Health of Returnees in Osijek Region and Required Special Measures of Health Care and Community Organization

Prlić, Lidija; Ebling, Zdravko; Glavina, Krešimir; Gmajnić, Rudika; Vuletić, Gorka; Kovačić, Luka; Tokalić, Martin

Source / Izvornik: **Collegium antropologicum, 2004, 28 - Supplement 2, 345 - 356**

Journal article, Published version
Rad u časopisu, Objavljena verzija rada (izdavačev PDF)

Permanent link / Trajna poveznica: https://urn.nsk.hr/urn:nbn:hr:142:065276

Coll. Antropol. **28** Suppl. 2 (2004) 345–356
UCD 364.444:325.254(497.5)
Original scientific paper

Health of Returnees in Osijek Region and Required Special Measures of Health Care and Community Organization

Lidija Prlić[1], Zdravko Ebling[1], Krešimir Glavina[2], Rudika Gmajnić[1], Gorka Vuletić[3], Luka Kovačić[3] and Martin Tokalić[4]

[1] Department of Family Medicine, Primary Health Care, Health Care Organization and Health Economics, Health Center »Osijek», Osijek, Croatia
[2] School of Medicine, University »J. J. Strossmayer», Osijek, Croatia
[3] School of Public Health »A. Štampar«, School of Medicine, University of Zagreb, Zagreb, Croatia
[4] Department of Surgery, University Hospital »Osijek», Osijek, Croatia

A B S T R A C T

Many citizens from the Osijek-Baranja County, in order to survive, left their homes during the 1991/92 war in Croatia and spent between 5 and 7 years in exile. The aim of this pilot research was to assess the health status (physical, mental and social) of refugee/returnee population and their use of health services, to identify the factors influencing their adaptation, and to propose the health programs, psychological and social support, which could help foster integration into the social and community life, education and employment. The study was done on a randomized sample of 589 respondents using the 2003 Croatian Health Survey with an additional questionnaire related to the problems of returnees. The results of the study show good organization of health service in returnees' communities, with exception of gynecological and dental services. There was also a presence of health transportation problem and the problem in the supply of medicines. Finally, the results show that the returnees' communities were dominated by social problems such as lack of employment, lack of support for elderly, poverty, and concerns for children's prospects. This implies the necessity for intervention in both mental and social aspects. Measures to be undertaken in the next stage of the Project will be aimed at the work in the refugee communities and based on public health working methods such as organization of the community by stimulating intergenerational solidarity, education and raising awareness of self-help.

***Key words**: returnees, refugees, displaced people, health, health care, Croatia*

Received for publication July 3, 2004

Introduction

During the 1991/1992 war in Croatia, the residents of the Osijek-Baranja County chose the option of survival by escaping from the enemy and spent 5–7 years in exile[1,2]. Stress of being displaced is far more traumatic than that of ordinary life. Coming back is never the same as leaving. They have been through many different and new social, political and economical changes on their said journey.

Physical health problems, psychological and social factors such as disturbances in social behavior, feeling depressed, financial difficulties and cognitive disturbances also have a strong influence on their personal satisfaction with everyday life. Studying the outcomes of medical care system, the modern medicine often recognizes that it is not enough to be focused on the main disease only, but rather take into consideration the above mentioned facts[3–5].

After leaving their home, the family of refugees faced difficulties to adapt starting from satisfying their basic needs to accepting new rules and values and creating social status in new environment. There is a spectrum of bad emotions such as moral pain, shame, loss of pride and lack of capability to express feelings and tension relief[6–8]. Soon after settling in their new environment, successfully or unsuccessfully, the family of refugees faced the prospect of returning to their ruined homes and completely changed environment.

The community of refugees-returnees was built on place specific fundamentals. The whole process is made more difficult considering the exceptional complexity of ethnical, cultural and geographical circumstances of the war in Croatia. The loss of life and goods created lots of personal, interpersonal and social repercussions for the population of refugee-returnees.

