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ΙΑΤΡΙΚΗ ΣΧΟΛΗ

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Η ΠΕΡΙΠΤΩΣΗ ΤΟΥ ΚΕΝΤΡΟΥ ΦΙΛΟΞΕΝΙΑΣ ΕΛΑΙΩΝΑ.

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SCHOOL OF MEDICINE

ACADEMIC DISSERTATION

SUBJECT: QUALITY OF LIFE OF ARABIC-SPEAKING REFUGEES IN GREECE. THE CASE OF ELAIONAS CAMP.

POSTGRADUATE STUDENT: POULAKI GEORGIA

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ΠΡΑΚΤΙΚΟ ΚΡΙΣΕΩΣ
ΤΗΣ ΣΥΝΕΔΡΙΑΣΗΣ ΤΗΣ ΤΡΙΜΕΛΟΥΣ ΕΞΕΤΑΣΤΙΚΗΣ ΕΠΙΤΡΟΠΗΣ ΓΙΑ ΤΗΝ ΑΞΙΟΛΟΓΗΣΗ ΤΗΣ ΔΙΠΛΩΜΑΤΙΚΗΣ ΕΡΓΑΣΙΑΣ

της Μεταπτυχιακής Φοιτήτριας: Πουλάκη Γεωργίας

Εξεταστική Επιτροπή

....., Επιβλέπων
....., Μέλος
.....,Μέλος

Η Τριμελής Εξεταστική Επιτροπή η οποία ορίσθηκε από την ΓΣΕΣ της Ιατρικής Σχολής του Παν. Αθηνών Συνεδρίαση της .....ης ..... 20... για την αξιολόγηση και εξέταση της υποψήφιας κας. Πουλάκη Γεωργία, συνεδρίασε σήμερα .../.../....

Η Επιτροπή διαπίστωσε ότι η Διπλωματική Εργασία του κας Πουλάκη Γεωργίας με τίτλο «ΠΟΙΟΤΗΤΑ ΖΩΗΣ ΑΡΑΒΟΦΩΝΩΝ ΠΡΟΣΦΥΓΩΝ ΣΤΗΝ ΕΛΛΑΔΑ. Η ΠΕΡΙΠΤΩΣΗ ΤΟΥ ΚΕΝΤΡΟΥ ΦΙΛΟΞΕΝΙΑΣ ΕΛΑΙΩΝΑ» είναι πρωτότυπη, επιστημονικά και τεχνικά άρτια και η βιβλιογραφική πληροφορία ολοκληρωμένη και εμπεριστατωμένη.

Η εξεταστική επιτροπή αφού έλαβε υπ’ όψιν το περιεχόμενο της εργασίας και τη συμβολή της στην επιστήμη, με ψήφους ..... προτείνει την απονομή στον παραπάνω Μεταπτυχιακό Φοιτητή την απονομή του Μεταπτυχιακού Διπλώματος Ειδίκευσης (Master's).

Στην ψηφοφορία για την βαθμολογία ο υποψήφιος έλαβε για τον βαθμό «ΑΡΙΣΤΑ» ψήφους ....., για τον βαθμό «ΛΙΑΝ ΚΑΛΩΣ» ψήφους ....., και για τον βαθμό «ΚΑΛΩΣ» ψήφους ..... Κατά συνέπεια, απονέμεται ο βαθμός «(Άριστα/Λίαν Καλώς/Καλώς)& (Βαθμός).....».

Τα Μέλη της Εξεταστικής Επιτροπής

....., Επιβλέπων (Υπογραφή)

....., Μέλος (Υπογραφή)

....., Μέλος (Υπογραφή)

ΠΕΡΙΛΗΨΗ

Εισαγωγή: Η παγκόσμια προσφυγική κρίση επηρέασε δυσανάλογα ιδιαίτερα τους Αραβόφωνους ανθρώπους στη Μέση Ανατολή. Ως αποτέλεσμα, αποκλείστηκαν δεκάδες χιλιάδες άνθρωποι στην Ελλάδα περιμένοντας για εγκρίσεις ασύλου, αποφάσεις μετεγκατάστασης ή επαναπατρισμού. Οι συνθήκες που επικρατούν στο ταξίδι και στους προσφυγικούς καταυλισμούς αποτελούν παράγοντες κινδύνου για τη σωματική και ψυχική υγεία. Πληθώρα ερευνών στον τομέα της δημόσιας υγείας χρησιμοποιεί αυτό-αναφερόμενους δείκτες Ποιότητας Ζωής για την εκτίμηση της επίδρασης των κοινωνικών προσδιοριστών της υγείας. Σκοπός αυτής της μελέτης είναι η διερεύνηση και εκτίμηση της ποιότητας ζωής των αραβόφωνων προσφύγων που διαμένουν στην Ελλάδα σε προσφυγικούς καταυλισμούς και εντός πόλεως και η σύγκριση των αποτελεσμάτων αυτών.

Μέθοδοι: Η έρευνα αυτή επικεντρώνεται στο δεύτερο μεγαλύτερο καταυλισμό της Αττικής, το κέντρο φιλοξενίας του Ελαιώνα, στο οποίο διαμένουν περίπου 1500 πρόσφυγες. Τα δεδομένα συλλέχθηκαν με το ερωτηματολόγιο Ποιότητας Ζωής του WHO (WHOQOL-Bref) και συγκρίνονται με αντίστοιχες έρευνες που έκαναν χρήση του ιδίου οργάνου και τα αποτελέσματα τους, στον ίδιο πληθυσμό, σε άλλες δομές, προκειμένου να δοθεί ένα πλαίσιο ερμηνείας και σχολιασμού στα ευρήματά μας.

Αποτελέσματα: Βρέθηκε ότι η μέση βαθμολογία για τους τέσσερις τομείς WHOQOL στον καταυλισμό του Ελαιώνα - φυσική, ψυχολογική, κοινωνική και περιβάλλον - είναι χαμηλή, ωστόσο υψηλότερη από αυτή σε άλλους καταυλισμούς, ακόμα και από αυτές σε ξενοδοχεία. Συγκεκριμένα, οι πρόσφυγες στον Ελαιώνα έχουν υψηλότερα σκορ στους τομείς υγεία- φυσικός τομέας, ψυχολογικός τομέας και περιβάλλον, σε σχέση με ένα δείγμα προσφύγων από τον καταυλισμό του Σκαραμαγκά και το ξενοδοχείο City Plaza. Ο κοινωνικός τομέας δε φάνηκε να

παρουσιάζει στατιστικά σημαντικές διαφορές ανάμεσα στον πληθυσμό που διαβιούν στις ως άνω δομές. Οι διαφορές στη βαθμολογία ανά τομέα, κυμάνθηκαν από μικρές έως μεγάλες, με τους περισσότερους τομείς να εμφανίζουν μεσαία επίδραση.

Συμπεράσματα: Στην προσπάθειά μας να ερμηνεύσουμε τις διαφορές στη βαθμολογία, ξεχωρίσαμε ορισμένες συνθήκες και πρακτικές που εμφανίστηκαν στον καταυλισμό του Ελαιώνα, οι οποίες θα μπορούσαν να εξηγήσουν τα διαφορετικά σκόρ. Αυτά τα ευρήματα μπορούν να βοηθήσουν στην περίπτωση χάραξης πολιτικής, καθώς φαίνεται ότι οι συνεργατικές και διεπιστημονικές προσεγγίσεις μπορούν να προετοιμάσουν καλύτερα τους επαγγελματίες υγείας. Επαναστατικά μοντέλα υγειονομικής περίθαλψης που λαμβάνουν υπόψη τις αντιλήψεις του πληθυσμού για τις πτυχές της ποιότητας ζωής, φαίνεται να είναι καλύτερα εξοπλισμένα να υπηρετήσουν τους κοινωνικούς προσδιοριστές υγείας και έτσι, έχουν περισσότερες δυνατότητες να μειώσουν τις ανισότητες στον τομέα της υγείας των προσφύγων και να προωθήσουν την ένταξη.

Λέξεις κλειδιά: Ποιότητα ζωής, Αραβόφωνοι πρόσφυγες, προσφυγική κρίση, WHOQOL-BREF ερωτηματολόγιο, Ελλάδα, καταυλισμός Ελαιώνα.

ABSTRACT

Introduction: The global refugee crisis has affected disproportionately people in the Middle East. Eventually this situation has left stranded tens of thousands of people in Greece awaiting for asylum approvals, relocation or repatriation decisions. Conditions prevalent at the journey and at refugee camps are degenerating physical and mental health. A plethora of research in public health is using self-reported Quality of Life indicators to assess the impact of social determinants on health (SDOH). The aim of this study is to explore and assess the quality of life of Arab-speaking refugees residing in Greece in several settings, such as refugee camps and urban settings, so as to compare these results.

Methods: This project is focusing on the second largest camp in Attica-Greece, namely Elaionas, hosting approximately 1500 refugees. Data were collected with WHO's Quality of Life (WHOQOL-Bref) questionnaire and compared to corresponding surveys using the same tool and their results, at the same population, in other settings, in order to provide a framework for interpretation and commentary on our findings.

Results: We found that average score on the WHOQOL four domains – physical, psychological, social, environment- is generally low, however, in Elaionas camp is higher than in other camps at the region, even from urban settings. In particular, refugees in Elaionas have higher scores in physical, psychological and environmental domains, as compared to a sample of refugees from Skaramagas camp and City Plaza Hotel. Social domain did not appear to have significant differences between the population living in the above settings. Score differences amongst domains, ranged from small to large, with most domains appearing a moderate impact.

Conclusion: In our quest to interpret the differences in scores, we managed to distinguish certain conditions and practices that appeared at

the camp of Elaionas, which could potentially explain the differences in scores and act as a linchpin for facilitating the integration of the population. These findings could be helpful in case of policy making, as it seems that collaborative, interdisciplinary training approaches can better prepare health care professionals. Robust health care models that take into consideration population perceptions of quality of life aspects may be better equipped to address social determinants of health, and thus have more potential to reduce refugee populations' health inequities and promoting integration.

Keywords: Quality of Life, Arabic-speaking refugees, refugee crisis, WHOQOL-BREF questionnaire, Greece, Elaionas camp.

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INTRODUCTION

Intensifying conflicts in countries of Syria, Yemen, Afghanistan, Iraq and Libya have caused an unprecedented movement of people, resulting to one of the worst humanitarian crises of the 21st century. According to United Nations Refugee Agency (UNHCR) figures, almost 5.5 million people have fled the Syrian conflict (1) seeking refuge in neighboring countries. Along with the wave of people travelling for safety, there are also people travelling for complex reasons seeking a better life (2).

A significant number of them reached the Greek shores and mainland on their way to the European North. The vast majority arrived by boats crossing the Aegean from the Turkish coast. In March 2016, European states closed their borders and signed the EU-Turkey Statement (3), a so-called temporary measure to stop “irregular migration” to Europe. Choosing a policy of containment, a lot of countries intensified border controls, placed fences, made violent push-backs and amplified sea guarding forces (4). This border control agenda taken by the EU leaders, intending to fight illegal routes to Europe, has actually increased the demand for smugglers and led to alternative more dangerous routes as the only option for those seeking protection (5), (6). Consequently, more than 16,000 people are dead and/or missing since 2014, trying to reach the Greek shores (1,7).

Currently there are 51,000 refugees and migrants registered in Greece, 39,500 of which are located in the mainland, and 11,500 stranded on the islands (8). Amongst them 3.400 separated and unaccompanied minors (9). The majority of refugees are staying in camps and almost 21,000 are accommodated in apartments and buildings in different cities under the UNHCR accommodation project (10). The mass influx of people compelled the formation of 54 temporary camps across Greece, that are now reduced to 37. According to the latest data from UNHCR since April 2018 (11), the numbers are distributed as follows: At Central Greece, currently there are 2 camps operating in Ritsona and Thermopiles hosting 1.240 people. Thessalia, in Koutsochero camp accommodates 682

people. North Greece has 4 camps hosting 814 people. In Central Macedonia there are 7 camps hosting 2.934 people and 3 more camps at Eastern Macedonia & Thrace, hosting 1.006 people. Western Greece in Andravida is hosting 216 people. The situation in Greek islands is devastating as the numbers of people hosted are exceeding the available infrastructures. Island of Lesvos is hosting 6.612 people accommodated at 2 camps Moria and Kara Tepe. At Vial camp in Chios, 1.272 people are hosted. Samos island has 1.937 refugees at Vathy camp. In Leros there are 537 people at Lepida camp and PIKPA building. Kos camp is hosting 930 refugees and migrants. Countries of origin are mainly Syrian Arab Republic, Iraq and Afghanistan.

At present, there are five camps in the region of Attica (12). Elaionas is the most central camp located five minutes' walk from a metro station, hosting 1500 persons. Scaramagas camp is hosting the largest number of people (2500) in Attica region and is located in an industrial area 30 minute from city center. Schisto camp and Malakasa camp are accommodating 746 and 916 people respectively. There are estimates that almost 1000 unregistered refugees and migrants are scattered in squats in abandoned hotels and buildings of Athens.

These numbers are expected to rise dramatically by the end of 2018. Although arrivals are significantly lower compared to the mass flow of 2015, there were 7,343 new arrivals by sea and land during the first 4 months of 2018, a 67% increase compared to the same period of 2017 (13). At the same time, relocation procedures to the EU countries are advancing slowly (14). From the 66,400 places that have been allocated for relocation from Greece, only 22,000 have been granted so far (15). Eventually this situation has left stranded tens of thousands of people in Greece awaiting for asylum approvals, relocation or repatriation decisions.

Why the Arabic-speaking population?

