologists and rehabilitation specialists. For example, the Institute for Mother and Child and the Clinical University Center in Zagreb, under IRC sponsorship, had cared for more than 50 Bosnian children with leukemia and solid tumors from January 1994 through February 1997. A Croatian pediatric oncologist who had treated many of these children was invited to spend a week at Sarajevo's University Clinical Center to help restart its children's oncology ward. During her stay she worked with the young pediatrician who would be in charge of the unit. (At this time there was only one trained pediatric oncologist remaining in Bosnia, and he had retired before the war began). To follow up the visit the pediatrician later spent a month studying the operation of the Children's Oncology Ward of Zagreb's Clinical Hospital Center.

## Discussion

A complex emergency is characterized by intermittent battles that erupt along shifting front lines and may engulf a country or a region in conflict for years. Often civilian areas are deliberately targeted, gradually destroying not only homes and villages but the health and educational infrastructure as well. Refugees fleeing such a conflict may have little incentive to return home. On reaching a host country those who are not accommodated in camps will scatter widely and may be compelled to move from place to place. Their needs then become difficult to address or even to categorize, leaving humanitarian organizations with few options beyond provision of short term services to a relatively small segment of the population.

As they migrate to urban centers of a host country, refugees will begin to use local clinics and hospitals, whether or not any arrangements have been made for them to do so. In such a setting it is wise to consider working with these centers to provide some of the health services needed by refugees. Instead of creating a parallel system of health care by operating clinics staffed by refugee or expatriate doctors, humanitarian organizations should consider how refugees might be accommodated within the host country's health system. NGO health staff can play a valuable role as mediators between host country doctors and the refugee community, serving as advocates for refugees while acknowledging the expertise available through the host country's health system.



The circumstances favoring collaboration with host country physicians are not unique to the former Yugoslavia; the author's experience with a similar project for Palestinian refugees in Lebanon has been described elsewhere [10].

Private voluntary organizations have several assets in a wartime setting, including a quick response time, the chance to experiment with new ideas, and the ability to serve as advocates for refugees and the displaced. They can also act as arbitrators, creating an atmosphere where talented individuals from different ethnic and professional backgrounds can work together. If they succeed in forming partnerships with local hospitals they will have a wide range of options for other joint projects in the postwar period.

Most of the constraints faced in implementing this project are commonly encountered in other settings. The first problem was the prejudice and intolerance encountered in a few Croatian doctors. The war had engendered nationalist sentiments that gave them license to express their intolerance of refugees in general and certain ethnic groups in particular. To some extent their attitudes waxed and waned with the changing political situation. In a few cases Medical Project doctors intervened to protest ethnic slurs made in front of a patient or a staff member, but such extreme behavior was rare. (Other Croatian institutions, however, provided unwavering support. For example, the IRC benefited from a long term partnership with Croatian Caritas, which provided accommodation for dozens of unaccompanied and convalescing Bosnian women and children in its group homes.)

The criteria for deciding which patients to include in a project of this kind can be discussed only briefly. In principle, the standard

S.B., a seven-year-old unaccompanied minor from East Mostar, was evacuated to the Institute for Mother and Child in Zagreb, where she underwent emergency neurosurgery in December 1993 for shrapnel wounds to the spinal cord complicated by meningitis. Inset photo shows S.B. at a rehabilitation center outside of Zagreb six months later. Except for residual left hand weakness and a muscle contracture in her left foot, she regained full neurologic function. Photo courtesy L. Richards, MD.

## The Cost of Care

Because overseas medical care, as well as accommodation for accompanying family members, was donated in kind to patients evacuated by the UN Special Medical Program (Medevac Program), it is not possible to directly compare the program costs of the IRC's Medical Project with the UN program. According to IOM estimates, the average cost per evacuated patient in the Special Medical Program was \$1,900 [7]. This figure included only staff and office costs and travel of patient and accompanying members, and not the costs of medical care.

Although there is too much variability in the IRC's patient population to allow for reliable estimates of the average cost of treating various illnesses and injuries, the reader can gain an idea of the costs of local treatment by looking at the flat rates paid by IRC for typical inpatient and outpatient care.