The presumption is that in those circumstances people have adaptation difficulties in new environment and could develop serious psychological problems due to their expectations and real capabilities of each individual and family[9]. This presumption is supported in numerous studies about refugees and returnees[10–12]. The above mentioned circumstances could have a significant influence on general health of refugee-returnee population, possibly with life-long consequences for future generations.

The studies so far amongst the population of refugees show significant changes and negative influences on general health as a result of exile and the adaptation within the new environment, despite the fact that in most cases it is receptive and supportive[13–15].

For evaluation of quality and efficiency of medical care in this complex situation, it is very important to observe the parameters such as health quality of life of that population. More precisely, the quality of life in relation to health is influenced by many subjective and objective factors such as health status, functional status, subjective opinion about health, understanding of the term 'health', one's own health experiences, symptoms, needs and desires, psychological disturbances, the standard of living, etc.

From medical point of view, it is very important to recognize these facts to plan the intervention, which could be completely unsuccessful if not oriented towards improving the health quality of life. For example, the fact that the pain is diminishing does not mean the person is ready to return to work, increase the level of physical activity, and reduce the intake of medications.

The methods for testing the quality of life in relation to health cannot be determined by individual parameters characteristic for each illness, but rather put

into the context of all physical characteristics of the population, characteristics of each respondent's individuality, and social circumstances in which a person lives[16,17].

The aim of the present study is to recognize basic health circumstances (physical, psychological and social) amongst the refugee-returnee population and the use of medical service, as well as the identification of the factors, which influence the process of adaptation of that population. We wish to propose measures in health care and organization of returnees' community, which could decrease the adaptation problems of their members.

Material and Methods

This study is a part of the Project »Health of returnees and their adaptation» carried out by the Department of Family Medicine, Organization of Primary Health Care and Organization of Health Care and Health Economics of the University Health Center, Osijek, and researchers from the School of Public Health »A. Štampar», Zagreb, and University Hospital, Osijek, participated in this study.

The study included participants randomly chosen from refugee-returnee population of 6 villages in Osijek-Baranja County. Those 6 villages experienced massive exodus of their inhabitants during the war in Croatia. Four typical villages were chosen based on refugees/returnees criteria: Čeminac, Dalj and Aljmaš, Erdut, Ernestinovo and Laslovo. A single representative was randomly selected from each refugee-returnee family; wife was chosen from the first family, husband from second, grandmother from third, grandfather from fourth, and the child from the fifth family. All data about refugee families were collected in cooperation with the Regional Office for Refugees in Osijek.

The Survey included 589 participants. In this study we used the questionnaire »2003 Croatian Health Questionnaire » which consists of health status questionnaire (SF 36), questionnaire about using health service, chronic diseases and drug use, eating habits, bad habits, structure of households and their financial circumstances, respondents characteristics and their subjective opinion about quality of life.

Health status was assessed using the Short Form 36 Health Survey questionnaire (SF-36)**.** It is short enough to be practical for use in large-scale studies. Although developed for clinical applications, SF-36 has been designed as a general outcome measure, which attempts to measure aspects of health that are important to all patients, and so is readily applicable to the general population.

The questionnaire contains 36 items that, when scored, yield 8 domains. Physical functioning – PF (10 items) assesses limitations in physical activities, such as walking and climbing stairs. The role physical – RP (4 items) and role emotional – RE (3 items) domains measure problems with work or other daily activities as a result of physical health or emotional problems. Bodily pain – BP (2 items) assesses limitations due to pain, and vitality – VT (4 items) measures energy and tiredness. The social functioning domain – SF (2 items) examines the effect of physical and emotional health on normal social activities, and mental health – MH (5 items) assesses happiness, nervousness and depression. The general health perceptions domain – GH (5 items) evaluates personal health and the expectation of changes in health – CH (1 item). All domains are scored on a scale from 0 to 100; with 0 representing the worst and 100 the best possible health state. The results are conventionally reported as a mean score for each dimension. One additional item (change in health – CH) com-

pares the respondent's assessment of her or his current health with that one year earlier[8].