The global refugee crisis has affected disproportionately people in the Middle East. For many decades the region has been a place of conflicts, tension and murky situations. Since the end of World War II, the establishment of Israel in 1948 and the US-Iraq War in 2003, the Middle East has produced the majority of world's refugees. Recently, the Syrian civil war that started in 2011 after the Arab Spring, has had profound impact to the country itself, the Middle East and the international system. The violence of the war has left thousands of casualties, a shattered health care system (16) and deterioration of immune programs. This context has allowed the reemerge of communicable diseases in Syria and hosting countries (17), (18), (19), (20). Conditions prevalent at the journey and at refugee camps are degenerating physical and mental health. Concerns about health consequences of living in camps as a model of interception are raised, and their limitations as long-term solutions are evident (21), (22). Chronic disease management is hindered: health system alienation and discrepancies, overcrowding and other detrimental factors lead to increased prevalence of health problems (18,23), (24), (25,26). Doocey et al, from neighboring countries of Lebanon and Jordan, in studies among Syrian refugees, report a high prevalence of chronic diseases. Implications for each country's health system are immense and the burden on refugees for out of pockets expenses is troublesome (25–27).

In an emergency department in Switzerland the most common presentation of Syrian outpatients was surgical due trauma, and medical due to acute infectious diseases (28). In a research undergone in Brussels, amongst asylum seekers mainly from Iraq and Syria, showed that one out of seven patients suffered from injuries (29). Almost 9% of the study population, were unaccompanied minors seeking asylum in Brussels. Another study in Turkey, amongst Arabic speaking parents and their perceptions of their children's dental health, has found that dental pain was the largest concern of the parents and that albeit they were

aware of the linchpin of oral hygiene, they declared to be unable to take proper care of their children (30).

Although research under the unstable environment of humanitarian emergencies might seem as a luxury, nevertheless there has been a significant amount of studies focusing on Middle East' s refugee's psychological status (21,31–34). A high prevalence of post-traumatic stress disorder, major depressive syndromes and generalized anxiety are evident. Accumulated exposure to severely traumatic events in place of origin, during the journey and on resettlement, can serve as explanations of these findings. Furthermore, having lost a loved one was reported by 87,6% of Iraqi asylum seekers in Netherlands, and found to be an independent predictor of psychopathology (33). Long asylum procedures, bureaucracy and lack of information, also have a significant effect in psychopathology (33,35). A recent report from MSF, documented the violence endured by refugees in their country of origin, during their journey, entering Turkey and tragically in Greece as well (35).

QOL and refugees

The health of individuals and communities does not have a single dominant aspect, but it is determined by a number of different factors combined together. A person's individual characteristics and behavior, the physical environment and the social and economic environment are some of the main aforementioned factors. Also, genetics, gender, education, income and social status, health services and so many others can be included in this list. Consequently, it is more appropriate to say that people's health is a result of their context of life (36).

In a societal framework the conditions in which people are born, grow, work, live, and age, shape the Social Determinants of Health (SDOH) (37). These conditions affect a wide range of health, functioning, and Quality of Life outcomes and risks. It is well known that differences in health are more dramatic in communities with poor SDOH such as low

income, substandard education, inappropriate housing, or unsafe neighborhoods.

According to the WHO, Quality of Life is defined as “the individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person’s physical health, psychological state, level of independence, social relationships and their relationship to salient features of the environment. (38).

As early as the 1970’s impressively consistent findings showed that self-rating measures are the best predictors of health status and mortality, independently of other factors (39), (40). Additionally, a plethora of research in public health is using self-reported QoL indicators to assess the impact of social determinants on health (41,42). Recently, QoL measures have proved useful in exploring societies and cultures in conflict-affected zones or in populations fleeing those situations such as refugees and migrants (41,43), (44), (45). It is evident that migration can exacerbate the factors shaping the SDOH and eventually can be regarded itself as an additional layer of those factors (46). Various studies have shown how refugees are at increased risk of suffering from numerous somatic and psychiatric disorders as compared to non-forced displaced immigrants. Pre-displacement stressors such as exposure to severe traumatic events can explain the high prevalence of mental disorders among adults and children refugees (32,47). Although some conflicts are short-lived, some others are endemic for decades, namely the examples of Palestine, Afghanistan, Kenya, Sierra Leone. In these cases, the general societal conditions expose generations to higher cumulative environmental stressors that may have a greater impact on self-rated health (48). However, studies measuring mental distress decades after the resettlement, point out that exposure to the new environment is also significant for refugee’s mental health (34).

Finally, there have been some discussions to include the political domain in QoL frameworks. Research focusing specifically on Palestinians has tried to shed light on perceptions of “a holistic appreciation of life under occupation” (49). Findings show that political conditions that influence senses of safety, stability and security, or questioning self-determination, involvement in decision-making and political freedom, are considered substantial determinants of people’s QoL (43,44) (50).

Aim and objectives of study

Currently there is no data, at least to our knowledge, on the quality of life of Arabic-speaking refugees residing in Greece. Arabic speakers are a rather homogeneous population in terms of culture and refugee experiences. They arrived in large numbers seeking refuge, experiencing sharp changes in their livelihoods. It is of outmost importance to collect and record data concerning the current status of this population in order to improve conditions and help to facilitate integration in the immediate future. This research addresses this gap and provides some valuable information on the health and well-being of refugees and migrants that are settled in Attica region. Consequently, the aim of this study is to explore and assess the quality of life of Arabic-speaking refugees residing in Greece and examine whether there are any differences in their QOL compared with refugees in other settings. The present study is part of a bigger project that collected data from two camps of Attica and a squatted hotel. This project is focusing on the second largest camp on Attica region, namely Elaionas, hosting approximately 1500 refugees. Data were collected with WHO’s Quality of Life (WHOQOL-Bref) questionnaire and compared to Skaramagas camp, one of the largest camps in Attica along with another setting namely City Plaza, a volunteer driven hotel in a squatted building in Attica region, in order to provide context to our findings. All three projects used the same tool and followed the same methodology.

Specific research questions are:

a) What are the characteristics of the QoL of Arabic-speaking refugees residing in Elaionas?

b) Are there any differences in QoL reported by refugees residing in other settings?

c) Comparison within Attica's region two largest camps Elaionas and Skaramagas and with City Plaza, a volunteer driven squatted hotel.

Description of setting

Apart from the general context of the setting, it is more practical to describe the circumstances from a Social Determinants point of view. For the purpose of this research, it will be helpful to organize the SDOH around five key domains as developed by the Healthy People 2020 initiative: (51)

- Economic Stability
- Education
- Health and Health Care
- Neighborhood and Built Environment
- Social and Community Context.

Elaionas description

Neighborhood and Built Environment

Elaionas camp is the second largest -size wise- camp at the mainland. It was the first open camp in Athens - Greece. Its construction begun on 4th of August 2015 and initially it was reckoned to host approximately 700 people (52). The camp is located only 2 kilometers west from the city center and 3,5 kilometers from Piraeus port, a highly industrial area, surrounded by garages, car workshops, transportation and other companies, dilapidated, probably squatted buildings, along with poor quality sidewalks and roads. However, the proximity of the camp to the metro station of Elaionas lays as one of the greatest advantages of the location of the camp. At the distance of 800 meters away or just a 10-minute walk, you can reach the subway that links with 2 more lines, let alone the bus lines and bus stop that is located within 10 meters from the camps' main entrance (53). The site was granted by the Municipality of Athens to Ministry of Migration under four conditions. In order for the Municipality to bestow the plot to Ministry of Migration, it had to be temporary, open, secured by the police and pliable with all salubrious and safety regulations (54).

Although police is present outside the camp entrance, its role isn't to be involved with the guardiancy of the camp perimeter or have regular walks inside. Plausibly, the sole reason for the police to make inferements is when there are disputes amongst POCs and/or with other personnel and in the case of prosecutors' orders.

First residents were moved on 16th of August 2015, from a park named Pedion tou Areos in central Athens. There was an expansion at the capacity in November of 2015, were the total accommodation capacity reached 1000 people. Currently Elaionas camp hosts approximately 1500 people in 348 containers, trailer-like homes that equals 5-8 people per container (if you exclude the containers dedicated to service providers).

That being said, you can find on average 1 to 2 families live at one trailer like home.
Residents at Elaionas, are free to move in and out the camp or even leave completely as they wish. You can sense this village like atmosphere the minute you walk in the camp. As you walk around, you can see open doors, children riding their bikes or hear them playing or coming back from school, smell the day's lunch or dinner and see women doing their everyday chores.

Elaionas camp is divided into 3 major sections.
Section A has approximately 120 Containers. Most service providers are located there, such as first reception and personnel from Ministry of Migration, coordinators of education from the Ministry of Education, the clinic and dental clinic run by KEELPNO – Greece's' Center for disease control and prevention- arm pick of Ministry of Health, social services, technical services, wash actors, laundry rooms, open outdoor gym, shaded wooden kiosk for social interaction across social services, UNHCR and many other actors are located at section A, either compiled and run by volunteers or payed staff.
As you enter Section B you are welcomed by a big football court in the middle of the section, surrounded by approximately 130 containers. At one edge there is a playground, while on the other edge lays a ''secret garden'' created and taken care of by the residents. Section B also hosts most of the unaccompanied minors and another laundry room, the mosque and two kindergartens.
Finally, Section C is the denser section with approximately 98 containers and another smaller playground, along with the Greek Army commanders' services and women safe space.

At the time of our study, mainly Afghans (42%), Syrians (31%) and Iranians (8%) composed the majority of the population. Other nationalities present were Iraqis (4%), Pakistanis (4%), Palestinians (1%), DR

Congolese (1%), Cameroon (1%), Malian (2%), Somalian (1%), Sierra Leone (1%), Stateless (2%) etc. Out of them, 64% where men and 36% women. Children represent approximately 38% of the population.

As welcoming as it can be, things are not that plushy and unperturbed at the camp, as they might seem. Residents might decorate their front doors and windows with flowers, expand their entrances with several material trying to resemble to front yards. Containers might be equipped with luxuries such as refrigerators, air condition, kitchen with sink and kitchen hood, a fully equipped bathroom with shower, washbasin, water heater and lavatory with flushing cistern. Although, by virtue of people are stranded for years in wait for their asylum and relocation process and in combination with the vaguely in Europe's posture, the psychology of residents constantly degenerates. They start to feel that they begin to lose their identity, that they are plain numbers just like the one on their case. Like a resident in Elaionas characteristically says in his blog in Huffington post: ''I lost my name, I was not Muhammad anymore, I was just a simple number, the number of my container, the number of my case'' (55). Muhammad found his way back to self-determination through being a teacher within the camp, at the side of volunteers operating on site. In Muhammads' words: ''I have returned to be a useful and helpful member of my community''. Others start businesses like mini markets by retailing appliances and products they got from a second-hand market in Athens' Elaionas neighborhood or Omonoias' cheap markets within the camp or run Falafel shops by selling falafel that they make, for just 1 euro!

Unfortunately, not all residents channel their feelings like the above examples. Inaction and uncertainty along with increased anxiety, often leads to alcohol and drug abuse, depression and self-harm. Even in an organized and supportive setting, is hard to combat the crux of the situation. And Elaionas is not immune against these behaviors either. Disputes, outbreaks of violence, fights and vandalisms are frequent and often threaten the calmness and safety of the camp.

Social and Community Context

Elaionas is an open camp and therefore you will not find incarcerated people amongst residents. When Elaionas camp was first ordained, used to host mostly Afghans, although that pattern quickly shifted, and several nationalities were hosted at the camp. The variety of countries of origin kept multiplying over the time, making it more and more difficult for diverse cultures to coexist. Worth's mentioning, that placement of residents at caravans is miscellaneous and had to do nothing with nationality and/or any other criteria. As a result, in all 3 sections of the camp you can find all kinds of Nationalities residing at approximately same proportion.

Health and Healthcare

Primary Health care is provided through KEELPNO – Hellenic Center for Disease Control and Prevention. The clinic operates Monday to Friday with one General surgeon, one Pediatrician, one Psychiatrist, two nurses, two midwives and four cultural mediators. From 9.00-15.00 with full staff and from 15.00-20.00 with minimum staff - security personnel, mostly for medication, triage and emergency cases. They also have a fully equipped and operational dental clinic along with two dentists and one specialized dentist for children that voluntarily offers her services on a weekly basis.

Last but not least, they also have in their power, one social worker and two psychologists, that work along other organizations at the social service and lease with the clinics for issuing social security numbers, serving vulnerable population and bring to notice special cases. However, their role is not limited to that. Especially the social workers along with cultural mediators often escort the patents to their medical appointments outside the camp, in an attempt to help them navigate the system.

Economic Stability

On 1st of February 2018, the camp transited to full cash assistance, since residents had all the necessary equipment to cook for themselves and therefore, food provision via catering, along with many WASH related and other NFIs stopped (56).

The vast majority of the residents already have issued social security numbers and many of them, actually the ones that got their asylum approval and they are fully registered, recognized refugees, already have tax identification number. For them is relatively easier to acquire a job. Actually, the social workers already found scholarships, booked interviews and assisted many of them to find jobs. However, the vast majority of residents rely on the financial aid provided by UNHCR, through several actors.

Education

Since October 2016, there was only non-formal education available for children residents of Elaionas, provided by Non-Governmental organizations on site. In our case, non-formal education was provided by SOS Children villages, who had a nursery school and gave lessons for Greek, English and Arabic language in an effort to teach children the official native/local language, as well as the international language and continue their study in their mother language. Along with Elaia, an organization compiled entirely of volunteers, that had classes with recreational activities.

