Asylum seeking parents' reports of health deterioration in their children since fleeing their home country

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Abstract

More than 50,000 asylum seekers scattered across Greece were waiting to have their cases processed in February 2016. Using unique survey data collected in six Greek refugee camps at the time, this paper explores the health of asylum seeking children as assessed by their parents. More than half of parents report that children's health had deteriorated considerably or greatly since commencing their flight and the longer the time spent in Greece the larger the share. The same tendency was found in a logistic regression model adjusting for educational level, sex and origin country. Feeling safe at current location and access to basic amenities were alleviating factors. The results call for increased attention to the needs of asylum seeking children in the Greek refugee camps and urgent action to alleviate potentially long-term impacts of the process of seeking asylum on these children.

Glossary terms

Refugee children; waiting time; reception conditions; health

Introduction

In the New York Declaration, which has been called "a milestone for global solidarity with refugees," (UNHCR 2017) a unanimous United Nations General Assembly declared that "We reaffirm and will fully protect the human rights of all refugees and migrants, regardless of status" (UN 2016). The needs of children were emphasized in particular as member states committed to "giving primary consideration at all times to the best interest of the child" (UN 2016).

The unprecedented global level of human mobility, which prompted the New York Declaration, was made perceptible to the European public eye during the years 2014-2016 as more than three million asylum applications were made in the EU28 (Eurostat 2018), with Greece becoming the entry point to more than 850,000 asylum seekers in 2015 alone (UNHCR 2015). Until February 2016, only 1.5 pct. of those arriving in Greece stayed to claim asylum in Greece (ECRE 2016); the vast majority continued their journey to other European destinations, most notably Germany and Sweden. In early 2016, EU pressure to stifle the migration flows lead to the closing and policing of the Greek borders with neighboring European countries, as well as the EU-Turkey agreement. In consequence, the 50,000 or so asylum claimants scattered in camps across Greece in 2016 faced long waiting times while their applications were processed by an administrative system unable to keep up with the workload. In May 2016, the time lag between pre-registration and full registration in Greece was estimated to average a full year (AIDA 2016). At the end of 2017, the processing time from full registration to first decision averaged six months and the time from pre-registration to full registration around 81 days, but more than 4,000 applicants remained who had waited in the excess of 12 months and more than 36,000 applications were still pending (AIDA 2018).

Combined with inadequate reception conditions, a prolonged period from flight to re-establishment contributes to making the well-being of this population a major public health concern (MSF 2016). Exposure to violence, physical, economic and sexual exploitation, before and during flight and after arrival in Greece is well documented (Pouilly 2018; Kivilcim 2016; Freedman 2016; Ben Farhat et al. 2018), as is the vulnerable health situation of those waiting to have their case processed (MSF 2017; Ben Farhad et al. 2018). While the number of arrivals in Greece has dropped tremendously since April 2016 and the waiting times have decreased, concerns remain about the conditions of asylum seekers in the Greek camps, not least following the 2017 change in policy mandating that even vulnerable groups are to stay on the islands until their first interview (MSF 2017).

Research among both refugee children and all children in general suggests that while the experience of trauma, poverty, uprooting and other stressors can cast a shadow over their entire life course (Duncan, Magnuson & Votruba-Drzal 2017; Cook et al. 2005), the amount of time spent in stressful situations has been highlighted as a crucial factor as to its effects (Evans & Cassells 2014). Even at the biological level, the detrimental effect of material deprivation on brain development has been given increasing attention (Noble et al. 2012; Hair et al. 2015). In addition to being exposed to many of these adverse influences simultaneously (Fazel et al. 2012), refugee children often spend large periods of time out of school both prior to and during flight (Sirin & Rogers-Sirin 2015), thus also falling far behind their peers in terms of their educational experience.

Building on this research and utilizing survey data collected in six refugee camps in Greece in 2016, this article explores the relationship between parents' assessment of their children's loss of health and the amount of time they have spent in Greece. In addition, it explores how the parents' assessments are related to their current accommodation conditions. As such, the analysis provides new input as countries review their efforts to ensure a consistent focus on the best interest of children no matter legal status.