We also used supplementary structured questionnaire about specific items for refugee-returnee population, which we deem important to estimate health related quality of life. 519 persons participated. The interview took approximately one hour. It was arranged and explained in advance and the participants accepted it well because they could recognize the positive effects of the study on their health prospects following the return.

Results

Health survey

The survey included 589 participants from 6 places in Osijek-Baranja County, with 43.8% men and 56.2% women. Table 1 shows population structure based on age and gender. The average period a person spent as a refugee was 82.9 months.

When asked »What is your opinion about finances in your household?« 59 participants (10%) answered: »a lot worse than average«; 215 (36.5%) said »somewhat worse than average«; and 16 (2.7%) said »better than average«.

When asked about their working status, the structure of participants showed as follows: workers 90 (15.3%); retired 84 (14.3%); pupils/students 217 (36.9%); unemployed 33 (5.6%); housewives 103 (17.5%); employers 9 (1.5%); others 53 (8.9%).

Health status data for 577 participants were analyzed. The average scores are shown in Table 2. There were differences in health status between selected places (lowest scores in bold font on Table 3).

SF-36 includes an HT item, which asks about the change in health over the preceding year[18]. This item is not used to score any of the eight dimensions (scales) but provides useful information about perceived changes in health status over time. The frequency distribution of scores is shown in Figure 1. Majority of people said that their health are the same as one year before, but 20% report the change for the worse.

TABLE 1
POPULATION STRUCTURE BASED ON AGE AND SEX

Age	Females N (%)	Males N (%)
18–29	96 (28.9)	76 (30.2)
30–44	51 (15.4)	48 (19.0)
45–64	107 (32.2)	70 (27.7)
65+	78 (23.5)	58 (23.1)

TABLE 2
AVERAGE SCORES ON HEALTH STATUS

Dimensions	N	X	SD
Physical functioning	577	78.71	25.66
Role limitation due to physical problems	572	74.69	40.69
Role limitation due to emotional problems	576	76.62	31.89
Social functioning	577	57.96	15.34
Mental health	576	55.17	16.15
Energy vitality	577	71.64	25.36
Pain	577	75.16	42.12
General health perception	577	47.72	15.37

The most of respondents (68.1% of male and 73.7% of female) reported their health to be the same as one year before; 0.4% men and 3.6% women said it was much better; and 6.2% men and 14.2% women said their health was much worse than one year before (Table 4).

The SF-36 profiles for three selected age groups are shown in Figure 2. The data generally show decreasing health with age increase, with the most pronounced differences occurring in the physical health scales. The oldest group showed the biggest increase in limitations due to physical and emotional problems.

Most of participants (65%) visited their doctor one to five times, 7.5% did not visit their chosen family doctor the preceding year and 22.7% visited their doctor more than ten times the preceding year.

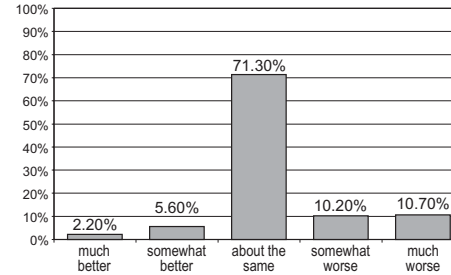

Fig. 1. Change in health in comparison to previous year.

Almost 100% of all participants had a family doctor. Most of them – 95% do not have any problems with waiting times or hospitality of staff at their doctor's surgery.

TABLE 3
AVERAGE SCORES ON EIGHT HEALTH STATUS DIMENSIONS FOR SELECTED OSIJEK-BARANJA PLACES

	Aljmaš	Čeminac	Dalj	Erdut	Ernestinovo	Laslovo
Physical functioning	67.67	90.17	90.55	63.51	70.90	69.05
Role limitation due to physical problems	52.08	88.36	98.00	47.64	59.94	60.71
Role limitation due to emotional problems	51.67	90.23	98.32	50.90	53.82	63.89
Social functioning	60.00	77.39	87.16	53.90	58.10	64.68
Mental health	45.47	54.62	46.84	41.68	55.28	44.71
Energy vitality	54.25	56.64	59.08	48.11	53.23	52.80
Pain	67.41	81.99	95.97	54.65	57.32	67.46
General health perception	49.53	58.88	62.88	49.22	59.51	56.74