In October 2016, was the onset for typical education for refugee children. With the registration of children in special Structures that were created for the Education of refugees by the Ministry of Education and operated exclusively for refugee children, within the same public schools for national population but as a separated class at evening hours (14.00-

18.00). That practically means that refugee children were able to attend formal education within public schools of the country, however separated and not mixed with local population. That changed pretty quickly for Elaionas camp exclusively! On September of 2017, the attendance to public schools for refugee children at the same morning classes along with local children became a reality.

Simultaneously, there were available additional classes of reception for refugee children, named zones of educational priority, carrying out as remedial teaching. These zones offered 15 remedial teaching hours per week and had duration up to two years. They were created especially for refugee children of which their linguistic abilities in Greek were still weak and not yet at the necessary level for them to attend at morning mixed classes together with the other children from the camp and local population, as a preparation step before their integration at the morning mixed classes.

For childrens' registration to be achieved, a special form was created that required the cooperation of two ministries, the Ministry of Education with the Ministry of Health. The form was called ADYM, standing for Individual Health Record of the Student and it was a prerequisite for the children's' registration in typical school, just like it happens for local population. This form requires the physical examination of the student, to exclude the possibility of any serious medical condition that precludes the students' participation in gymnastics and other physical activities and it has as well a section to verify vaccination status of the children.

In November 2017, typical nursery school begun to operate within the site as an annex of the public nursery schools of Ministry of Education, run by teachers detached from country's other nursery schools within the city.

Integration and attendance of refugee children in primary and high school was very well accepted by local community, with culmination the celebration that took place in Elaionas camp on 20th of March in 2018,

were both children from the local community and refugee children attending at the same schools were gathered with their parents to celebrate the end of school year at the camp in a fest that had theatrical performances, reciting of poems, art and handcraft exhibition, face painting and of course a lot of singing, dancing, playing and food.

The largest problems with integrating refugee children in typical schools lay at the higher secondary level of education and tertiary level due to limited positions in classes, lack of personnel and mostly due to the absence of respective reception remedial classes to prepare students for higher education, along with linguistic obstacles.

METHODS

Sample

By design, this is a cross-sectional study. Study population comprised of Arabic-speakers men and women aged 18 years old and above, seeking international protection and having arrived in Greece since 2011, living in the same residence/camp for the last three months. Data were collected as part of a greater project that included two camps and a squat hotel in Athens. Participants were drawn from the camp sites of Elaionas (n=204), Skaramagas (n=301) and the squat hotel City Plaza (n=50). All three of these residences are located within the Prefecture of Attica. Sample collection regarding Elaionas project was conducted within March 2018.

Fieldwork

To collect demographic data as well as information on perceived quality of life, we used the translated in Arabic and validated version of WHOQOL-BREF (57), (58), (59) questionnaire. Magpi application on tablets and smartphones was used for filling-in the questionnaires. Apart from being a quick and convenient tool, the use of Magpi application helps in preventing errors both during data collection as well as during data

analysis (60). We decided to use the door to door approach in order to collect our sample. Therefore, we visited all the caravans, upon permission from the camps' Management, one by one, guided by the camps' maps aspiring to locate all persons that were inside at that time and met the study's eligibility criteria. Initially the scope of the research was clearly and comprehensively described to each one of the respondents. It was made clear to them that all the information collected via the questionnaires is anonymous and strictly confidential and any referral to the results will be general and by no means recognizable. Every single respondent was asked for a verbal consent before proceeding. The interpreter assisted those who were illiterate.

Limitations

Eventually, certain limitations were imposed on the study. Since it was unlikely that they would accept to come to a private room, where privacy would be ensured, the data collection was inevitably performed inside the caravans in the presence of third persons. A factor that might have influenced their replies. Particularly while interviewing women, a male individual most usually was overseeing the replies. Another significant limitation is the potential influence of the male gender of the interpreters on the replies of illiterate women. Moreover, there was difficulty in finding the optimal time to visit containers, as inhabitants were usually sleeping up to sometimes early noon (13:00). Even in the afternoon, it was difficult to find all the inhabitants of a caravan present at the time of the visit.

<u>Elaionas camp additional limitations and number of denials</u>

For Elaionas camp specifically another limitation was present. At February 2018, there was a swap onto full cash assistance in parallel with a change of cash assistance provider actor on site. Hence, a new validation of data was needed, which for the first time was performed along with the list of fully registered residents at the camp from the Ministry of Migration, with the usage of both tablets (cash actor) and

hardcopies (Ministry of Migration). That resulted in the identification of numerous people that resided at the camp however unregistered, that either were getting cash by previous cash actor as a result of a systemic error or the usage of an older residents' identity, or the identification of people that did not receive any cash at all. The management of those people by the Ministry of Migration and communication of that was unknown to us. Therefore, and due to the fact that the collection of our data was proximate time wise to the validation of eligible POC's to cash assistance might have inferred with their answers and/or their answers could potentially be a mean of protesting against handling of the above-mentioned categories of residents.

For Elaionas camp specifically, out of the total people we approached for our research, we had only 2 denials.

Pilotic phase

Initially, a pilotic collection of data was conducted in the Welcommon structure, in which 20 refugees who met the eligibility criteria participated.

MEASURES

A. The tool

To collect demographic data as well as information on perceived quality of life, we used the adapted version of the World Health Organization's (WHO) brief version (57).

The definition of health as being not merely the absence of disease or infirmity, raised the need of QoL measurements in clinical trials and epidemiological studies to assess the impact of miscellaneous procedures and other conditions on the subject's general feeling of well-being (61). Psychometric measurements of QoL should particularly be addressed to special groups of people like heavily ill or disabled patients,

caregivers of the elderly, immigrants, homeless, refugees and generally individuals who live in highly stressful conditions (62).

World Health Organization Quality of Life Group has defined quality of life as “individual’s’ perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (59). The word “perceptions” leads to a concept of quality of life that is far beyond the conventional understanding of health, related to reduction of morbidity and mortality alone. It encompasses the individual’s experience upon his or her health, environment and social and community framework the way he or she uniquely interacts and defines it.

In 1997, WHOQOL Group has developed WHOQOL-Bref questionnaire, as a psychometric quality of life assessment tool to be used explicitly globally and cross-culturally. It was developed in 15 international field centers simultaneously, involving patients, community members and health professionals. WHOQOL questionnaire, originally included 236 items in the pilot study. After an initial assessment, 100 of those items were included in a revised version, the WHOQOL-100. All these 15 international field centers agreed that this questionnaire include 24 facets that are regarded as important to assess quality of life, which can be further divided into four domains: Physical, psychological, social relationships and environment. (57,58,61). WHOQOL-100 was regarded as too lengthy for some research projects. Hence, the need of an abbreviated version was erased. WHOQOL Group agreed that, to maintain comprehensiveness, any abbreviated version of the WHOQOL-100 should include at least one item from each of the above mentioned 24 facets. Therefore, 20 field centers based within 18 countries were used to select the items to be included in a brief version. They had to select one item from each of the 24 facets of the WHOQOL-100 and another two from the Overall Quality of Life and General Health facet. Therefore, WHOQOL-BREF was developed. (61).

WHOQOL-BREF came to address the needs of studies that need a reliable and accurate but also brief and convenient to use questionnaire on quality of life assessment. It has been initially assessed in 23 countries (n=11,830). One of its beneficial characteristics is that it can be easily used in cross-cultural studies, as it was simultaneously developed in diverse cultures and the terms included in it are culture-neutral (58).

It contains totally 26 items. Comparison of the results of application of the WHOQOL-100 and the WHOQOL-BREF questionnaires, gave very similar results. It has been shown that WHOQOL-BREF is quite adequate to assess domains relevant to quality of life in miscellaneous cultures worldwide (61,62).

Later the tool was cross-validated in an international study on the natural history of depression, named Longitudinal Investigation in Depression Outcomes (LIDO) (n=2,359). It was proved that WHOQOL-BREF is a valid and reliable psychometric instrument appropriate for use in multicultural settings (62). A recent meta-analysis which examined the WHOQOL-BREF responsiveness, including 117 papers (n=2,084), regarding 11 different cultures showed that interventions, treatments and major changes in life significantly affect the instrument's domain scores regardless the age of the individuals and the time between the initial interview and the follow-up (63).

WHOQOL-BREF is now being available in almost 50 different languages and it is currently the most commonly used psychometric instrument for QoL worldwide. It is reported to have been used on 60,000 individuals who live in 100 countries. It permits the conduction of multi-center quality of life research, and the comparison of results obtained in different centers (63).

Limitations such as failing to measure QoL patients who are not able to communicate, are a challenge for further development of measures. WHOQOL-Old and Children's WHOQOL are being developed to meet the

needs of the elderly and the children. Similarly, disease-specific modules such as for patients suffering from cancer, like the one that have being created for HIV positive patients, are currently under development, as well as modules adapted to special population groups, as the elderly, refugees etc. (64).

WHOQOL is expected to be used in broad-ranging ways, such as clinical trials, evaluating the impact of interventions onto quality of life and it is also anticipated to be useful in cases of disease impairment for which recommended treatment may be mostly palliative.

The questionnaire contains 26 questions, which measure the following broad domains: Physical health (7 items), psychological health (6 items), social relationships (3 items) and environment (8 items).

The above questions are on a scale of 1-5, with 5 being the strongest in the majority of them (very satisfied/very good), apart from three questions, where 5 is the weakest (very dissatisfied/very poor).

The WHOQOL-BREF can be scored in three ways, through raw scores and two transformation methods, the first that creates domain scores within the range of 4–20, and the second that creates domain scores within the range of 0–100 (57).

The measure has good internal consistency, ranging from 1/40.60–0.90.
Apart from the questions included in the WHOQOL-BREF, we also collected demographic information such as gender, age, education, marital status and income.
A reply to all of the questions was required, except the one related to sexual activity, which was kept as non-required out of respect for potential culture-related timidity of the respondents.

As the study-population consisted of Arabic speakers, we used the Arabic version of WHOQOL-BREF (Arabic version), which has been proved to be a valid cross-cultural instrument, with psychometric properties very

similar to the WHO 23 country report. It was developed by Ohaeri and Awadalla in 2009 and evaluated by them in Kuwait (65). Apart from culture-related limitations that for example prevented them from collecting their sample house-to-house, this Arabic translation was found to have high reliability and validity indices. Both the intra-class correlation for the test-retest statistic and the internal consistency values for the full questionnaire, as well as the domains had a Cronbach's alpha 0.7. The results of this validation provided additional evidence that WHOQOL-BREF is a cross-culturally valid tool. Seven years later, Heyam F. Dalky et al, in order to conduct a study on the burden of mental illness stigmatization in Jordan, they decided to proceed to a new evaluation of the psychometric properties of the Arabic version of WHOQOL-BREF in advance to their main study. They also found significant similarity of the psychometric properties, compared to those reported by Ohaeri and Awadalla in 2009. Alpha coefficients were all above the minimum 0.70, apart from the social domain, in which Cronbach's alpha was 0.69, sharply inferior to the cutoff score 0.70 (66).

B. Methodology of Statistical analysis

SPSS version 23 was used for analyzing the data at present study.

Before entering the data, the appropriate coding was given to each camp (0 for Skaramagas camp, 1 for Elaionas camp and 2 for City Plaza), along with coding definition for each question variable according to SPSS Survival manual, instructions of use and entering data (67). Following the insert of the data to the platform, cleaning and screening of the data was necessary and applied to ensure the exemption from errors. We did check our data thoroughly, through the number of valid and missing cases, that our mean scores were within range, as well as our minimum and maximum values. There were no missing data, apart from the question regarding level of satisfaction from sexual life, that was left optional, along

with 4 people that did not specify the amount of cash assistance they receive and 2 more that did not specify their medical condition while being ill. All other values were found within the expected range.

After applying all the necessary tests, we proceeded to manipulating the raw data and further analysis. We reversed the negative questions, that allowed us to proceed to catholic and uniform orders for all data added to the platform and most importantly allowed us to perform reliability tests through Cronbach Alpha, to assess the internal consistency of our data. The Cronbach alpha coefficient for all 26 items was .915, indicating that the items have relatively high internal consistency. (see table 1.a)

RELIABILITY STATISTICS		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
0,915	0,916	26

Table 1.a, reliability statistics

Like mentioned, results of WHOQOL-Bref questionnaire, can be scored in three ways, through mean scores or through two transformations. First that creates domain scores within the range of 4-20 and second within the range of 0-100. First transformation (4-20), was used to analyze QoL scores for each setting, for each of the four domains of the WHOQOL-BREF were calculated and tested for equality of means through independent t-tests. (see tables 1.b – t-test 0-1 and 1.c – t-test 1-2).

