Aim. To describe the health status of formally recognized refugees from the former Yugoslavia in the Netherlands, and analyze the relationship between experienced traumatic events and health status. Methods. A random sample of refugees was taken from randomly selected municipalities. One hundred and two persons received a postal questionnaire. Forty percent filled out the questionnaire completely. Well-validated self-assessment scales were used to measure six dimensions of health status. Traumatic experiences were assessed by the Harvard Trauma Questionnaire. Physical aspects of health status were measured by the three dimensions of the Medical Outcome Study (MOS) Short-form General Health Survey (SF-20) which consisted of the dimensions “physical functioning”, “subjective health”, and “pain”. Social health was measured by the two dimensions of the SF-20, “role fulfilling” and “social functioning”. Results. The refugees showed vulnerable health. A significant group had an accumulation of health problems. These were mostly unrelated to sociodemographic variables. Many of the refugees experienced several traumatic events. These experiences were clearly related to all health problems. Conclusions. The refugees from the former Yugoslavia scored low on standardized health measurement scales. This was primarily due to their traumatic experiences in combination with their refugee status. There is a need for health services to prevent the accumulation of (future) health problems.

Key words: health status; the Netherlands; PTSD; refugees; trauma

In most West-European countries, refugees, after having received an “official status” of a refugee, are cared for by regular health care services. Many of the refugees have traumatic experiences and need special attention (1). Logghe (2), however, concludes that most health care authorities do not have a plan to meet the health needs of the refugees. Actually, very little is known about the health status of the refugees and some reports call for a need to assess their health status (3). In general, it might be expected that many refugees have a post-traumatic stress disorder (PTSD) because of traumatic experiences in their (former) home-land and because of being in exile. PTSD has mostly been studied among Vietnam veterans (4,5).

This study presents data on the problems of the “A-status” refugees in the Netherlands. A-status refugee means that the refugee has officially been recognized as a refugee for humanitarian reasons and is allowed to stay in the Netherlands. For practical reasons, this study concentrates on the refugees from former the Yugoslavia. Case studies report on the extremely poor physical and mental conditions of refugees when they are in the process of recognition. This is as much the case in Croatia and Bosnia-Herzegovina (3) as in the West-European countries. In most countries, they are placed in the refugee camps where conditions are not favorable for overcoming traumatic experiences. Nevertheless, the health care in such camps in the Netherlands is adequately organized (2).

The health status of refugees may be expected to be worse than the health status of “normal” West-Europeans since many refugees have experienced traumatic events. This research analyzes whether this is the case. Mental health can mostly be threatened by traumatic events. However, physical and social aspects of health are also often trauma-related. Important question is whether refugees indeed have major physical complaints and are able to function socially? Answers to such questions are important since they indicate the need for specific health care and risk for future health problems. The research question under study concerns a description of the health status of refugees from the former Yugoslavia who have been recognized as refugees (“A-status”). Their physical, mental and social health is as much in our interest as it is in theirs. In addition, the effect of traumatic events on health status was analyzed.
Subjects and Methods

In the Netherlands, all 685 municipalities have population registers that specify (former) nationality, date of birth, gender and date of entrance in the municipality (and in the Netherlands). A random sample of 56 was taken out of the 685 municipalities. These 56 municipalities were asked to send, free of charge, a list of all inhabitants originating from the former Yugoslavia who were recognized as inhabitants after September 1, 1991. However, most municipalities have delegated their registration tasks to commercial companies, which means that some of them did not want to cooperate for financial reasons. Indeed, nineteen did not respond. Twenty-five of the municipalities sent the list with names, addresses, gender, and age. Twelve municipalities refused to cooperate for privacy reasons of their citizens.

The sample of households was made from the lists provided by the 25 municipalities, i.e., out of all households (with the same names and addresses), we selected the person who first had his/her birthday after September 1, 1996, and was 18 years or over. A sample of 102 persons was taken out of these households. These respondents were sent a questionnaire with a return envelope.

The questionnaire was bilingual: in Dutch and in Croatian. The response rate was 40%.

The respondents were equally distributed for gender and age as compared to the total sample, except for those 55 years of age and older who were overrepresented (12% response-rate vs 7% in the sample) among the respondents.

The low response rate was probably due to several reasons: most refugees were not familiar with surveys; they feared that filling out the questionnaire could have negative consequences on their stay, and they may have felt uncertain about filling out questionnaires due to difficulties in reading and writing.