TABLE 4
FREQUENCY DISTRIBUTION FOR ITEM »HEALTH RELATIVE TO ONE YEAR AGO« BY SEX

Sex		Much better	Somewhat better	About the same	Somewhat worse	Much worse
Males	N	1	16	175	49	16
	% (within sex)	0.4%	6.2%	68.1%	19.1%	6.2%
Females	N	12	17	244	11	47
	% (within sex)	3.6%	5.1%	73.7%	3.3%	14.2%

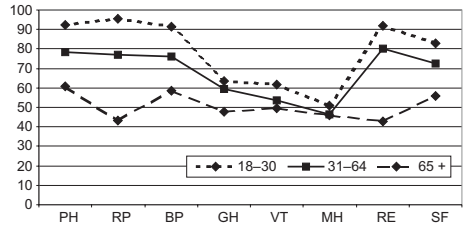

Fig. 2. Health profiles for the three selected age groups.

Fig. 3. Distribution of answers to question about general satisfaction with one's own quality of life.

Dentist have 77.7% of all participants, and only 35% asked women have a gynecologist. Around 51.2% have moderate difficulties with the traveling distance to their dentist, 40% of them find that visiting the dentist is too expensive. Women mentioned the same problem for visiting their gynecologist: 63.4% thought they have big problems with traveling distance to their gynecologist, and 71.5% find this too expensive as well. In the preceding year 56% of all participants did not visit a specialist the, 19% of them visited a specialist once to twice, and a quarter of all participants visited them more than twice. 15% of all participants were hospitalized the preceding year at least once.

Several questions were asked about chronic illness and taking medications. The participants were asked: »Which chronic illnesses do you have and did you take any medications last week?» There were 19 chronic illnesses reported by participants. Although the answers were based on anamnestic method, we could recognize high prevalence of some chronic illnesses in the sample. For example, 12.9% participants had diabetes, 27.5% hypertension, and 11.7% gastritis or ulcer (Table 5 and Table 6).

Figure 3 shows distribution of answers related to question about general satisfaction with one's own quality of life. Participants were asked to mark the position on the scale, which had 11 parts (answer 0 means »I am not satisfied at all», whereas answer 10 means »I am completely satisfied»). The average value on the quality of life scale was 5.85. During exile, the health status deteriorated for

TABLE 5
ANSWERS ABOUT SEVERAL CHRONIC ILLNESSES

	Illness (%)	Drugs (%)
Lumbal pain	34.3	21.1
Rheuma	26.7	16.2
Varices	22.5	1.1
Hypertension	27.5	24.4
Gastritis or ulcer	11.7	10.8
Diabetes	12.9	3.4
«Weak« heart	19.7	3.4
Mental illnesses	15.7	9.4
Elevated serum lipids	16.2	10.3
Bronchitis	12.2	12.2

TABLE 6
PARTICIPATION IN PREVENTIVE EXAMINATION DURING LAST YEAR

Examination	%
Breasts	36.5
Uterus	41.3
Prostate	3.2
Blood Pressure	42.1
Glucose in blood	27.4
Thyroid gland	2.9
Colon	2.4
General preventative examination	3.7

188 (36.2%) participants, and 305 (58.8%) thought their health status remained more or less the same.

Some adapting difficulties when they returned home had 183 (35.3%) participants, 271 (52.2%) did not have any problems, 57 (11%) though they did not adapt in returnee community at all. The adaptation speed posed a more serious problem for the participants. Problems with adaptation have some of participant: 10.5% answered that they did not find themselves in the community because of lack of knowledge about the new environment, 5.2% did not want to join, 37.5% joined the community more slowly than they expected, and 46% adapted almost instantly.

When asked: »During returning, what bothered you most?» the participants said that the main problem was that they could not see the prospects for their children – 228 (44%), lack of employment 158 (30.4%), poverty 39 (7.5%), whereas meeting people who caused them grief was mentioned by only 26 (5%) participants.