Independent t Test 0-1

		Levene's Test for Equality of Variances		t-test for Equality of Means						
DOMAIN	Equal Variances	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
PHYS	assumed	0,409	0,523	-3,113	503	0,002	-0,9204	0,29567	-1,50129	-0,3395
	not assumed			-3,083	421,214	0,002	-0,9204	0,29851	-1,50716	-0,33363
PSYCH	assumed	0,254	0,615	-5,498	503	0	-1,55681	0,28318	-2,11317	-1,00046
	not assumed			-5,479	430,619	0	-1,55681	0,28416	-2,11534	-0,99829
SOCIAL	assumed	0,607	0,436	-1,71	503	0,088	-0,66843	0,39091	-1,43644	0,09959
	not assumed			-1,716	440,851	0,087	-0,66843	0,38963	-1,43418	0,09733
ENVIR	assumed	0,029	0,864	-5,088	503	0	-1,32618	0,26063	-1,83824	-0,81413
	not assumed			-5,038	420,76	0	-1,32618	0,26321	-1,84356	-0,80881
Q1	assumed	0,629	0,428	-4,39	503	0	-0,417	0,095	-0,604	-0,23
	not assumed			-4,367	428,165	0	-0,417	0,096	-0,605	-0,229
Q2	assumed	0,969	0,325	-3,17	503	0,002	-0,375	0,118	-0,608	-0,143
	not assumed			-3,177	439,644	0,002	-0,375	0,118	-0,607	-0,143

Table 1.b, t-test 0-1

Independent t Test 1-2

		Levene's Test for Equality of Variances		t-test for Equality of Means						
DOMAIN	Equal variances	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
PHYSICAL	Assumed	1,388	0,240	2,940	252,000	0,004	1,52930	0,52018	0,50485	2,55375
	Not assumed			3,126	81,040	0,002	1,52930	0,48925	0,55585	2,50275
PSYCH	Assumed	0,751	0,387	2,880	252,000	0,004	1,42641	0,49527	0,45100	2,40181
	Not assumed			2,932	76,544	0,004	1,42641	0,48645	0,45766	2,39515
SOCIAL	Assumed	1,371	0,243	0,144	252,000	0,886	0,09412	0,65440	-1,19507	1,38331
	Not assumed			0,159	85,710	0,874	0,09412	0,59238	-1,08354	1,27178
ENVIR	Assumed	5,440	0,020	-0,645	252,000	0,520	-0,28627	0,44415	-1,16099	0,58844
	Not assumed			-0,790	102,515	0,431	-0,28627	0,36222	-1,00469	0,43214
Q1	Assumed	0,013	0,908	1,503	252,000	0,134	0,24900	0,16600	-0,07700	0,57600
	Not assumed			1,566	78,897	0,121	0,24900	0,15900	-0,06700	0,56600
Q2	Assumed	0,728	0,394	3,959	252,000	0,000	0,79600	0,20100	0,40000	1,19100
	Not assumed			4,191	80,537	0,000	0,79600	0,19000	0,41800	1,17400

Table 1.c, t-test 1-2

Then we compared Elaionas camp with Skaramagas and City plaza in pairs and measured the effect size through Cohen's d scale to estimate the impact of each domain in self-reported overall QoL by the residents of each setting. (see table 2.a, 0-1 means at 4-20 plus Cronbach A and table 2.b, 1-2 means at 4-20 plus Cronbach A).

Eleonas - Skaramagas Means 4-20 and Cronbach a'							
Domain	Camp	N	Mean	Std. Deviation	Std. Error Mean	Cronbach alpha	Effect size
PHYS	0 Skaramagas	301	12,186	3,19355	0,18407	0.281	small
	1 Eleonas	204	13,1064	3,35654	0,23501		
PSYCH	0 Skaramagas	301	10,4563	3,09959	0,17866	**0.498**	medium *to large*
	1 Eleonas	204	12,0131	3,15619	0,22098		
SOCIAL	0 Skaramagas	301	12,2924	4,34001	0,25015	0.156	no stat difference
	1 Eleonas	204	12,9608	4,26652	0,29872		
ENVIR	0 Skaramagas	301	9,2375	2,81322	0,16215	**0.459**	medium *to large*
	1 Eleonas	204	10,5637	2,9613	0,20733		
Q1	0 Skaramagas	301	2,37	1,037	0,06	0.40	medium
	1 Eleonas	204	2,79	1,064	0,075		
Q2	0 Skaramagas	301	2,84	1,312	0,076	0.292	small *to medium*
	1 Eleonas	204	3,22	1,295	0,091		

Table 2.a, 0-1 means at 4-20 plus Cronbach A

Eleonas - City Plaza Means 4-20 and Cronbach a'							
Domain	Camp	N	Mean	Std. Deviation	Std. Error Mean	Cronbach alpha	Effect size
PHYS	1 Eleonas	204	13,1064	3,35654	0,23501	**0.479**	medium to large
	2 City Plaza	50	11,5771	3,0343	0,42911		
PSYCH	1 Eleonas	204	12,0131	3,15619	0,22098	**0.459**	medium to large
	2 City Plaza	50	10,5867	3,06436	0,43337		
SOCIAL	1 Eleonas	204	12,9608	4,26652	0,29872	0.166	no stat difference
	2 City Plaza	50	12,8667	3,61717	0,51154		
ENVIR	1 Eleonas	204	10,5637	2,9613	0,20733	0.111	no stat difference
	2 City Plaza	50	10,85	2,10017	0,29701		
Q1	1 Eleonas	204	2,79	1,064	0,075	0.243	small
	2 City Plaza	50	2,54	0,994	0,141		
Q2	1 Eleonas	204	3,22	1,295	0,091	**0.646**	large
	2 City Plaza	50	2,42	1,18	0,167		

Table 2.b, 1-2 means at 4-20 plus Cronbach A

Finally, standard linear regression was applied to explore how each of our 4 domains (Physical, Psychological, Social and Environment) relate to each socio-demographic variable and if any of the variables could be predictive to any domain. Most of the independent variables had no significant correlation with our 4 domains, beyond a few small correlations in some expected fields.

RESULTS

In Elaionas camp we distributed and collected 204 questionnaires, out of which 71 were filled out by women (34,8%) and 133 completed by men (65,2%). Syria accounted as country of origin for 142 persons (69,6%), while 34 people originated from Iraq (16,7%), 15 from Palestine (7,4%), 2 from Lebanon (1%), 2 from Yemen (1%), 2 from Egypt (1%), 2 from Sudan (1%), 2 from Somalia (1%), 1 from Jordan (0,5%), 1 from Kuwait (0,5%) and 1 from Algeria (0,5%).

As for the age breakdown, 46,6% of the population aged between 25 and 34 years old (n=95), followed by the age group of 35-44 years at the percentage of 20,1% (n=41), with small difference from the age group of 18-24 years old that represented 19,6% of the population (n=40), 45-54 years old group ranged 9,3% (n=19), 55-64 years old 3,9% (n=8) and 1 person aged between 75-84 years old (0,5%).

The majority of the population was married 53,4% (n=109), followed by single 35,3% (n=72) out of which 88,8% were men (n=64), 16 persons were widowed (7,8%), while 7 people were divorced (3,4%), (see tables 3.a, 3.b, 3.c and 3.d demographics at appendix section).

On our research 18 people (8,8%) had no education at all. 61 people (29,9%) of the population undergone only to primary education, followed by 59 people (28,9%) that finished secondary education. Higher secondary education attained by 18,6% of the population sample (n=38), while merely 13,7% of the population (n=28) attained Tertiary education. (see table 4.a, Education).

At the time of our study, 182 people of the population (89,2%), received cash assistance, 18 did not receive any money (8,8%) and 4 people (2%) did not answer the question. (see table 6.a, Income).

Furthermore, at the question: ‘’are you currently ill?’’, 121 people (59,3%) replied that they were healthy, while 83 people (40,7%) that they were ill. (see table 5.a, Are you currently ill?). The majority of the population stated

they suffered from psychological issues (n=13), amongst them 1 person stated he had been a victim of torture. Followed by chronic diseases (n=11), (such as heart disease, diabetes, thyroid disease, etc). 7 people stated they have an injury and/or a disability, 3 people appeared with upper respiratory tract infection, another 3 with musculoskeletal issues, 3 more people stated that they suffer from an autoimmune system disease, 2 with neurological issues (such as epilepsy), 2 with ophthalmological issues, 1 woman said she has primary infertility, while another one said she has polycystic ovarian syndrome. Tuberculosis was reported by one person. While 2 did not specify their sickness and another 3 had other disease. (see table 5.b, Disease).

The mean QoL scores as presented after the transformation in 4-20, in Elaionas camp for Physical domain is depicted as 13,1064, for Psychological domain represented at 12,0131, for Social relationships was 12,9608 and for Environment ranked at 10,5637. Lastly, for questions Q1 representing: ‘’How would you rate your quality of life?’’ was 2,79 and for Q2 representing: ‘’How satisfied are you with your health?’’ was 3,22.

DISCUSSION

Following the mass refugee influx from Middle Eastern and other countries in 2015, Greece as one of the main reception countries especially for conflict affected areas from Middle East and had to find a copying mechanism to respond to the new needs raised immediately. That resulted to the opening and commission of 54 initially temporary camps side to side across the country (12). From the beginning and by definition they could not be identically alike, bar none the structure and environment both within and around them, due to different characteristics and specific needs of each location, that came along with the specific needs of the population hosted in each camp, disparate actors operating inside and the management of each.

In the present study, we compared the self-reported QoL of Arabic speaking refugees that resided in 2 of the largest camps in Attica region and in one squatted hotel organized and run by activists and volunteers within the prefecture of Attica. As it is well documented that the environment in which we live in is able to influence and affect, our beliefs, behaviors and outcomes in our health and other areas, through the interaction and the experiences made and lived in it (37,51), we studied the structure of each setting, located the differences amongst them and examined if and how they affected self-reported QOL of the population of our study.

Refugees residing in Elaionas, scored higher in Psychological and Environmental domain than in Skaramagas camp. With a Cohen's d effect size 0,498 and 0,459 respectively, indicating a moderate effect (0,30 – 0,49), just below the cut off limit to large effect (0,5 - 1.0). This suggests that the respondents in Elaionas camp reported to have enough money to meet their needs, felt safer in their daily life and were relatively more satisfied with the conditions of their living space, access to health services, transportation and information available on site, as well as having more opportunities for leisure and/or recreational activities than respondents in Skaramagas camp at the time of our research. It seems that the context created by the camp management and the provisions on behalf of operating actors on site in combination with the key location of Elaionas camp and good transportation services could be viewed as favorable. Residents in Elaionas, also scored higher in Physical domain and questions Q1 and Q2. With a Cohen's d effect size 0,281 for Physical, 0,4 for Q1 and 0,292 for Q2, indicating a small (0,10 – 0,29) although borderline to moderate effect and a clear moderate effect regarding the physical domain. This suggest that respondents in Elaionas rated slightly higher their overall quality of life and were more satisfied from their health and access to healthcare at the time of our study. Social relationships domain developed no statistical difference amongst the two camps.

Congruent to previous comparison, Elaionas and City Plaza had no statistical difference at Social relationships domain but additionally, developed no statistical difference at the domain of Environment and a small effect size in Q1 (with a score of 2.43). Suggesting that residents of both settings were equally satisfied by both their overall quality of life and the environment in which they live in. With residents of Elaionas expressing slightly better satisfaction over their overall QoL. A possible explanation could be that City Plaza is also located near the city center and therefore shares similar physical environment with Elaionas camp in terms of noise, pollution and built space. While both are linked with legitimate transportation services and shops. We weren't granted permission to visit the rooms at City Plasa which constitutes a possible limitation for further justification on these specific outcomes. A key finding of our research constitutes that residents in Elaionas as compared to residents in City Plaza scored higher in Physical and Psychological domain, as well as in Q2 question. Manifesting a large effect size (Cohen's d: 0,646) at Q2 referring to level of satisfaction of the respondents with their health, along with a moderate effect size in Physical (Cohen's d: 0,479) and Psychological (Cohen's d: 0,459) domain, however borderline to a large effect size. Suggesting that residents in City Plaza evaluated lower the quality and accessibility to health services provided in comparison with residents of Elaionas. This outcome could be explained through the rudimentary health care services provided in City Plaza by volunteers with limited capacities in terms of equipment, medication, cultural mediation and ability to lease and possibly escort patients to other health structures outside the hotel. Also, the high turn-over of the volunteers is not promoting the continuity of treatment in terms of follow up and makes it harder for the patients to engage with doctor and/or other medical personnel and their advices. In lien, in Elaionas camp the presence of KEELPNO, arm pick of Ministry of Health, is well organized and owns larger capacity in terms of skilled staff, equipment, medication (vaccines included), cultural mediators and

different capacity to lease with hospitals and other health structures. They also have the propensity and focus turned into integration, that is often facilitated through escorting the patients to their appointments by providing both cultural mediation at the time of the examination and in other heath structures along with an effort to literate the patients by assisting them to navigate the system.

A possible limitation could constitute the smaller sample size in City Plaza and would be expedient to re-measure it upon building up the sample size, as an indispensable condition before reifying inferences.

The univariate outcome of no statistical difference amongst all three settings in social domain, is in line with the homogeneity of the population sample of our study and possibly by the cultivation of feelings of brotherhood amongst Arabic speaking population. Another possible amplifying factor could be the similarities of the Mediterranean culture, climate and temperament with Anatolia, that possibly render Greece as a more familiar place to their culture.

It was found that population of our study were either men (62%) or women (38%), most likely from Syria (65,4%) or Iraq (25,2%), pertaining at the reproductive age range (89,3%), most likely married (52,3%), with little (primary 22,5%) or middle (secondary and higher secondary 53,2%) education (n=555).

Moreover, differences were found amongst Elaionas camp and the other two settings at the level of education, health status at the time of our research and financial aid provision.

It was found that Elaionas residents scored lower in education, with 47,5% of residents attained middle education instead of 57,2% in Skaramagas camp and 52% in City Plaza. Stronger disparities were observed at financial assistance and health status.