The questionnaire contained questions on sociodemographic data (gender, age, marital status, living arrangements, and education), traumatic experiences, and health status. The sociodemographic data were measured in a traditional way with precoded questions. Traumatic experiences were assessed by using the Harvard Trauma Questionnaire (8). The scale contained 16 items indicating a traumatic event (e.g., lack of food and water, isolation, rape, kidnapping); each item could be scored as: experienced, seen, heard or not applicable. In this study, we present the scores on experienced and seen events. The score ranged from 0 to 16. Physical aspects of health status were measured by three dimensions of the MOS Short-form General Health Survey (SF-20) which consisted of the dimensions: “physical functioning”, “subjective health”, and “pain” (7,8). “Physical functioning” refers to the abilities to perform daily activities. “Subjective health” asks for the evaluation of the health status by the person himself/herself and “pain” asks for the pain experience. Social health was measured by the two dimensions of the SF-20, “role fulfilling” and “social functioning”. The first evaluates the ability to do jobs or housekeeping, the second refers to social limitations due to the health condition (going out, seeing friends). Reliability and validity of these dimensions have been proved (8). The scores were in accordance with the international protocols (8). Mental aspects of health status were assessed by the “psychological health” dimension of the SF-20, and the CES-D (9) indicating symptoms of depression. The SF-20 and CES-D scores follow international agreement and may be compared to other studies. The SF-20 scales ranged from 0-100, and CES-D from 0-60.

The data were analyzed by frequencies, average scores, and Pearson correlation, using SPSS-PC+ (SPSS Inc., Chicago, Ill, USA).

Results

Characteristics of the Respondents

Half (20) of the respondents were women, and half were men. Almost half (46%) of the respondents were in the age category of 25-34 years. This indicates that the majority of the refugees are indeed related to the younger age group, which is relevant for the future health issues. Data obtained by the municipalities showed that most young people lived together and had children. Accordingly, two thirds of the respondents lived together with a partner.

The education level of the respondents was relatively high: 40% completed high school education and among these, almost half graduated from the university. Seventeen percent completed only elementary school education. Despite a high education level, only a few respondents had a job (10%).

Traumatic Experiences

The Harvard Traumatic Questionnaire describes multiple stressful events that refugees have experienced. Only 6 persons (15%) did not experience a traumatic event and 66% experienced five or more traumatic events.

The number of seen traumatic events was surprisingly much lower. Twenty-three respondents (56%) reported not to have seen a traumatic event.

Combination of the two scores shows that six persons who did not experience a traumatic event did
not see one either. However, this combination score also shows that no less than two-thirds of the respondents have experienced and/or seen 10 traumatic events or more. These figures indicate that this population is at risk.

Health Dimensions
As mentioned before, three aspects of health were measured, i.e., physical, mental, and social aspects (Table 1).

Table 1: Mean score and standard deviation of physical, mental, and social status health indicators among 41 refugees from the former Yugoslavia living in the Netherlands. [view this table]

For physical health three dimensions are presented. As explained in the Methods section, the scales were standardized and ranged from 0 to 100, apart from depression, for which the range was from 0-60. The higher the score on physical functioning and subjective health, the better the health status. The score for pain was reversed to the two former. It means that the refugees reported relatively frequent pain and a low score on subjective health, as might have been expected. The scores on physical functioning were relatively “normal”.

Psychological health seemed to have a low score among refugees, while the average score on depression was dramatic. The CES-D measured reactive depression, and a score higher than 16 was considered as “possible case” of depression. The fact that the average score was 22.6 and that actually two-thirds of the respondents had a score of 16 or higher indicates the enormous problems these people experienced.

Social health is characterized by two dimensions, i.e., role fulfillment and social functioning. The scores of the refugees from the former Yugoslavia were relatively normal. The score on role fulfillment indicates that refugees were taking care of the activities of daily living. The social functioning of the refugees was evidently poor.

The correlations (not shown in the tables) between the dimensions of health aspects were relatively high. They ranged between 0.92 (pain and depression) and 0.41 (psychological health and role fulfillment). Psychological health showed the lowest correlation with other dimensions. Physical health (i.e., physical functioning, subjective health, and pain) showed the highest correlation with other dimensions. These high correlations suggest that there are refugees with a lot of health problems (cumulation) while others have none.