Discussion

Demographic data from our study are more or less similar to data from Croatian Health study, which made them comparable (Table 7).

This study included younger participants, both males and females. This fact could have some influence on morbidity because age and chronic illness are connected variables.

In Figure 4, health status profile from Osijek-Baranja sample is shown in comparison to profile of general Croatian population. Both profiles have the same shape, however the biggest difference occurs in mental health dimension where Osijek-Baranja sample has distinctively lower average score. In his review of studies about refugees, Keyes quotes that in all analyzed studies he found lower scores in mental status of participants[20]. Lower mental health status is probably the result of accumulated stress[21,22]. A

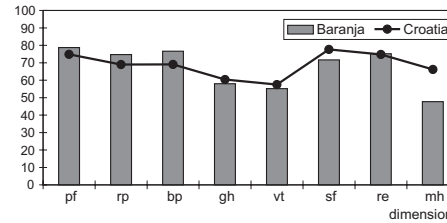

Fig. 4. Health status profile of Osijek-Baranja sample in comparison to Croatian study.

TABLE 7
DEMOGRAPHIC DATA FROM THE TWO STUDIES

		CHS		ES		Returnees	
		N	%	N	%	N	%
Males	18–29	242	8.4	54	9.7	76	30.2
	30–64	1714	59.3	329	58.9	118	46.7
	65+	934	32.3	176	31.5	58	23.1
	Total	2890		559		252	
Females	18–29	628	10.2	110	8.7	96	28.9
	30–64	3534	57.2	708	56.1	158	47.6
	65+	2018	32.7	443	35.1	78	23.5
	Total	6180		1261		332	

CHS – data from Croatian Health Study 2003 for Croatia[19]
ES – data from Croatian Health Study 2003 for Eastern Slavonia

group of Croatian authors showed changes in the endocrine system of war refugees in Croatia[23].

People from the village of Erdut reported the lowest scores in all eight dimensions, followed by people from Aljmaš, who reported low physical functioning and general health and more role limitations due to physical, as well as emotional problems, compared to people from other places.

Most people reported that their health was the same as one year before, but 20% reported a change for the worse. The distribution was typical and the same can be found in general Croatian population.

Figure 3 shows the comparison of results from SF 36 survey for all three age groups. We expected lower values with age increase, but surprisingly, the results show that for all three age groups the values for mental status are low and equal. There is also a visibly low score for all age groups in vitality and general health opinion. Such answers were determined by fatigue, lack of energy and pessimism. Financial status values show that this population had bigger money problems than the rest of the Croatian population. Furthermore, the results do no t show any health care failures and some factors point out to the increased use of health service compared to the rest of the population.

The results from study about the usage of health care in Eastern Slavonia are similar – 99.8% of all participants have their own GP.

In this study, 7.5% of participants did not visit their GP at all the preceding year. There is a significant difference in general population of Eastern Slavonia, where almost 19% did not visit their GP the preceding year. There is also a difference in the number of visits between the two studies. 58% participants amongst refugee-returnee population visited their GP once or twice, whereas in the general population of Eastern Slavonia only 22.7% visited their GP once to twice the preceding year. Those were not the patients with chronic illnesses who visited their doctor usually more than five times per year.

Visiting specialists varied slightly in both studies; 11.1% of participants visited specialists 6–10 times and 9.9% more that 10 times. Amongst general population of eastern Slavonia, the corresponding results were 6.5% and 3.5%. It shows that refugees-returnees were not deprived in any segment of health care.

Some more noticeable problems were present when visiting dentists and gynecologists. Not registered with a dentist were 22.3% of all participants, and 65% were not registered with a gynecologist; in comparison with the general population of Eastern Slavonia, where only 0.2% were not registered with the dentist and 1.2% not registered with a gynecologist. Also, most of the participants complained about the traveling distance to both services and expenses related to their usage.

The number of hospitalizations was rather similar in both studies – between 12–13% participants were hospitalized at least once in the preceding year.