In Elaionas camp 91% of the population, enjoy the privilege of financial

aid, while in Skaramagas 47,9% of the population were entitled to it and regarding City Plaza only the 10%! Furthermore, the amount of money refugees receive fall between a range defined by Greece's cash Alliance, a partnership between UNHCR and five INGO and it is uniformed towards all refugees who are eligible to it, regardless of which setting they live in Greece, it is rather proportional to the number of the members of each family. However, miscellaneous merits of money were recorded, that fell out of the standardized range defined by cash actors in all three settings (68), (69). That could potentially imply that more people do not receive financial assistance officially from cash actors and therefore, the amount of money they submitted onto the questionnaires as a reply to the question, could be expound as an economic assistance by some family member back home or already moved on to Europe, or a friend, or even a source of income acquired either legally or illegally instead.

Additionally, at the time of our study, 40,7% of the population in Elaionas camp, reported that they are ill, where in City Plaza the equivalent percentage ranged at 60% of the population and for Skaramagas layed at 35,9%. In a cross-sectional study this is not indicative of any inferences. However, despite the rapid changes in epidemiology of multiple conditions that are seen amongst refugees in countries with high immigration rates, most of the reported diseases followed the usual pattern that is expected to be seen amongst refugee population (psychological issues, upper respiratory infections, musculoskeletal, chronic diseases etc..) in all three settings (25,29). The high prevalence of ill people in City Plaza could be due to smaller sample.

Worth's mentioning that the way residents in Elaionas camp, phrased their responses with accuracy, by using the right terminology for attributing the diseases was impressive. More targeted answers were given by the residents of Elaionas as compared to the other two settings. Yet quite surprising in reckon with the mean educational level of the population in Elaionas camp, that fall slightly behind as compared to the

other two settings. One possible explanation could be that due to the fact that the majority of the population resides at the same camp for up to 2 years and health actors (KEELPNO) remained the sole health actor on site and stable ever since, their literacy was increased by increased interaction with medical personnel, along with the multiple visits to health centers, polyclinics and hospitals. However, this assumption merits further research and most likely would have helped if additional data such as numbers of visits to health actors/polyclinics and/or hospitals had been recorded.

The ‘’escorting patients’’ (to other health structures) practice wasn’t originally planned by KEELPNO team, but acted upon experience of many missed appointments and many more empty visits to health structures outside the camp, with patients coming back from the hospital with no medical reports, no prescription, no laboratory and imaging results. Upon observing patients being so frustrated and unwilling to visit the hospital, even in emergency cases.

In an international study of literature review in 22 countries, refugee experiences of general practice in countries of resettlement is being studied. In that review, most common barriers emerged in accessing and navigating health system, as well as refugee perspectives of reasons they result in problematic doctor-patient relationships was characteristically described and analyzed. Revealing that continuity with the same health provider and cultural mediator amplified the built of a trustworthy and familiar environment that helped to result in better health care and mitigate the dissonance between their expectations of health care and actual health care (71). A Quasi-Experimental Study in Germany, a country that is known for its initial restrictive and conditional access to health care against refugees and asylum seekers, reveals that the effect of the implementation of restriction policies ultimately increases health costs per capita, due to late diagnosis and treatment (70).

CONCLUSION

It is the first time, at least to our knowledge, that differences in health related QOL amongst refugees residing at urban and camp settings was investigated and the characteristics of Arabic speaking refugees and self-reported QOL were ever scrutinized in Athens, Greece.

We were interested to broach in the characteristics of Arabic speaking refugees residing at Elaionas camp and their self-reported quality of life and if their results differ from other refugees residing in Skaramagas camp and urban settings – City Plaza, as it is well documented that the environment in which we leave in, may affect our health outcomes (39). From our research it was found that residents in Elaionas developed higher scores in overall QoL against the other two settings. They were more satisfied with their quality of life and their health, felt safer, believed that they had a healthier physical environment, enough money to meet their needs, better access to health services, information and transportation system. Social relationships did not differ from site to site.

The results vacillated from a small to large effect in some domains, with most of the domains appearing a moderate size effect, indicating that steps towards improving conditions and therefore overall QoL of the population are urgently needed in all three sites.

Key finding of parent study was that residents in Elaionas camp despite having lower educational background, responded with greater accuracy to the type of illness they had (either chronic or acute). This random policy observed in Elaionas (of escorting patients to health system) stands promising, as it seems that practical support to refugees in understanding, accessing and navigating the health system was potentially able to increase their health literacy. Indicating that the consistency of health providers along with multiple interaction with them, worked as a succor for residents to engage better with health practitioners in and out of site.

Another key finding of this study was that due to 91% of the population in Elaionas camp were granted with financial assistance. Residents there

reported that were able to enjoy life more and felt they were having enough money to meet their daily needs, in addition to 47,9% in Skaramagas and 10% in City Plaza. That deviation is also reflected at psychological domain by having a moderate, borderline large effect size, as compared to both of the other two sites. Indicating that financial assistance is able to affect their psychological status for the better.

Each country owns and applies different healthcare systems and policies relating to reception and coping with refugee and asylum seekers (health) needs and expectations. Lack of knowledge of the healthcare system is a significant contributor to health disparities especially for refugees with limited language proficiency. Low health literacy is an important barrier to quality preventive care. An increasing body of research conclude to self-reported QoL as a method of choice for assessing social and environmental correlates of health, especially in vulnerable population, who's living under excessive and continuous stress and duress, like refugees (41,62). Yet, little was known about QoL of refugees living in Athens-Greece. Our research addressed that gap.

It seems that collaborative, interdisciplinary training approaches can better prepare health care professionals. Robust health care models that take into consideration population perceptions of quality of life aspects may be better equipped to address social determinants of health, and thus have more potential to reduce refugee populations' health inequities and promoting integration.

ETHICS

Ethical approval was sought from the University of Athens, as well as from the Hellenic Centre for Disease Control and Prevention (KEELPNO). KEELPNO also provided Arabic interpreters for the camp settings.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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APPENDIX 1: tables

GENDER

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
1 female	71	34,8	34,8	34,8
2 male	133	65,2	65,2	100
Total	204	100	100	

Table 3.a, Gender

NATIONALITY

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
1 Syria	142	69,6	69,6	69,6
2 Iraq	34	16,7	16,7	86,3
3 Jordan	1	0,5	0,5	86,8
4 Lebanon	2	1	1	87,7
5 Palestine	15	7,4	7,4	95,1
6 Kuwait	1	0,5	0,5	95,6
7 Sudan	2	1	1	96,6
8 Egypt	2	1	1	97,5
9 Algeria	1	0,5	0,5	98
10 Yemen	2	1	1	99
15 Somalia	2	1	1	100
Total	204	100	100	

Table 3.b, Nationalities

DOB

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
1 18-24	40	19,6	19,6	19,6
2 25-34	95	46,6	46,6	66,2
3 35-44	41	20,1	20,1	86,3
4 45-54	19	9,3	9,3	95,6
5 55-64	8	3,9	3,9	99,5
7 75-84	1	0,5	0,5	100
Total	204	100	100	

Table 3.c, Date of Birth – age breakdown

MARITAL

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
1 Single	72	35,3	35,3	35,3
2 Married	109	53,4	53,4	88,7
3 Widowed	16	7,8	7,8	96,6
4 Divorced	7	3,4	3,4	100
Total	204	100	100	

Table 3.d, Marital Status

EDUCATION

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
1 None at all	18	8,8	8,8	8,8
2 Primary	61	29,9	29,9	38,7
3 Secondary	59	28,9	28,9	67,6
4 Higher Secondary	38	18,6	18,6	86,3
5 Tertiary	28	13,7	13,7	100
Total	204	100	100	

Table 4.a, Education

ARE YOU CURRENTLY ILL ?

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
0 yes	83	40,7	40,7	40,7
1 no	121	59,3	59,3	100
Total	204	100	100	

Table 5.a, Are you currently ill?

INCOME				
Valid	Frequency	Percent	Valid Percent	Cumulative Percent
0 No	18	8,8	9	9
6	1	0,5	0,5	9,5
15	1	0,5	0,5	10
16	1	0,5	0,5	10,5
90	5	2,5	2,5	13
100	1	0,5	0,5	13,5
130	1	0,5	0,5	14
140	1	0,5	0,5	14,5
150	96	47,1	48	62,5
200	3	1,5	1,5	64
240	1	0,5	0,5	64,5
250	1	0,5	0,5	65
280	7	3,4	3,5	68,5
300	3	1,5	1,5	70
340	15	7,4	7,5	77,5
350	2	1	1	78,5
380	1	0,5	0,5	79
400	19	9,3	9,5	88,5
420	1	0,5	0,5	89
450	19	9,3	9,5	98,5
490	1	0,5	0,5	99
500	2	1	1	100
Total	200	98	100	
Missing	System	4	2	
Total	204	100		

Table 6.a, Income

DISEASE

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
No	150	73,5	73,5	73,5
arthritis	1	0,5	0,5	74
Left limb impairment	1	0,5	0,5	74,5
asthma	2	1	1	75,5
Asthma and stomach ulcer	1	0,5	0,5	76
Eczema	1	0,5	0,5	76,5
Slipped disc	1	0,5	0,5	77
burns	1	0,5	0,5	77,5
epilepsy	2	1	1	78,4
Heart disease	1	0,5	0,5	78,9
Heart disease	2	1	1	79,9
depression	1	0,5	0,5	80,4
depression	1	0,5	0,5	80,9
Neurological problems	2	1	1	81,9
Lower back pain	1	0,5	0,5	82,4
Ophthalmological issues	1	0,5	0,5	82,8
Ophthalmological issues	1	0,5	0,5	83,3
primary infertility	1	0,5	0,5	83,8
rheumatoid arthritis	1	0,5	0,5	84,3
rheumatoid arthritis	1	0,5	0,5	84,8
Polycystic ovarian syndrome	1	0,5	0,5	85,3
Abdominal trauma	1	0,5	0,5	85,8
Trauma at right limb	1	0,5	0,5	86,3
Tuberculosis	1	0,5	0,5	86,8
thyroid	1	0,5	0,5	87,3
Psychological issues	2	1	1	88,2

Psychological issues	1	0,5	0,5	88,7
Psychological issues	1	0,5	0,5	89,2
Psychological issues	2	1	1	90,2
Psychological issues	1	0,5	0,5	90,7
anaemia	1	0,5	0,5	91,2
burn at right foot	1	0,5	0,5	91,7
Diabetes, high artery pressure, cholesterol	1	0,5	0,5	92,2
Hearing disability (left)	1	0,5	0,5	92,6
Upper respiratory infection	1	0,5	0,5	93,1
Upper respiratory infection	1	0,5	0,5	93,6
polycystic kidney disease	1	0,5	0,5	94,1
pregnancy	1	0,5	0,5	94,6
Psychological issues	2	1	1	95,6
Psycological issues	1	0,5	0,5	96,1
stomach ache, pain at kidney	1	0,5	0,5	96,6
Fractions at both feet from explosion	1	0,5	0,5	97,1
Victim of torture	1	0,5	0,5	97,5
yes	1	0,5	0,5	98
yes	2	1	1	99
Internal bleeding at ear	1	0,5	0,5	99,5
spondylolysis	1	0,5	0,5	100
Total	204	100	100	

Table 5.b Disease

APPENDIX 2: Extended Greek Abstract

Εισαγωγή

Η ένταση των συγκρούσεων στις χώρες της Συρίας, της Υεμένης, του Αφγανιστάν, του Ιράκ και της Λιβύης προκάλεσε μια άνευ προηγουμένου μετακίνηση ανθρώπων, με αποτέλεσμα μια από τις χειρότερες ανθρωπιστικές κρίσεις του 21ου αιώνα. Σύμφωνα με τα στοιχεία των υπηρεσιών των Ηνωμένων Εθνών για τους Πρόσφυγες (UNHCR), σχεδόν 5,5 εκατομμύρια άνθρωποι εγκατέλειψαν τη συριακή διαμάχη αναζητώντας καταφύγιο σε γειτονικές χώρες. Μαζί με το κύμα των ανθρώπων που αποφάσισαν να ταξιδέψουν για ασφάλεια, υπάρχουν και άνθρωποι που ταξιδεύουν για σύνθετους λόγους αναζητώντας μια καλύτερη ζωή.

Ένας σημαντικός αριθμός από αυτούς, έφτασε στις ελληνικές ακτές και την ενδοχώρα στο δρόμο προς τον ευρωπαϊκό βορρά. Η μεγάλη πλειοψηφία έφτασε με σκάφη και φουσκωτές λέμβους που διασχίζουν το Αιγαίο από την τουρκική ακτή. Τον Μάρτιο του 2016, τα ευρωπαϊκά κράτη έκλεισαν τα σύνορά τους και υπέγραψαν τη δήλωση ΕΕ-Τουρκίας, ένα λεγόμενο προσωρινό μέτρο για την παύση της "παράνομης μετανάστευσης" στην Ευρώπη. Επιλέγοντας μια πολιτική συγκράτησης, πολλές χώρες εντατικοποίησαν τους ελέγχους στα σύνορα, έβαλαν φράκτες, έκαναν βίαιες απωθήσεις και ενίσχυσαν τις δυνάμεις ασφαλείας στις θάλασσες. Αυτή η ατζέντα ελέγχου των συνόρων, που υιοθέτησαν οι ηγέτες της ΕΕ σκοπεύοντας να καταπολεμήσουν τις παράνομες διαδρομές προς την Ευρώπη, αύξησε στην πραγματικότητα τη ζήτηση για λαθρεμπόρους και οδήγησε σε εναλλακτικές, πιο επικίνδυνες διαδρομές ως τη μόνη επιλογή για εκείνους που ζητούν προστασία. Κατά συνέπεια, περισσότεροι από 16.000 άνθρωποι είναι νεκροί ή αγνοούνται από το 2014, προσπαθώντας να φτάσουν στις ελληνικές ακτές.