Methods

The data used in this analysis stem from the REHEAL project (Stathopoulou et al., this issue). The REHEAL general survey among asylum-seekers residing in official camps in Greece was conducted at six locations and includes 367 respondents. Potential respondents were sampled by asking a single person from every third lodging who had knowledge of English, Arabic or Farsi to fill out the questionnaire. Concerning data collection locations, the REHEAL survey overlaps in one location (Samos) with the data material used in (Ben Farhad et al. 2018), while uniquely providing survey data from the camps of Eleonas, Skaramagos, and Schisto in the greater Athens area, as well as Diavata near Thessaloniki and Veria in Northern Greece.

Out of the entire sample of 367 respondents, respondents were selected who were parents accompanied by children and who responded to the relevant questionnaire items (see Figure 1). The final samples consisted of 159 respondents with complete information about parents' assessment of children's health and 143 respondents with complete information concerning all relevant variables. Among the sample of 143 respondents used in the regression analysis, 47 pct. were from Syria, 38 pct. from Afghanistan and 15 pct. from other places, principally Iraq and Iran.

[Insert figure 1 here]

The analysis proceeded through descriptive statistics and the calculation of odds-ratios through logistic regression. The model fit was diagnosed in two ways. A link test was performed by regressing the outcome variable on the linear predicted value and the squared linear predicted value from the original regressions to test for model specification errors, and a Hosmer-Lemeshow test was run using 10 equal sized quantiles of the estimated probabilities to test goodness-of-fit. None of these tests gave cause for concern.

The outcome variable was parents' assessment of whether their children's health had deteriorated since fleeing their home country. The respondents were given the question "To what extent have you lost any of the following things because of fleeing your home?" and asked to consider for 12 different items, including 'Children's health', whether they had lost it 'Not at all', 'To a small degree', 'To a moderate degree', 'To a considerable degree' or 'To a great degree'. For this analysis, their responses were dichotomized as children's health being 'stable' (the former three categories) or having 'deteriorated' (the latter two categories) (see Table 1).

Length of stay in Greece was reported by respondents as a number of months and days since arrival in Greece and recoded as either 0-3 months, 4-6 months or more than 7 months. To shed light on reception conditions, respondents were also asked to indicate whether they had access to a number of amenities (see Table 3). Other variables used include self-reported sex, origin country and educational level (categories based on number of years of schooling completed). Finally, respondents were asked 'How safe do you feel in your current location?' and could respond 'Very safe', 'Somewhat safe', 'Not very safe' or 'Not safe at all', which was dichotomized as feeling safe (the former two categories) and not feeling safe (the latter two).

Power calculations were undertaken using the Stata command 'powercal' for generalized linear models (see Newson 2004). The statistical power was calculated to be around 0.40-0.45 in a simple logistic regression with only length of stay as a predictor of the outcome variable. Assuming an odds-ratio and a standard error for the '7+ months' category of the length of stay variable similar to the ones found in the simple regression, the calculations suggested that a sample of at least 361 observations would be needed for power to reach 80 pct. at a significance level of 0.05. In addition to this limitation, as it was not possible to assess how representative the sample was of the base population and the pragmatic sample selection methodology cannot be considered a guarantee of randomization. The results should therefore be approached only as suggestive of actual relationships.

Results

Table 1 shows the distribution of the responses to the primary outcome variable concerning the deterioration of their children's health since the beginning of their flight. Most parents (56 pct.) described their children's health as having deteriorated to a 'considerable' or a 'great' degree. The remaining 44 pct. described the health as more or less stable, having deteriorated to a 'moderate' or 'small' degree only, or not at all.

[Insert: Table 1: Parents' assessment of children's loss of health.]

Table 2 shows the distribution of the respondents according to their length of stay in Greece, their origin country, sex and educational level. Of particular interest to this analysis, Table 2 shows that the share of those who assessed their children's health as deteriorating is larger the longer the respondents had been in Greece. Meanwhile, there were also differences by ethnic group, sex and educational level. The share was largest for Afghans and smallest for Syrians.