The blood pressure results were on average the same in both studies – the values for refugee-returnee population were – 133.5 mm Hg for systolic component, and 83.0 mm Hg for diastolic component, heartbeat 75.6, whereas for the population of Eastern Slavonia average systolic component was 134.9 mm Hg, diastolic 81.0 mmHg, and heartbeat 73.3.

The scale of subjective quality of life shows difference between the average value for refugee-returnee population of 5.85 and 6.3 for the overall Croatian population.

As to availability of medications, a huge number of chronic patients were taking

medications; for example, of 27.5% of participants who said that they had hypertension, 24.4% were taking medications. Furthermore, out of 16.2% of those who said that they had elevated values of serum lipids, 10.3% were taking medications. The results are based on anamnestic data, so we believe that for a thorough analysis and conclusions we need more detailed medical documentation. However, we could observe high frequency of chronic illnesses and other health difficulties. For example, 12.9% of all participants had diabetes, 11.7% had gastritis or ulcer, and 15.7%.had mental illnesses

When we look at eating habits, we recognize some differences between the two studies. Amongst refugee-returnee population, 4.6% do not eat breakfast at all, and 24.6% participants eat breakfast regularly, whereas amongst population from Eastern Slavonia 14.5% do not eat breakfast at all, and 51.6% eat breakfast on a regular basis. Therefore, it means that 70.8% of refugee-returnee population does not eat breakfast regularly.

Conclusions

Refugees-returnees are a new and specific category of population from health service organization aspect. While identifying physical and psychological state of participants, we noticed that many of them suffered from chronic, mental and other health related illnesses, as well as adaptation problems. The study by Mandić et al., about psychosocial status of refugees from Eastern Slavonia, showed significant psychological and social difficulties in the process of adaptation[24]. These manifested as fear, anxiety, loss of self-confidence, despair, anger and panic, and were more common in women and married people as well as those with lower level of education. Concerns with one's own prospects, children's prospects, prospects for parents and relatives as well as possessions were more common in male participants. Only 6.5% of men and 2.4% of women accepted rationally the fact of being a refugee. Following a fortnight of psychosocial help, 30% of women and 40% of men still suffered from insomnia, loss of appetite, depressive problems and headaches, which pointed towards the necessity for the application of new methods and treatments in psychosocial help for refugees. Mandić and colleagues also pointed problem with insomnia in refugee population[25]. The results of the study show good organization of health service in returnee communities, with exception of gynecological and dental services. There is also a presence of health transportation problem and the problem in the supply of medicines – the lack of pharmacies in places where significant number or returnees established new communities, with significant number of patients taking medicines for their illnesses.

Finally, the results show that the returnee communities were dominated by social problems such as lack of employment, lack of support for elderly, poverty, concerns for children's prospects, etc.

This implies the necessity for intervention in both mental and social aspects. Measures to be undertaken in the next stage of the Project will be aimed towards the work in the refugee communities and based on public health working methods such as organization of the community by stimulating intergenerational solidarity, education and strengthening of awareness about self-help[26,27].

Basically, in places of research, meetings were held with representatives from schools, religious organizations, local government, health institutions and the general public to discuss their findings. In the same locations, representatives in the community noticed important problems such as unemployment, care for elderly, bad transport connections with the City of Osijek, young people not showing

any interest in communal activities, etc. After raising awareness for these problems, they started to take special measures to improve the lives of returnees. These activities did not give good results because of insufficient integration, since they were all partial measures. The representatives of local communities with pleasure accepted support aimed at organizing integrated set of measures for the whole community – schools, sports organizations and volunteers. These measures were to improve the health and social life of the returnees. Planned activities would be based on existing social values and strengths of the communities and their various ethnic groups. The prominent role was played by the health services, supported by the Osijek Health Center.