Σήμερα υπάρχουν 51.000 πρόσφυγες και μετανάστες εγγεγραμμένοι στην Ελλάδα, 39.500 από τους οποίους βρίσκονται στην ηπειρωτική χώρα και 11.500 στα νησιά . Μεταξύ αυτών βρίσκονται και 3.400

ασυνόδευτοι ανήλικοι. Η πλειοψηφία των προσφύγων διαμένουν σε κέντρα φιλοξενίας και σχεδόν 21.000 φιλοξενούνται σε διαμερίσματα και κτίρια σε διάφορες πόλεις στο πλαίσιο του προγράμματος στέγασης της UNHCR. Η μαζική εισροή ανθρώπων υπαγόρευσε τον σχηματισμό 54 προσωρινών καταυλισμών σε όλη την Ελλάδα, οι οποίοι στη συνέχεια μειώθηκαν σε 37.

Επί του παρόντος υπάρχουν πέντε κέντρα φιλοξενίας στην περιοχή της Αττικής . Ο Ελαιώνας είναι η κεντρικότερη δομή, που απέχει πέντε λεπτά με τα πόδια από τον ομώνυμο σταθμό του μετρό και φιλοξενεί 1500 άτομα. Το καμπ του Σκαραμαγκά φιλοξενεί το μεγαλύτερο αριθμό ατόμων (2500) στην Αττική και βρίσκεται σε βιομηχανική περιοχή 30 λεπτά από το κέντρο της πόλης. Το καμπ στο Σχιστό και στη Μαλακάσα φιλοξενούν 746 και 916 άτομα αντίστοιχα. Υπάρχουν εκτιμήσεις ότι σχεδόν 1000 μη εγγεγραμμένοι πρόσφυγες και μετανάστες είναι διάσπαρτοι σε καταλήψεις σε εγκαταλελειμμένα ξενοδοχεία και κτίρια της Αθήνας.

Αυτοί οι αριθμοί αναμένεται να αυξηθούν δραματικά μέχρι τα τέλη του 2018. Παρόλο που οι αφίξεις είναι σημαντικά χαμηλότερες σε σχέση με τη μαζική ροή του 2015, οι θαλάσσιες και χερσαίες αφίξεις έφτασαν τις 7.343 κατά τους πρώτους 4 μήνες του 2018, αύξηση κατά 67% από την ίδια περίοδο το 2017 (13). Ταυτόχρονα, οι διαδικασίες μετεγκατάστασης στις χώρες της ΕΕ προχωρούν με αργούς ρυθμούς (14). Από τις 66.400 θέσεις που έχουν διατεθεί για μετεγκατάσταση από την Ελλάδα, μόνο 22.000 έχουν χορηγηθεί μέχρι στιγμής (15). Σαν αποτέλεσμα, η κατάσταση αυτή έχει αφήσει αποκλεισμένους δεκάδες χιλιάδες ανθρώπους στην Ελλάδα που περιμένουν για εγκρίσεις ασύλου, αποφάσεις μετεγκατάστασης ή επαναπατρισμού.

Γιατί ο αραβόφωνος πληθυσμός;

Η παγκόσμια προσφυγική κρίση επηρέασε δυσανάλογα τους ανθρώπους στη Μέση Ανατολή. Για πολλές δεκαετίες, η περιοχή υπήρξε τόπος συγκρούσεων, έντονων και θολερών καταστάσεων. Από το τέλος του Β Παγκοσμίου Πολέμου, την ίδρυση του Ισραήλ το 1948 και τον πόλεμο

ΗΠΑ-Ιράκ το 2003, η Μέση Ανατολή παρήγαγε την πλειοψηφία των προσφύγων στον κόσμο. Πρόσφατα, ο εμφύλιος πόλεμος της Συρίας που ξεκίνησε το 2011 μετά την Αραβική Άνοιξη, είχε βαθιές επιπτώσεις στην ίδια τη χώρα, στη Μέση Ανατολή και στο διεθνές σύστημα.

Η βία του πολέμου έχει αφήσει χιλιάδες θύματα, ένα κατακερματισμένο σύστημα υγειονομικής περίθαλψης (16) και υποβάθμιση των εμβολιαστικών προγραμμάτων ανοσοποίησης. Το πλαίσιο αυτό επέτρεψε την επανεμφάνιση μεταδοτικών ασθενειών στη Συρία και στις χώρες υποδοχής (17-19). Οι συνθήκες που επικρατούν στο ταξίδι και στα στρατόπεδα προσφύγων εκφυλίζουν τη σωματική και ψυχική υγεία. Εκφράζονται ανησυχίες σχετικά με τις συνέπειες στην υγεία αναφορικά των κέντρων φιλοξενίας, καθώς είναι εμφανείς οι περιορισμοί τους ως μακροπρόθεσμες λύσεις (20,21). Η διαχείριση των χρόνιων νοσημάτων παρεμποδίζεται: η αλλοίωση του συστήματος υγείας και οι ασυμφωνίες, ο υπερπληθυσμός και άλλοι επιβλαβείς παράγοντες οδηγούν σε αυξημένο επιπολασμό προβλημάτων υγείας (18,22,23). Οι Doocey et al, από τις γειτονικές χώρες του Λιβάνου και της Ιορδανίας, σε μελέτες μεταξύ Σύριων προσφύγων, αναφέρουν μια μεγάλη επικράτηση χρόνιων ασθενειών (24). Οι συνέπειες για το σύστημα υγείας κάθε χώρας είναι τεράστιες και η επιβάρυνση των προσφύγων για τα έξοδα που αναγκάζονται να πληρώνουν οι ίδιοι είναι προβληματική (25,26).

Σε ένα τμήμα επειγόντων περιστατικών στην Ελβετία η πιο κοινή αιτία προσέλευσης των εξωτερικών ασθενών από Σύριους, ήταν χειρουργική λόγω τραύματος και λόγω οξέων λοιμωδών νοσημάτων (27). Σε μια έρευνα που διεξήχθη στις Βρυξέλλες, μεταξύ αιτούντων άσυλο κυρίως από το Ιράκ και τη Συρία, έδειξε ότι ένας στους επτά ασθενείς υπέφερε από τραύματα (28). Σχεδόν το 9% του πληθυσμού της μελέτης ήταν ασυνόδευτοι ανήλικοι που ζητούν άσυλο στις Βρυξέλλες. Μια άλλη μελέτη στην Τουρκία, μεταξύ των αραβόφωνων γονέων και των αντιλήψεων για την υγεία των παιδιών τους, διαπίστωσε ότι ο οδοντικός πόνος ήταν το μεγαλύτερο μέλημα των γονέων και ότι αν και γνώριζαν τη σπουδαιότητα

της στοματικής υγιεινής, δήλωσαν ότι δεν μπορούν να αναλάβουν τη φροντίδα των παιδιών τους σε αυτό τον τομέα (29).

Παρόλο που η έρευνα στο ασταθές περιβάλλον ανθρωπιστικών καταστάσεων έκτακτης ανάγκης μπορεί να φαντάζει πολυτέλεια, ωστόσο, υπάρχει ένας σημαντικός αριθμός μελετών που επικεντρώνονται στην ψυχολογική κατάσταση των προσφύγων στη Μέση Ανατολή (21,30-33). Ο υψηλός επιπολασμός διαταραχής μετατραυματικού στρες, μείζονα καταθλιπτικά σύνδρομα και γενικευμένο άγχος είναι εμφανείς. Η συσσώρευση έκθεσης σε σοβαρά τραυματικά συμβάντα στον τόπο προέλευσης, κατά τη διάρκεια του ταξιδιού και την επανεγκατάσταση, μπορεί να χρησιμεύσει ως επεξήγηση αυτών των ευρημάτων.

Ποιότητα Ζωής

Σύμφωνα με τον ΠΟΥ, η Ποιότητα Ζωής ορίζεται ως "η αντίληψη του ατόμου για τη θέση του στη ζωή στο πλαίσιο του πολιτισμού και των αξιακών συστημάτων στα οποία ζει και σε σχέση με τους στόχους, τις προσδοκίες, τα πρότυπα και τις ανησυχίες του. Πρόκειται για μια ευρεία έννοια που επηρεάζεται με πολύπλοκο τρόπο από τη σωματική υγεία, την ψυχολογική κατάσταση, το επίπεδο ανεξαρτησίας, τις κοινωνικές σχέσεις και τη σχέση τους με τα χαρακτηριστικά του περιβάλλοντος »(37).

Από τα εντυπωσιακά συνεπή ευρήματα ήδη από το 1970 προέκυψε ότι τα μέτρα αυτό-αξιολόγησης είναι οι καλύτεροι παράγοντες πρόβλεψης της υγείας και της θνησιμότητας, ανεξάρτητα από άλλους παράγοντες (38,39). Επιπλέον, μια πληθώρα ερευνητικών μελετών στη δημόσια υγεία χρησιμοποιεί αυτό-αναφερόμενους δείκτες QOL για να αξιολογήσει τις επιπτώσεις των κοινωνικών προσδιοριστών υγείας στην υγεία διαφόρων πληθυσμών (40,41). Πρόσφατα, τα μέτρα του QOL αποδείχθηκαν χρήσιμα στην εξερεύνηση των κοινωνιών και των πολιτισμών σε περιοχές που πλήττονται από συγκρούσεις ή σε πληθυσμούς που εγκαταλείπουν επικίνδυνες καταστάσεις όπως οι πρόσφυγες και οι μετανάστες (41-43).

Είναι προφανές ότι η μετανάστευση μπορεί να επιδεινώσει τους παράγοντες που διαμορφώνουν τους κοινωνικούς προσδιοριστές υγείας

και τελικά μπορεί να θεωρηθεί ως πρόσθετο στρώμα αυτών των παραγόντων (44). Διάφορες μελέτες έχουν δείξει πώς οι πρόσφυγες διατρέχουν αυξημένο κίνδυνο να υποφέρουν από πολλές σωματικές και ψυχιατρικές διαταραχές σε σύγκριση με τους μη εξαναγκασμένους εκτοπισμένους μετανάστες. Οι παράγοντες πίεσης πριν από τη φυγή, όπως η έκθεση σε σοβαρά τραυματικά συμβάντα, μπορούν να εξηγήσουν τον υψηλό επιπολασμό των ψυχικών διαταραχών μεταξύ ενηλίκων και παιδιών προσφύγων (31,45). Αν και ορισμένες συγκρούσεις είναι βραχύβιες, μερικές άλλες είναι ενδημικές για δεκαετίες, δηλαδή παραδείγματα της Παλαιστίνης, του Αφγανιστάν, της Κένυας και της Σιέρρα Λεόνε. Σε αυτές τις περιπτώσεις, οι γενικές κοινωνικές συνθήκες, που εκθέτουν τις γενιές σε υψηλότερους σωρευτικούς περιβαλλοντικούς παράγοντες πίεσης, μπορεί να έχουν μεγαλύτερο αντίκτυπο στην αυτό-αξιολόγηση της υγείας (46). Ωστόσο, μελέτες που μετρούν την ψυχική δυσφορία δεκαετίες μετά την επανεγκατάσταση, επισημαίνουν ότι η έκθεση στο νέο περιβάλλον είναι επίσης σημαντική για την ψυχική υγεία των προσφύγων (33).

Σκοπός και στόχοι της μελέτης

Επί του παρόντος, δεν υπάρχουν στοιχεία, τουλάχιστον εξ όσων γνωρίζουμε, σχετικά με την ποιότητα ζωής των αραβόφωνων προσφύγων που διαμένουν στην Ελλάδα. Οι αραβόφωνοι είναι ένας μάλλον ομογενής πληθυσμός όσον αφορά την κουλτούρα και τις εμπειρίες των προσφύγων. Έφθασαν σε μεγάλους αριθμούς που αναζητούσαν καταφύγιο, βίωναν αιχμηρές αλλαγές στον τρόπο διαβίωσής τους. Είναι εξαιρετικά σημαντικό να συλλέγονται και να καταγράφονται δεδομένα σχετικά με την τρέχουσα κατάσταση αυτού του πληθυσμού, προκειμένου να βελτιωθούν οι συνθήκες και να διευκολυνθεί η ένταξή τους στον κοινωνικό ιστό στο άμεσο μέλλον. Η έρευνα αυτή αντιμετωπίζει το κενό αυτό και παρέχει κάποιες πολύτιμες πληροφορίες για την υγεία και την ευημερία των προσφύγων και των μεταναστών που εγκαθίστανται στην περιοχή της Αττικής. Συνεπώς, ο σκοπός αυτής της μελέτης είναι να διερευνήσει τα χαρακτηριστικά των αραβόφωνων

προσφύγων που διαβιούν στην Αττική σε κάμπς και άλλες δομές (όπως ξενοδοχεία), να αξιολογήσει την ποιότητα ζωής τους και να εξετάσει εάν υπάρχουν διαφορές στο QOL τους σε σύγκριση με τους πρόσφυγες σε άλλα περιβάλλοντα. Η συγκεκριμένη μελέτη αποτελεί μέρος ενός μεγαλύτερου έργου που συγκέντρωσε δεδομένα από δύο καμπ της Αττικής και ένα ξενοδοχείο υπό κατάληψη. Το έργο επικεντρώνεται στο δεύτερο μεγαλύτερο καμπ, αυτό του Ελαιώνα, το οποίο φιλοξενεί περίπου 1500 πρόσφυγες. Τα δεδομένα συλλέχθηκαν με το ερωτηματολόγιο WHO Quality of Life (WHOQOL-BREF) και συγκρίθηκαν με τις αντίστοιχες έρευνες από το κάμπ του Σκαραμαγκά και του ξενοδοχείου City Plaza, που χρησιμοποίησαν το ίδιο εργαλείο και μεθοδολογία στον ίδιο πληθυσμό στόχο, σε άλλο περιβάλλον, προκειμένου να παρασχεθεί ένα πλαίσιο σχολιασμού και συζήτησης για τα ευρήματά μας.