Relations between Health Dimensions and Sociodemographic Variables
The presented data show that the health status of refugees is bad, in particular as far as subjective health, mental health, and social functioning are concerned. All refugees with the “A-status” are at risk. Nevertheless, it is interesting to analyze whether among them there are people even more at risk. Table 2 shows the correlations between sociodemographic variables and health measurements. It is evident that, based on sociodemographic characteristics, no special group can be identified to be at risk for special care. The correlations between age and physical functioning, subjective health and role fulfillment were as expected. Older people, in general, have more problems in performing the activities such as household chores or walking and experience a poorer health than younger people. If people live alone, they experience more psychological problems, as reported by other authors (1,2).

Table 2: Pearson correlations between sociodemographic variables and health status indicators (p<0.05) in 41 refugees from the former Yugoslavia living in the Netherlands. [view this table]

Relations between Health Dimensions, Age, and Traumatic Events
The next step in the analysis was to look for the association between sociodemographic data, health status indicators, and traumatic events (Table 3). Experienced and seen traumatic events were not correlated with any of the sociodemographic variables except age. The correlation with age can be regarded a normal finding. The older respondents reported more experienced traumatic events but fewer seen traumatic events.

Table 3: Pearson correlation between traumatic experiences and age and health status indicators (p<0.05) in 41 refugees from the former Yugoslavia in the Netherlands. [view this table]

Experienced traumatic events were associated with all health dimensions, whereas seen traumatic events were significantly correlated only with more pain. Refugees who experienced more traumatic events reported worse physical functioning, worse subjective health, and more pain. They also had a lower score on psychological health, depression, role fulfillment, and social functioning.
Remarkable finding was an almost absent correlation between seen traumatic experiences and health status indicators.

Discussion
Refugees from the former Yugoslavia reported many health problems, physical, mental, and social. Comparison of scores on health dimensions with international data indicates that the refugees were worse off. Their scores were relatively low (meaning worse) for subjective health, psychological health, and social functioning, and relatively high (meaning worse) for pain and depression, as compared to data from the Dutch population in a random sample of Dutch adults. For example, an average CES-D score of 8.0 was found in a representative Dutch sample; another at random selected sample of people between 18-65 years of age resulted in an average CES-D score of 9.7 (9). An average of 22.6 among the refugees in our study was remarkably higher!

Their health problems were not much related to demographic characteristics, but highly related to experienced traumatic events. Many refugees reported to have experienced a variety of traumatic events. The reported numbers are dramatic. It is understandable that persons with such experiences report so many health problems. The correlations between experienced traumatic events and health status confirm the prevalence of PTSD among refugees from the former Yugoslavia. Evidently, seen traumatic events had less effect on such a disorder. The experiences themselves seem to be overwhelming.

Among the sociodemographic variables, the influence of age on health status could be expected. The absence of relationship between gender and health status and/or traumatic experiences is remarkable in view of the recent finding that the risk for PTSD is higher among women (10). The question arises how reliable these reports on experienced traumatic events are. One could argue that people might exaggerate to justify their refugee status. However, the respondents already have an official refugee status. Besides, it was made clear that the research was confidential and could not interfere with any official claim, rights etc. No selection, as far as could be observed from age, gender, and location, occurred among the respondents. Although the response rate is low, the findings may be seen as representative for the refugees from the former Yugoslavia in the Netherlands.

The outcomes of this study are hampered by a relatively low response of 40%. However, in a recent survey among Dutch citizens using a mailed questionnaire the response rate was 45% (11). There might be two reasons for the low response rate. One is related to the findings of our study - people with traumatic experiences and in a bad health condition may be reluctant to participate in a survey. The other is that many persons in the sample are probably not familiar with surveys and have problems with reading the questions.

The outcomes might be considered representative for the refugees from the former Yugoslavia. The instruments used to assess the health status are reliable and valid. The findings indicate that serious health problems have to be expected among the refugees presently and in the future. This raises the question of how to organize the health care for the refugees. It should be done in such a way that the services are accessible. This group of people will experience a barrier in asking for help because of cultural differences, language problems, and because of the traumatic events. Recent research in Switzerland among health care providers showed low consultation of asylum seekers and refugees (12). Special health promotion and prevention programs should be developed to meet the needs of the refugees.

References

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