All necessary contacts were made with local schools during the current academic year, to introduce the formation of a group for care of the elderly as a part of both free school and out of school activities, which included visiting old people as well as groceries supply, supply of medicines, help with reading, help with basic housework, opening of sports clubs aimed at bringing together young people from different ethnic backgrounds, etc. Family support will be particularly encouraged. Food supplies for these people are planned from Osijek with anticipated home deliveries. Adaptation Projects for homes for the elderly will also be suggested. Osijek Health Center will introduce gynecological examinations for all women of fertile age, who did not have a check in the previous two years. These would begin in autumn. There is also an agreement in place for actions such as free glucose tests with subsequent healthy eating advice sessions, free of charge blood pressure checks and advice on the prevention of arteriosclerosis and secondary prevention of chronic illnesses. The plan also includes bringing a mammograph to returnee communities of the villages of Ernestinovo and Laslovo. All of these initiatives will be carefully monitored and evaluated and the health services will be actively involved in all health and social matters.

Problems must be brought to the attention of every individual as well as the attention of the whole community, with the aim to improve the functioning in everyday life.

Regional Bureau for refugees in Osijek and the students of the School of Medicine in Osijek expressed their wish to participate in the research and the program of health care support and social support.

REFERENCES

1. EBLING, Z., T. SANTO, N. MANDIĆ, K. GLAVINA, V. SERIĆ, D. LAUFER, Mil. Med., 165 (2000) 929. — 2. EBLING, Z., B. JANKOVIĆ, A. VUKOVIĆ, Med. Vjesn., 1–2 (1992) 109. — 3. FUGL-MEYER, A. R., R. MELIN, K. S. FUGL-MEYER, J. Rehabil. Med., 34 (2002) 239. — 4. MELIN, R., K. S. FUGL-MEYER, A. R. FUGL-MEYER, J. Rehabil. Med., 35 (2003) 84. — 5. MCKEVITT, A., J. REDFERN, V. LA PLACA, C. D. A. WOLFE, Clin. Rehab., 17 (2003) 865. — 6. MANDIĆ, N., Z. EBLING, Journal of Refugee Studies, 7 (1994) 317. — 7. MANDIĆ, N., Z. EBLING, Soc. Psihijatr., 20 (1992) 69. — 8. BABIĆ-BANASZAK, A., L. KOVAČIĆ, L. KOVAČEVIĆ, G. VULETIĆ, A. MUJKIČ, Z. EBLING, CMJ, 43 (2002) 396. — 9. ROUSSEAU, C., M. MORALES, P. FOXEN, Medicine and Psychiatry, 25 (2001) 135. — 10. SABIN, M., B. LOPES CARDOZO, L. NACKERUD, R. KAISER, L. VARESE**,** JAMA, 290 (2003) 635. — 11. HOLLIFIELD, M., T. D. WARNER, N. LIAN, B. KRAKOW, J. H. JENKINS, J. KESLER, J. STEVENSON, J. WESTERMEYER, JAMA, 288 (2002) 611. — 12. KALAFI, Y., H. HAGH-SHENAS, A. OSTOVAR, Psychological Reports, 90 (2002) 262. — 13. SAMARASINGHE, K., B. ARVIDSSON, Scandinavian Journal of

Caring Sciences, 16 (2002) 292. — 14. HONDIUS, A. J., L. H. VAN WILLIGEN, W. C. KLEIJN, H. M. VAN DER PLOEG, Journal of Traumatic Stress, 13 (2000) 619. — 15. BIJEDIĆ, Z., E. BOSKAILO, R. MERMELSTEIN, I. PAVKOVIĆ, Journal of Nervous and Mental Disease, 188 (2000) 416. — 16. MOLLICA, R. F., K. MCINNES, N. SARAJLIĆ, J. LAVELLE, I. SARAJLIĆ, M. P. MASSAGLI, JAMA, 282 (1999) 433. — 17. PRLIĆ, L., Med. Fam. Croat., 4 (1996) 7. — 18. WARE, J. E., K. K. SNOW, M. KOSINSKI, B. GANDEK: SF-36 Health Survey: Manual and interpretation guide. (The Health Institute, New England Medical Center, Boston, 1993). — 19. ANONYMOUS: Hrvatska zdravstvena anketa 2003. Preliminarni rezultati za istočnu Slavoniju. — 20. KEYES, E. F., Issues in Mental Health Nursing, 21 (2000) 397. — 21. VAN DEN HEUEWEL, W. J., CMJ, 39 (1998) 356. — 22. AJDUKOVIĆ, M., Adolescence, 33 (1998) 209. — 23. SABIONCELLO, A., D. KOCIJAN-HERCIGONJA, S. RABATIĆ, J. TOMAŠIĆ, T. JEREN, L. MATIJEVIĆ, M. RIJAVEC, D. DEKARIS, Psychosomatic Medicine, 62 (2000) 502. — 24. ŠPOLJAR-VRŽINA, S. M., Coll. Antropol., 24 (2000) 565. — 25. MANDIĆ, N., Z. EBLING, M. DELALLE-ZEBIĆ, Liječ. Vjesn., 116 (1994) 291. — 26. LANG, S., CMJ, 40 (1999) 438. — 27. FOX, P. G., J. M. COWELL, A. C. MONTGOMERY, M. A. WILLGERODT, International Journal of Psychiatric Nursing Research, 4 (1998) 423.