Ειδικά ερευνητικά ερωτήματα είναι: α) Ποια είναι τα χαρακτηριστικά του QOL των αραβόφωνων προσφύγων που κατοικούν στο κέντρο φιλοξενίας του Ελαιώνα; β) Υπάρχουν διαφορές ανάμεσα επίπεδα QOL που αναφέρουν οι πρόσφυγες που κατοικούν στο κέντρο φιλοξενίας του Ελαιώνα από αυτά που αναφέρουν οι πρόσφυγες που διαμένουν σε άλλες τοποθεσίες.

ΜΕΘΟΔΟΛΟΓΙΑ

Δείγμα

Πρόκειται για μια συγχρονική μελέτη. Ο πληθυσμός μελέτης αποτελείται από άνδρες και γυναίκες ηλικίας άνω των 18 ετών που αναζητούν διεθνή προστασία, έχουν φτάσει στην Ελλάδα από το 2011 και ζουν στην ίδια κατοικία / κατασκήνωση για τους τρεις τελευταίους μήνες. Τα δεδομένα συλλέχθηκαν στο πλαίσιο ενός μεγαλύτερου σχεδίου που περιλάμβανε δύο κέντρα φιλοξενίας και ένα ξενοδοχείο υπό κατάληψη στην Αθήνα. Η παρούσα μελέτη επικεντρώνεται στο καμπ του Ελαιώνα, στο νομό Αττικής. Η συλλογή δειγμάτων πραγματοποιήθηκε εντός του Μαρτίου του 2018.

Έρευνα πεδίου

Για τη συλλογή των δημογραφικών στοιχείων καθώς και των πληροφοριών σχετικά με την ποιότητα ζωής, χρησιμοποιήσαμε την μεταφρασμένη στα αραβικά και επικυρωμένη έκδοση του ερωτηματολογίου WHOQOL-BREF (52,53). Η εφαρμογή Magpi σε tablet και έξυπνα τηλέφωνα χρησιμοποιήθηκε για τη συμπλήρωση των ερωτηματολογίων. Εκτός από το ότι είναι ένα γρήγορο και βολικό εργαλείο, η χρήση της εφαρμογής Magpi βοηθά στην αποφυγή σφαλμάτων κατά τη συλλογή δεδομένων και διευκολύνει την ανάλυση.

Αποφασίσαμε να χρησιμοποιήσουμε την προσέγγιση από πόρτα σε πόρτα για να συλλέξουμε το δείγμα μας. Επισκεφθήκαμε όλα τα τροχόσπιτα του καταυλισμού, ένα προς ένα, ακολουθώντας τους χάρτες του καταυλισμού, με σκοπό να εντοπίσουμε όλα τα άτομα που ήταν εκείνη τη στιγμή μέσα και πληρούσαν τα κριτήρια επιλεξιμότητας της μελέτης. Προφορική συναίνεση προ της συμμετοχής στην έρευνα ζητήθηκε από όλους τους συμμετέχοντες, ενώ ένας Αραβόφωνος διερμηνέας βοηθούσε όσους δεν μπορούσαν να διαβάσουν στη συμπλήρωση και υποβολή των απαντήσεων.

Ανάλυση

Τα δεδομένα αναλύθηκαν με την έκδοση SPSS 23. Τα ψυχομετρικά χαρακτηριστικά της αραβικής μετάφρασης του οργάνου αξιολογήθηκαν με εσωτερική αξιοπιστία. Ο συντελεστής alpha για τα 26 στοιχεία ήταν .915, υποδηλώνοντας ότι τα στοιχεία έχουν σχετικά υψηλή εσωτερική συνοχή. Η μέση βαθμολογία για κάθε τομέα του WHOQOL-BREF υπολογίστηκε σε πρώτες βαθμολογίες και στη συνέχεια μετατράπηκε σε κλίμακα 4-20 για να γίνει σύγκριση με τα αποτελέσματα των άλλων δομών.

Χρησιμοποιήθηκε πρότυπη δοκιμή γραμμικής παλινδρόμησης προκειμένου να ελεγχθεί εάν οποιοσδήποτε από τους τέσσερις τομείς (φυσικός, ψυχολογικός, κοινωνικός τομέας και περιβάλλον) μπορεί να προβλεφθεί από οποιαδήποτε από τις κοινωνικο-δημογραφικές

μεταβλητές. Διενεργήθηκε one sample t-test για τη σύγκριση των μέσων βαθμών ανά τομέα των προσφύγων που διαμένουν στη δομή του Ελαιώνα με μέσες βαθμολογίες από άλλες δομές και υπολογισμός της επίδρασης της διαφοράς αυτής μέσω του Cohen's d effect, προκειμένου να μεταφράσουμε αν οι όποιες διαφορές προκύψουν αντιστοιχούν σε μικρή, μεσαία ή μεγάλη επίδραση.

Αποτελέσματα

Κοινωνικο-δημογραφικά χαρακτηριστικά των ερωτηθέντων.

Επιτεύχθηκε ποσοστό ανταπόκρισης 98,9%, μιας και είχαμε μόνο 2 αρνήσεις σε πληθυσμό δείγματος 204 ατόμων. Σχεδόν διπλάσιοι άνδρες συμμετείχαν στη μελέτη 65,2% (N= 133) από ότι γυναίκες 34,8% (N=71). Η μεγάλη πλειοψηφία των ερωτηθέντων (86,9%) προέρχεται από τη Συρία και το Ιράκ, ενώ χώρες όπως Παλαιστίνη, Λίβανο, Υεμένη, Αίγυπτος, Σουδάν κ.α, ακολουθούν με μικρότερα ποσοστά. Η συντριπτική πλειοψηφία 95,6% των ερωτηθέντων βρίσκονταν στην αναπαραγωγική ηλικία (18-44 ετών). Στην οικογενειακή κατάσταση υπερέχουν οι παντρεμένοι (53,4%) των ελεύθερων (35,3%), εκ των οποίων η συντριπτική τους πλειοψηφία ήταν άνδρες (88,8% των αδέσμευτων). Ωστόσο αρκετά μεγάλο ποσοστό κατείχαν οι χήρες/οι (7,8%). Δεκαοκτώ άνθρωποι στην έρευνά μας δεν έλαβαν καμία απολύτως εκπαίδευση (8,8%), το 30% του δείγματος μας είχε ολοκληρώσει το δημοτικό σχολείο ή/και το γυμνάσιο, το 18,6% το λύκειο, ενώ μόλις το 13,7% είχε βαθμό τριτοβάθμιας εκπαίδευσης.

Τη χρονική στιγμή που διεξήχθη η έρευνά μας, 89,2% του πληθυσμού λάμβανε οικονομική βοήθεια, έναντι 8,8% που απήντησαν πως δεν λαμβάνουν καθόλου χρήματα, ενώ 4 άνθρωποι δεν έδωσαν καμία απάντηση.

Οι μέσες τιμές ανά τομέα προ, αλλά και μετά τη μετατροπή τους στην κλίμακα 4-20, (φυσικό, ψυχολογικό, κοινωνικό και περιβάλλον) στη δομή του Ελαιώνα βρέθηκαν σχετικά χαμηλές, σύμφωνα με τη μικρότερη και μεγαλύτερη τιμή που μπορεί να πάρει ο κάθε τομέας, ωστόσο υψηλότερες

από τις άλλες δύο δομές. Συγκεκριμένα οι μέση τιμή για το φυσικό τομέα ήταν 13.1064, για τον ψυχολογικό τομέα 12.0131, για τον κοινωνικό τομέα 12.9608, ενώ για το περιβάλλον 10.5637.

Σύγκριση με τον καταυλισμό του Σκαραμαγκά

Οι πρόσφυγες που κατοικούν στον Ελαιώνα, σημείωσαν υψηλότερη βαθμολογία στον Ψυχολογικό και Περιβαλλοντικό τομέα από ό, τι στο καταυλισμό του Σκαραμαγκά. Εμφανίζοντας μέτρια επίδραση με (Cohen's d) 0,498 και 0,459 αντίστοιχα, (0,30 - 0,49), ακριβώς κάτω από το όριο αποδοχής για μεγάλη επίδραση (0,5 - 1,0). Φαίνεται ότι οι ερωτηθέντες στο καταυλισμό του Ελαιώνα ανέφεραν ότι είχαν αρκετά χρήματα για να καλύψουν τις ανάγκες τους, ένιωθαν ασφαλέστερα στην καθημερινότητά τους και ήταν σχετικά πιο ικανοποιημένοι με τις συνθήκες του χώρου διαβίωσης τους, την πρόσβαση στις υπηρεσίες υγείας, τις μεταφορές και τις διαθέσιμες πληροφορίες στο χώρο, καθώς επίσης πως έχουν περισσότερες ευκαιρίες για ψυχαγωγικές δραστηριότητες από τους ερωτηθέντες στο καταυλισμό του Σκαραμαγκά κατά την περίοδο της έρευνάς μας. Φαίνεται πως το πλαίσιο που δημιουργήθηκε από τη διοίκηση του στρατοπέδου και τους επιχειρούντες φορείς, σε συνδυασμό με την κεντρική θέση του καταυλισμού του Ελαιώνα και τις καλές υπηρεσίες μεταφορών επέδρασσε ευνοϊκά. Οι κάτοικοι στον Ελαιώνα, επίσης σημείωσαν υψηλότερη βαθμολογία στο φυσικό τομέα και στις ερωτήσεις Q1 και Q2. Με Cohen's d 0,281 για το Physical, 0,4 για το Q1 και 0,292 για το Q2, υποδεικνύοντας ένα μικρό (0,10 - 0,29) αν και οριακά μέτριο αποτέλεσμα και μία σαφή μέτρια επίδραση όσον αφορά τον φυσικό τομέα. Υποδηλώνοντας πως οι ερωτηθέντες στον Ελαιώνα βαθμολόγησαν ελαφρώς καλύτερα τη συνολική ποιότητα ζωής τους και ήταν πιο ικανοποιημένοι από την υγεία τους και την πρόσβαση σε υπηρεσίες υγείας κατά τη διάρκεια της μελέτης μας. Ο τομέας των κοινωνικών σχέσεων δεν εμφάνισε στατιστική διαφορά ανάμεσα στα δύο στρατόπεδα.

Σύγκριση με το ξενοδοχείο υπό κατάληψη - City Plaza

Σε συνέχεια της προηγούμενης σύγκρισης, ο Elaionas και το City Plaza δεν εμφάνισαν στατιστική διαφορά στον τομέα των κοινωνικών σχέσεων, αλλά επιπλέον δεν εμφάνισαν στατιστική διαφορά στον τομέα του περιβάλλοντος. Ενώ εμφάνισαν μικρή επίδραση στο Q1 (2,43). Υποστηρίζοντας ότι οι κάτοικοι και των δύο δομών είναι εξίσου ικανοποιημένοι τόσο από τη συνολική ποιότητα ζωής τους όσο και από το περιβάλλον στο οποίο ζουν. Με τους κατοίκους του Ελαιώνα να εκφράζουν ελαφρώς μεγαλύτερη ικανοποίηση για το συνολικό QoL τους. Μια πιθανή εξήγηση θα μπορούσε να είναι ότι το City Plaza βρίσκεται εξίσου κοντά στο κέντρο της πόλης και ως εκ τούτου μοιράζεται το ίδιο φυσικό περιβάλλον με το καταυλισμό του Ελαιώνα. Ενώ και οι δύο δομές συνδέονται με καλές και τακτικές υπηρεσίες μεταφορών και καταστήματα. Ωστόσο, δεν μας δόθηκε άδεια να επισκεφθούμε τα δωμάτια στο City Plaza, γεγονός που αποτελεί πιθανό περιορισμό για περαιτέρω σχολιασμό και αιτιολόγηση αυτών των αποτελεσμάτων. Ένα βασικό εύρημα της έρευνάς μας είναι ότι οι κάτοικοι στον Ελαιώνα σε σύγκριση με τους κατοίκους του City Plaza σημείωσαν υψηλότερη βαθμολογία στον φυσικό και ψυχολογικό τομέα, καθώς και στο δεύτερο ερώτημα Q2. Εμφανίζοντας μεγάλη επίδραση (Cohen's d: 0,646) στο Q2 που αναφέρεται στο επίπεδο ικανοποίησης των ερωτηθέντων με την υγεία τους, μαζί με μια μέτρια επίδραση στον φυσικό και ψυχολογικό τομέα (Cohen's d: 0,479) και (Cohen's d: 0,459) αντίστοιχα. Υποδεικνύοντας ότι οι κάτοικοι του City Plaza αξιολόγησαν χαμηλότερα την ποιότητα και την προσβασιμότητα σε υπηρεσίες υγείας σε σύγκριση με τους κατοίκους του Ελαιώνα.