While the majority of both male and female respondents reported that their children's health had deteriorated, the share was a few percentage points higher for female respondents (59.4 pct. opposed to 53.7 pct.). Finally, the relationship between the assessment of children's health and the respondents' educational level was more uneven, ranging from 46.4 pct. for those with 9-11 years of schooling to 66.7 pct. for those with 12 years of schooling. Both those with less than 9 years of schooling (by far the largest group) and those with more than 12 years of schooling fell halfway between those extremes at 56.9 and 54.5 pct., respectively.

[Insert: Table 2: Loss of health across other variables]

Table 3 lists various accommodations amenities, ranging from access to showers and toilets to access to phones and charging units, and splits them by the respondents' assessment of their children's health. On the one hand, the table shows that access to certain amenities was near universal, such as showers, toilets, free food, and blankets. Comparing the assessments of children's health between those who had access to these amenities and those who did not does not make much sense, given the small numbers in the 'no' category. On the other hand, access to other amenities such as a bed, a sheltered room, facilities that are cleaned, a phone, and, strikingly, feeling safe in the current location, was much more unevenly distributed between the respondents. Almost six in ten respondents felt 'not very' or 'not at all' safe in their current location, for example. Of these, the share of those who assessed their children's health as deteriorating was 10 percentage points higher than for those who felt 'very' or 'somewhat' safe.

Other noteworthy differences in the assessment of children's health across the amenities were access to a bed (53.8 pct. versus 60 pct.), access to a sheltered room (51.6 pct. versus 60.3 pct.), access to a mattress (52.1 pct. versus 66.7 pct.), and access to free hygiene items (53.8 pct. versus 63.9 pct.). Among the smaller sample of female respondents only, almost six in ten did not sleep in a separate section, and among those 75 pct. reported that their children's health had deteriorated compared with 39.1 pct. of those who did sleep in a separate section.

[Insert: Table 3: Loss of health across reception conditions in Greece (2-13) and feeling safe]

Finally, Table 4 lists the results of the logistic regression with respondents' assessment of the development in their children's health as the dependent variable. The explanatory variables were time in Greece, the number of amenities that respondents had access to (dichotomized in two approximately even groups), and feeling safe in current location. The odds-ratio for those who had spent 4-6 months in Greece was 1.72 compared with those who had spent 0-3 months in Greece, and 2.8 for those who had spent 7+ months in Greece. The latter odds-ratio had a p-value of 0.062. The odds-ratio for having access to the median number of amenities or more (>7 out of 12) was 0.68 while for not feeling safe it was 1.62; both not significant at a 95 pct. confidence level. The sparse data material did not permit interactions between the three variables.

Adjusting for educational level, sex and country of origin, the odds-ratios for time in Greece dropped to 1.49 and 2.02 respectively. In other words, after the inclusion of control variables the difference in odds remained fairly large, 49 pct. and 102 pct. respectively. None of these differences were significant at a 95-pct. confidence level, however. The odds-ratio for access to amenities increased to 0.78 and for not feeling safe to 2.15, the latter with a p-value of 0.049.

[Insert: Table 4: Loss of health and length of time in Greece (regression) adjusted for country of birth, sex and educational level]

Discussion

In brief, the results suggest that (1) the longer time spent in Greece, the greater the extent to which parents' report that their children's health had deteriorated since fleeing their home; (2) feeling unsafe in their current location is associated with worse health in children while (3) access to amenities, indicating the reception conditions, is associated with more stable health. In other words, the amount of time spent waiting in the refugee camps appears to be detrimental, but reception conditions in the refugee camps also matter a great deal, for better or for worse. These trends do not disappear when adjusting for the educational level, sex and origin country of the respondents. As already mentioned, the small N of the study is a clear limitation as to the possibilities of statistical inference, but it is at the same time striking that, given this small data material, the findings suggest such clear relationships.

At a simple descriptive level, the finding that more than half of the parents report that their children's health has deteriorated is very concerning. Equally concerning is the finding that the majority of the respondents do not feel safe in their current location, and that a large portion of the refugees do not have access to such basic amenities as a sheltered room, facilities that are cleaned, and, for women, a separate sleeping section. This finding corroborates the concerns that have been raised against the reception conditions in the Greek refugee camps and the vulnerable position of many asylum-seekers (MSF 2016; MSF 2017; Pouilly 2018; Kivilcim 2016; Freedman 2016).