L. Prlić

Department of Family Medicine, Primary Health Care, Health Care Organization and Health Economics, Health Center »Osijek«, Park kralja Petra Krešimira IV. 6., 31000 Osijek, Croatia
e-mail: lidija.prlic@os.htnet.hr

ZDRAVLJE POVRATNIKA U OSJEČKOJ REGIJI I POTREBA ZA SPECIFIČNIM MJERAMA ZDRAVSTVENE SKRBI I ORGANIZACIJE U LOKALNOJ ZAJEDNICI

S A Ž E T A K

Građani područja županije Osječko-baranjske tijekom Domovinskog rata 1991/1992. godine, izabravši put opstanka napuštanjem ratne zone, proveli su u progonstvu 5–7 godina. Prognanici, a danas povratnici su suočeni s nizom promjena na društvenom i ekonomskom životu, što često prate ozbiljni psihološki problemi koji zahtijevaju vrlo brzu intervenciju. Rad je dio istraživanja u sklopu projekta Ocjena zdravstvene snage i mogućnost adaptacije prognanika koje provodi Katedra obiteljske medicine, primarne zdravstvene zaštite, organizacije zdravstvene zaštite i zdravstvene ekonomike Medicinskog fakulteta u Osijeku, a u kojem sudjeluje Dom zdravlja Osijek, Škola narodnog zdravlja »A. Štampar« iz Zagreba i Klinička bolnica Osijek. Cilj istraživanja utvrditi je osnovno zdravstveno stanje (fizičko, psihičko i socijalno) prognaničko-povratničke populacije, korištenje zdravstvene službe i identificiranje čimbenika koji utječu na adaptaciju prognanika povratnika, te izrada programa zdravstvene, psihološke, socijalne i društvene potpore, kojima će se poboljšati ukupno zdravstveno stanje, brža integracija u zajednicu, školovanje i zapošljavanje. Učestvovalo je 589 ispitanika iz stratificiranog uzorka. Korišten je upitnik »Hrvatska zdravstvena anketa 2003» i dopunski strukturirani upitnik o specifičnim prognaničko-povratničkim čimbenicima. Rezultati pokazuju da mnogi ispitanici boluju od kroničnih bolesti, mentalnih poteškoća vezanih za adaptacijske tegobe, zdravstvena služba dobro je organizirana osim gine-

kološke i stomatološke službe, prisutan je problem transporta bolesnika kao i relativni nedostatak ljekarni u povratničkim mjestima koja su ispitivana, dominiraju socijalni problemi kao što su nezaposlenost, nedostatak pomoći starima i nemoćnima, siromaštvo te nedostatak perspektive za budućnost djece. Rezultati ukazuju na potrebu intervencije kako na zdravstvenom planu, tako i na socijalnom planu. Planirane intervencije u sklopu Projekta, u povratničkim mjestima, temeljit će se na javno-zdravstvenim metodama kao što su organizacija društvene zajednice poticanjem međusobne solidarnosti, edukacijom i jačanjem svijesti o samopomoći i solidarnosti.