For children, the flat rate on the medical-surgical ward was \$65 per day. The flat rate for treatment of children with leukemia was \$150 per day and the price per bed-day in the intensive care unit was \$300. Costs for adult care were somewhat higher. Outpatient physiotherapy for children cost \$10 per hour, and the cost of inpatient rehabilitation (i.e., boarding) was \$50 per day for a child and \$20 per day for the accompanying parent.

used in accepting patients was that once a patient's condition was treated, he or she could be expected to lead an active and independent life or, in the case of disabled patients, could be cared for in his or her community. Once accepted, all of the costs of a patient's care in Croatia, including rehabilitation and followup hospital admissions in Croatia, were covered.

The project's admission guidelines posed an ethical problem primarily with cancer patients. Because of budget constraints, only a limited number of Bosnian adults could be accepted for cancer therapy in Croatia and the damaged infrastructure of Bosnian hospitals made support of even simple oncology services in that country financially impossible. In practice, all children with cancer referred from Bosnia were accepted for evaluation and treatment, as were all adults with early-stage, potentially treatable tumors. If the patient relapsed following therapy, however, and further treatment was regarded as only palliative, the patient was usually released to the care of his or her family in Bosnia. This decision was made after discussing the case with the patient's doctor and family and was undertaken only if the patient was stable enough to travel.

Although admission criteria could be simply stated in theory, the circumstances of the war made it difficult to gain much of a medical history of patients coming from conflict areas where diagnostic services were limited, and there were often long delays

before a patient could be transported. Many patients proved to be more critically ill than described in their medical reports. (see box :Outcome Data). A few died while awaiting transport because the roads were blocked by fighting. A few others died shortly after admission. Other critically ill patients, however, made remarkable recoveries, including a child evacuated from Mostar by military ambulance with injuries similar to Irma's (see photo, page 33).

Establishing good rapport with the Croatian doctors and dentists who cared for the children was essential. Although the Medical and Dental Projects compensated hospitals and health centers, they did not directly benefit the doctors on the staff, many of whom had to deal with an increased patient load. Hospital and clinic staff were government employees who were paid a fixed monthly salary. Some were able to supplement their government salaries by seeing private patients after hours, but many were not. To provide these doctors and dentists with incentives, the projects donated books and periodicals to hospital libraries, issued certificates of appreciation to participating staff, and organized continuing education seminars on topics chosen by the doctors.

The impact of the Medical and Dental Projects can be measured quantitatively by the number of patients it covered (Figure 1). But perhaps its most important contribution was its ability to channel the good will and expertise of local health professionals and to strengthen local health services during the war and the postwar period.

## Recommendations

The activities initiated by the Medical Project were guided by practical considerations that would be applicable to refugee host areas in other complex emergencies:

• *Begin with health services for children.* Article 24 of the International Convention on the Rights of the Child states that "the child has a right to the highest standards of health and medical care attainable," and that "[States] shall...strive to see that no child is deprived of access to effective health services" [11].

• *Include a wide scope of beneficiaries.* The Medical Project was open to all children who could derive significant long term benefit from the services it offered. These words were carefully chosen to discourage referrals of children needing extraordinary interventions, such as organ transplants, and children who would need eventual institutionalization. With its limited budget it focused on a small number of critically ill inpatients and a larger number of outpatients needing short-

term care. The goal was to reach children whose usual source of medical care was interrupted by the war and the emphasis was on maintaining the same standard of care that existed before the war began. Such a standard would, of course, vary according to the resources available in the region

• **Offer something tangible to the host country's health system.** International NGOs working in a host country may encounter resentment at the perceived favoritism shown to refugees. This is particularly true when regional conflicts have caused economic hardship to the host country and have displaced thousands of families. To address this problem the Medical Project allocated a portion of its budget every year to support services for Croatian children, including hospital care, recreational programs, and health education.

• **Include an educational component.** This can be done, for example, by sponsoring conferences around topics of interest to health staff, recruiting local academic specialists as consultants and conference speakers, organizing patient education programs, and subsidizing the cost of educational materials prepared by local professional societies. The value of educational sessions arises not only from the transmission of information but also from the opportunity for health professionals to meet with each other, to discuss their experiences, and to establish or renew contacts. These sessions and conferences boosted the morale and self esteem of both Bosnian and Croatian health professionals by acknowledging their status and their contributions during the war. Such opportunities can help lower barriers of mistrust and build a reservoir of good will.

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