The conclusion that time spent waiting correlates with the deterioration of children's health also resonates well with the qualitative findings of Ben Farhad and colleagues (2018). While not reporting any relationship between time in Greece and anxiety scores, their qualitative material underlines how asylum seekers in the Greek refugee camps come to describe their situation as 'hopeless' and that they report how the feelings of uncertainty increasingly wears them down in terms of both their mental and psychosocial well-being.

Beyond the context of the Greek refugee camps, several studies have highlighted the importance of post-flight factors for the long-term well-being of refugees in general and refugee children in particular (Porter and Haslam 2004). For example, Gorst-Unsworth and Goldenberg (1998) suggest that poor social support is a stronger predictor of depressive morbidity than trauma factors. Montgomery (2008) finds that experiences in exile were stronger predictors of internalizing and externalizing in children's behaviors 8-9 years after immigration than pre-migration factors. Morgan and colleagues (2017) find that post-migratory predictors, such as isolation and insecurity about immigration status, were significantly associated with PTSD scores. While these examples extend across contexts and refugee trajectories, the central insight is that post-flight factors that are amenable to policy and grass-root action in receiving countries are tremendously important for refugee families to establish the kind of stability necessary for children's well-being. Our findings can be considered a modest addition this pool of evidence.

In conclusion, this paper suggests that in order to give primary consideration to the best interest of children irrespective of status, as all members of the United Nations General Assembly have declared their commitment to do, countries should minimize the time that refugee children spend in uncertainty about their future and ensure adequate reception conditions where refugee families as a minimum requirement feel safe.

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Tables and figures

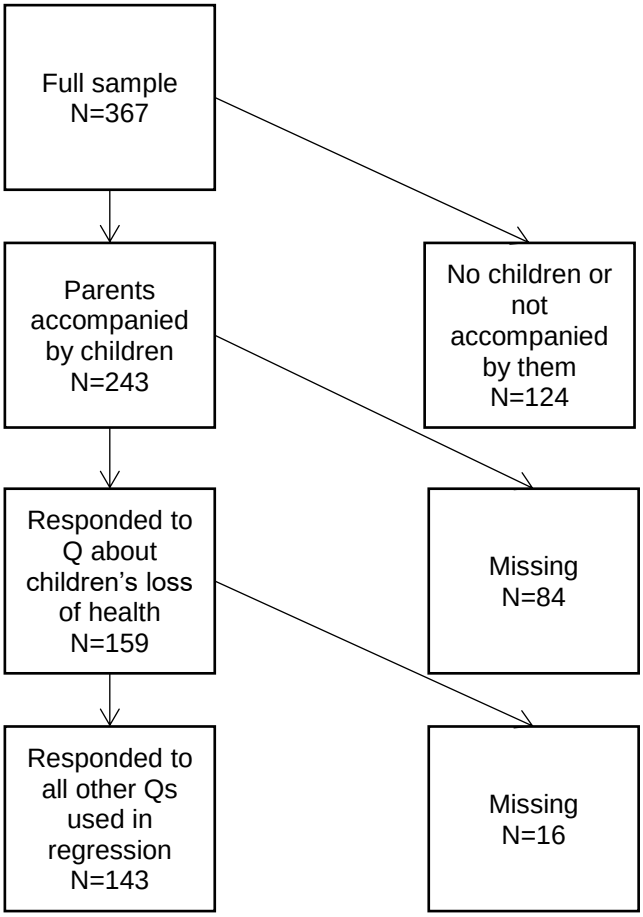

Figure 1: Flow chart of sample selection

Table 1: Parents' perceptions of children's health

Children's health	No.	%	"To what extent have you lost any of the following things because of fleeing your home?" - Children's health	No.	%
Stable	70	44.0	Not at all	31	19.5
			To a small degree	16	10.1
			To a moderate degree	23	14.5
Deteriorating	89	56.0	To a considerable degree	15	9.4
			To a great degree	74	46.5