Συζήτηση

Στην παρούσα μελέτη διερευνήσαμε τα χαρακτηριστικά και συγκρίναμε την αυτό-αναφερόμενη ποιότητα ζωής των Αραβόφωνων προσφύγων που κατοικούν σε 2 από τους μεγαλύτερους καταυλισμούς στην περιοχή της Αττικής και σε ένα ξενοδοχείο υπό κατάληψη που οργανώθηκε και

διοικείται από ακτιβιστές και εθελοντές στο νομό Αττικής. Διαπιστώσαμε ότι η μέση βαθμολογία για τον καταυλισμό του Ελαιώνα και για τους τέσσερις τομείς WHOQOL - φυσική, ψυχολογική, κοινωνική, περιβάλλον - είναι σχετικά χαμηλή, ωστόσο, υψηλότερη τόσο από τον καταυλισμό του Σκαραμαγκά, όσο και από αυτή στο ξενοδοχείο City Plaza, σε όλους τους τομείς (εκτός από τον κοινωνικό τομέα). Εμφανίζοντας από μικρή έως μεγάλη στατιστικά σημαντική επίδραση, με τους περισσότερους τομείς να εμφανίζουν μέτρια επίδραση. Το ενιαίο αποτέλεσμα της μη εμφάνισης στατιστικά σημαντικής διαφοράς μεταξύ των τριών δομών στον κοινωνικό τομέα θα μπορούσε να εξηγηθεί από την ομοιογένεια του πληθυσμού του δείγματος της μελέτης μας και ενδεχομένως από την καλλιέργεια συναισθημάτων αδελφοσύνης μεταξύ του αραβόφωνου πληθυσμού. Ένας άλλος πιθανός ενισχυτικός παράγοντας θα μπορούσε να είναι οι ομοιότητες της μεσογειακής κουλτούρας, του κλίματος και της ιδιοσυγκρασίας με την Ανατολή, που πιθανόν καταστούν την Ελλάδα σα χώρα πιο οικεία στην κουλτούρα τους.

Επιπλέον, διαπιστώθηκαν διαφορές μεταξύ του καταυλισμού του Ελαιώνα και των άλλων δύο δομών στο επίπεδο της εκπαίδευσης, της κατάστασης υγείας κατά τον χρόνο της έρευνας και της παροχής οικονομικής ενίσχυσης.

Αξίζει να σημειωθεί, πως ο τρόπος με τον οποίο οι κάτοικοι του Ελαιώνα διατύπωσαν τις απαντήσεις τους με ακρίβεια, χρησιμοποιώντας τη σωστή ορολογία για την απόδοση των ασθενειών ήταν εντυπωσιακός. Οι πιο στοχευμένες απαντήσεις δόθηκαν από τους κατοίκους του Ελαιώνα σε σύγκριση με τις άλλες δύο δομές (πίνακας 5.b). Παρά το γεγονός πως ο μέσος όρος εκπαίδευσης του πληθυσμού στο καταυλισμό του Ελαιώνα ήταν χαμηλότερος από τις άλλες δύο δομές. Μία πιθανή εξήγηση θα μπορούσε να αποτελεί η πολύμηνη παραμονή του πληθυσμού στη χώρα (ως απόρροια του γεγονότος των καθυστερήσεων στα αιτήματα ασύλου και επανεγκατάστασης) και δη στον ίδιο καταυλισμό (παραμονή έως και 48 μήνες), σε συνδυασμό με τη σταθερότητα των φορέων υγείας (ΚΕΕΛΠΝΟ) όπου ήταν και είναι ο μοναδικός πάροχος παροχής

φροντίδας υγείας στον καταυλισμό από την έναρξή του. Είναι πολύ πιθανό ο αλφαβητισμός τους αναφορικά με την πάθησή που αντιμετωπίζουν και η ικανότητά τους να χρησιμοποιούν υπηρεσίας υγείας να αυξήθηκε, ως απόρροια της αυξημένης αλληλεπίδρασης με το ιατρικό προσωπικό και σε συνδυασμό με τις πολλαπλές επισκέψεις σε κέντρα υγείας, πολυκλινικές και νοσοκομεία. Καθώς επίσης στον Ελαιώνα είδαμε να εφαρμόζεται μία πρακτική συνοδείας των ασθενών από κοινωνικούς λειτουργούς και διερμηνείς, στις λοιπές δομές υγείας, σε μία προσπάθεια να τους βοηθήσουν να εξυπηρετηθούν, να γνωρίσουν το σύστημα υγείας της χώρας και να μάθουν να το χρησιμοποιούν. Ωστόσο, αυτή η υπόθεση χρήζει περαιτέρω διερεύνησης και πιθανότατα θα βοηθούσε η συλλογή επιπλέον στοιχείων όπως: αριθμός επισκέψεων στο ιατρείο της δομής/ σε άλλους φορείς υγείας/ πολυκλινικές/ νοσοκομεία.

Ένα άλλο βασικό συμπέρασμα αυτής της μελέτης ήταν ότι στον Ελαιώνα το 91% του πληθυσμού λάμβανε οικονομική βοήθεια, έναντι του 47,9% στο Σκαραμαγκά και του 10% στο City Plaza. Αυτή η απόκλιση αντικατοπτρίζεται επίσης στον ψυχολογικό τομέα, έχοντας μια μέτρια, οριακά μεγάλη επίδραση, σε σύγκριση με τις δύο άλλες δομές και τον περιβαλλοντικό τομέα, έχοντας και πάλι μια μέτρια, οριακά μεγάλη επίδραση αποτελέσματος, σε σύγκριση με το Σκαραμαγκά. Υποδεικνύοντας ότι οι κάτοικοι στον Ελαιώνα δήλωσαν ότι κατάφεραν να απολαύσουν περισσότερο τη ζωή τους και ένοιωσαν ότι είχαν αρκετά χρήματα για να καλύψουν τις καθημερινές τους ανάγκες. Αυτό φαίνεται να επηρεάζει την ψυχολογική τους κατάσταση προς το καλύτερο όπως αντανακλάται και από τις απαντήσεις τους.

Επιπλέον, το ποσό των χρημάτων που λαμβάνουν οι πρόσφυγες ως οικονομική ενίσχυση, κυμαίνεται ανάμεσα σε ένα εύρος που καθορίζεται από τη Greece cash Alliance, μία σύμπραξη μεταξύ της UNHCR και πέντε διεθνών μη κυβερνητικών οργανώσεων και είναι ενιαία έναντι όλων των προσφύγων που είναι επιλέξιμοι για αυτό, ανεξάρτητα από τη δομή και τις συνθήκες κάτω από τις οποίες ζουν στην Ελλάδα. Το ποσό που λαμβάνει ο κάθε πρόσφυγας και η κάθε οικογένεια είναι αναλογικό με τον

αριθμό των μελών της. Ωστόσο, καταγράφηκαν διάφορα χρηματικά ποσά, τα οποία έπεσαν εκτός της τυποποιημένης κλίμακας που καθορίστηκε από τους συντελεστές παρόχους και στις τρεις δομές (πίνακας 6.a). Υποδηλώνοντας ότι περισσότεροι άνθρωποι είτε δεν λαμβάνουν χρηματοοικονομική βοήθεια από τους επίσημους φορείς και ως εκ τούτου, το χρηματικό ποσό που υπέβαλαν στα ερωτηματολόγια ως απάντηση είτε εκφράζει οικονομική βοήθεια από κάποιο μέλος της οικογένειας στην πατρίδα ή στην Ευρώπη, είτε κάποια πηγή εισοδήματος που αποκτήθηκε νόμιμα ή παράνομα.

Περιορισμοί

Λόγω του συγχρονικού χαρακτήρα αυτής της μελέτης, τα ευρήματα αντικατοπτρίζουν μια κατάσταση σε μια συγκεκριμένη χρονική περίοδο και συνεπώς δεν μπορούν να γενικευθούν. Ο υποκειμενικός χαρακτήρας αυτών των μέτρων μπορεί να συσχετιστεί με προσωπικές εμπειρίες. Πιθανόν να υπάρχει μια τάση έκφρασης δυσαρέσκειας με σκοπό κάποιας μορφής διαμαρτυρίας ως προς μέτρα της τοπικής διοίκησης της δομής ή/και βελτίωση συνθηκών ή ακόμα και σε ένα ευρύτερο πλαίσιο, για να προωθηθούν διαδικασίες μετεγκατάστασης. Τέλος, το δείγμα στο City Plaza ήταν σαφώς μικρότερο από αυτό των άλλων δύο δομών ξεχωριστά.

Συμπεράσματα

Είναι η πρώτη φορά, τουλάχιστον εξ όσων γνωρίζουμε, όπου τα χαρακτηριστικά και πιθανές διαφορές στην ποιότητα ζωής των Αραβόφωνων προσφύγων που διαβιούν στη χώρα μας σε καταυλισμούς και αστικές περιοχές, διερευνήθηκαν.

Από την έρευνά μας διαπιστώθηκε ότι οι πρόσφυγες που κατοικούν στο καταυλισμό του Ελαιώνα βαθμολόγησαν σχετικά χαμηλά την ποιότητα ζωής τους, σύμφωνα με τις ελάχιστες και τις μέγιστες τιμές του ερωτηματολογίου WHOQOL-BREF. Ωστόσο, η βαθμολογία τους ήταν υψηλότερη από αυτή των άλλων δυο δομών σε όλους τους τομείς (εκτός από τον κοινωνικό), καθώς δήλωσαν πως είναι πιο ικανοποιημένοι από

την ποιότητα ζωής και την υγεία τους, σε σύγκριση με το καταυλισμό του Σκαραμαγκά και το ξενοδοχείο City Plaza. Φαίνεται να νοιώθουν πιο ασφαλής, πιστεύουν πως έχουν ένα υγιέστερο φυσικό περιβάλλον, αρκετά χρήματα για να καλύψουν τις ανάγκες τους, καλύτερη πρόσβαση σε υπηρεσίες υγείας, πληροφορίες και συστήματα μεταφοράς. Οι κοινωνικές σχέσεις δεν διέφεραν από δομή σε δομή, καθώς δεν αναπτύχθηκε στατιστικά σημαντική διαφορά ανάμεσά τους στον αντίστοιχο τομέα.

Βασικό εύρημα της μελέτης ήταν ότι οι κάτοικοι του Ελαιώνα, παρά το γεγονός ότι είχαν χαμηλότερο εκπαιδευτικό υπόβαθρο, ανταποκρίθηκαν με μεγαλύτερη ακρίβεια στο είδος της ασθένειας που είχαν (χρόνιες ή οξείες). Υποδεικνύοντας ότι η συνέπεια των πάροχων υπηρεσιών υγείας σε συνδυασμό με την πολλαπλή αλληλεπίδραση με αυτούς λειτούργησε βοηθητικά στους κατοίκους να επικοινωνούν βέλτιστα με τους επαγγελματίες υγείας τόσο εντός, όσο εκτός της δομής. Φαίνεται ότι οι συνεργατικές και διεπιστημονικές προσεγγίσεις μπορούν να προετοιμάσουν καλύτερα τους επαγγελματίες υγείας.

Ακόμη σημαντική παρατήρηση αποτελεί πως η οικονομική ενίσχυση που λάμβανε η συντριπτική πλειοψηφία του πληθυσμού στη δομή του Ελαιώνα, φάνηκε να επηρεάζει θετικά την ψυχολογική κατάσταση των κατοίκων, που δήλωναν πως ήταν σε θέση να απολαύσουν τη ζωή περισσότερο και αισθανόταν ότι είχαν αρκετά χρήματα για να καλύπτουν τις καθημερινές ανάγκες τους, συγκριτικά με τις άλλες δύο δομές.

Κάθε χώρα κατέχει και εφαρμόζει διαφορετικά συστήματα και πολιτικές υγειονομικής περίθαλψης σχετικά με την υποδοχή και την αντιμετώπιση των αναγκών και προσδοκιών των προσφύγων και των αιτούντων άσυλο. Η έλλειψη γνώσης του συστήματος υγειονομικής περίθαλψης συμβάλλει σημαντικά στις ανισότητες στον τομέα της υγείας, ιδίως για τους πρόσφυγες με περιορισμένη γλωσσική επάρκεια. Το χαμηλό επίπεδο γνώσεων για την υγεία αποτελεί σημαντικό εμπόδιο στην λήψη φροντίδας υγείας και την πρόληψη. Ένας αυξανόμενος όγκος έρευνας καταλήγει στην αυτό-αναφερόμενη QoL ως μέθοδο επιλογής για την αξιολόγηση

των κοινωνικών και περιβαλλοντικών συσχετισμών της υγείας, ειδικά στον ευάλωτο πληθυσμό, ο οποίος ζει υπό υπερβολικό και συνεχή άγχος και καταναγκασμό, όπως οι πρόσφυγες. Ωστόσο, λίγα ήταν γνωστά για το QoL των προσφύγων που ζούσαν στην Αθήνα-Ελλάδα. Η έρευνά μας αντιμετώπισε αυτό το κενό.

Επαναστατικά μοντέλα υγειονομικής περίθαλψης που λαμβάνουν υπόψη τις αντιλήψεις του πληθυσμού για τις πτυχές της ποιότητας ζωής, φαίνεται να είναι καλύτερα εξοπλισμένα να υπηρετήσουν τους κοινωνικούς προσδιοριστές υγείας και έτσι, έχουν περισσότερες δυνατότητες να μειώσουν τις ανισότητες στον τομέα της υγείας των προσφύγων και να προωθήσουν την ένταξη.

List of Abbreviations

UNHCR = United Nations High Commissioner for Refugees
EU = European Union
US = United States (of America)
QoL = Quality of Life
SDOH = Social Determinants of Health
WHO = World Health Organization
EKEPY = National Center of Operation for Health
KEELPNO = Hellenic Center for Disease Control and Prevention
ADYM = Individual Health Card of the Student
POC = Persons of Concern
WHOQoL = World Health Organization Quality of Life
WHOQoL-BREF = World Health Organization Quality of Life Brief (questionnaire)
WASH = Water, Sanitation and Hygiene
NFI = Non-Food Items
INGO = International Non-Governmental Organization