Table 2: Children's health across other variables

	Children's health					
	Stable		**Deteriorated**		**Total**	
	No.	%	No.	%	No.	%
Length of stay in Greece						
0-3 months	12	57.1	9	42.9	21	100
4-6 months	29	49.1	30	50.9	59	100
7+ months	24	34.8	45	65.2	69	100
Total	65	43.6	84	56.4	149	100
Origin						
Syrian	38	53.5	33	46.5	71	100
Afghan	22	36.7	38	63.3	60	100
Others	10	41.7	14	58.3	24	100
Total	70	45.2	85	54.8	155	100
Sex						
Male	44	46.3	51	53.7	95	100
Female	26	40.6	38	59.4	64	100
Total	70	44.0	89	56.0	159	100
Educational level						
Less than 9 years	31	43.1	41	56.9	72	100
9-11 years	15	53.6	13	46.4	28	100
12 years	8	33.3	16	66.7	24	100
Above 12 years	15	45.5	18	54.5	33	100
Total	69	43.9	88	56.1	157	100

Table 3: Children's health and access to amenities in refugee camps

	Children's health					
	Stable		Deteriorated		Total	
	No.	%	No.	%	No.	%
Access to shower (N=157)						
Yes	64	43.5	83	56.5	147	100
No	5	50.0	5	50.0	10	100
Access to toilets (N=155)						
Yes	60	41.4	85	58.6	145	100
No	8	80.0	2	20.0	10	100
Access to free food (N=155)						
Yes	59	41.8	82	58.2	141	100
No	9	64.3	5	35.7	14	100
Access to sheltered room (N=153)						
Yes	46	48.4	49	51.6	95	100
No	23	39.7	35	60.3	58	100
Access to a bed (N=157)						
Yes	54	46.2	63	53.8	117	100
No	16	40.0	24	60.0	40	100
Access to a mattress (N=154)						
Yes	58	47.9	63	52.1	121	100
No	11	33.3	22	66.7	33	100
Access to a blanket/sleeping bag (N=158)						
Yes	61	43.9	78	56.1	139	100
No	8	42.1	11	57.9	19	100
Facilities are cleaned (N=152)						
Yes	45	45.0	55	55.0	100	100
No	21	40.4	31	59.6	52	100
Access to free hygiene items (N=155)						
Yes	55	46.2	64	53.8	119	100
No	13	36.1	23	63.9	36	100
Access to a phone (N=156)						
Yes	40	46.5	46	53.5	86	100
No	28	40.0	42	60.0	70	100
Access to a charging unit (N=155)						
Yes	54	45.8	64	54.2	118	100
No	13	35.1	24	64.9	37	100
Sleeping in separate section† (N=55)						
Yes	14	60.9	9	39.1	23	100
No	8	25.0	24	75.0	32	100
Feeling safe in current location (N=157)						
"Very" or "somewhat"	33	50.0	33	50.0	66	100
"Not very" or "not at all"	36	39.6	55	60.4	91	100

† This question was only answered by female respondents

Table 4: Children's health regressed on length of stay in Greece and access to amenities. Logistic regression

	Without controls N=143		**With controls** N=143	
	OR	CI	OR	CI
Length of stay in Greece				
0-3 months (ref.)	-	-	-	-
4-6 months	1.77	[0.61-5.08]	1.49	[0.49-4.50]
7+ months	2.68	[0.95-7.57]	2.02	[0.67-6.07]
Access to amenities				
Below median (ref.)	-	-	-	-
Median and above	0.68	[0.34-1.38]	0.78	[0.37-1.62]
Feeling safe in current location				
Feeling safe (ref.)	-	-	-	-
Not feeling safe	1.82	[0.90-3.64]	2.15	[1.00-4.58]
Educational level				
Less than 9 years (ref.)	-	-	-	-
9 years	-	-	0.90	[0.32-2.47]
12 years	-	-	1.75	[0.57-5.37]
More than 12 years	-	-	1.02	[0.39-2.63]
Sex				
Male (ref.)	-	-	-	-
Female	-	-	1.48	[0.69-3.16]
Origin country				
Other (ref.)	-	-	-	-
Syria	-	-	0.56	[0.19-1.63]
Afghan	-	-	1.51	[0.51-4.51]