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Original Article

Identifying the quality of life in Afghan adolescent migrants in Turkey: A fieldwork with nursing diary perspective

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Abstract

Aim: This study aims to determinate Quality of life, from the perspective of nurses and Afghan Migrant children in Turkey.

Material and Methods: This study used method includes quantitative and qualitative nurses' diary. The research was conducted with Afghan children aged 14-18 (n=254) and 20 nurse practitioners. Socio-demographic questionnaire and Short Form Health Survey (SF-36) were utilized as a quantitative data. Qualitative data collected by nursing diary to explain the quality of life of migrant children.

Results: Socio-demographic data collected the study for 218 houses as 1.841 Afghans and study samples. SF-36 mean scores were 72.80±1.45 in the physical functioning, 71.80±1.27 social functioning, 78.46±2.36 in the physical problems, 82.28±2.13 in the emotional problems, 67.10±0.84 mental health, 56.34±0.97 in the energy and vitality, 70.62±1.39 in the bodily pain and 56.25±0.87 in the general perception of health. As a result of observing the selves and Afghans population, and reflecting on them by diaries, the nurse practitioners have raised plenty of concerns about their condition of life and faced with many cultural difficulties.

Conclusion: This study has provided evidence Afghan migrants have a low quality of life which was affected by cultural and social resources.

Keywords: Adolescent; afghan; migrant; nurse; quality of life.

INTRODUCTION

Afghans' migration to other countries has increased significantly in the last decades depend on socio-economic difficulties and a prolonged conflict in Afghanistan (1). Turkey has been used a place of permanent residence for some of them since 1982.

Migrating families may have been exposed to extreme conditions that reduce their capacity to adapt to new environments and affect their quality of life. Financial responsibilities, financial challenges, and unemployment can make residential instability more unbearable so it causes anxiety for family members (2-7). Migrant families face a range of difficulties that can influence child-rearing methods, correspondingly trauma experience, separation of family members and country, changes in family roles, and poor access to healthcare and education. Cultural differences in migrant families' children in child-rearing practices have limited quality of life because of a lack of cultural information (4,8-11). Therefore, migrant children have a critical prescription for migrant populations. The migration of Afghans is almost ¼, the monthly statistics of children aged 0-17 in 2017 (12).

Maintaining quality of life and good health can be very difficult for many immigrants. Measuring the health condition of a migrant population is not only about mortality and morbidity, but additionally concerns the assessment of Quality of Life (QOL) (13,14). Quality of Life is a multi-dimensional concept, which contains critical areas such as psychological wellbeing, social relationships, personal beliefs, economic circumstances, physical health and their relationships to invincible features of the environment. Migration health especially QOL for children has become an important area among the field of medical sciences (3,8,15). It is very important for nurses to care for these needs and know how to recognize the problems of youth with a refugee background (15). In addition, there is a need

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for complex data involving different perspective for use mix method research in fieldwork.

Home visiting is an important and long-standing nursing process. Despite general consensus about the benefits of home visiting in public health, little investigation of the home visiting process has been performed. In order to achieve the benefits of nursing diary perspectives and identifying the health necessities of migrant children that are often oversight need to be prioritized the healthcare visits (5,16-18). Although well-child health care visits are beneficial in identifying health problems early, there has been limited research on children from refugee backgrounds for using these services. A recent study was carried out in order to determinate the quality of life, from the nurses' point of view and Afghan Migrant children in Hatay/Turkey. The aim of study is to determinate the quality of life in Afghan adolescent migrants from the perspective of nurses in Turkey.

MATERIAL and METHODS

Study design

A mixed-methods strategy includes quantitative and qualitative nurses' diary was used within recent research in fieldwork. The quantitative points of the study searched level of quality of life on migrant children; whereas the qualitative point of the current study explored the observations of nurses according to the diary that was noted by the nurse practitioners home visit. This strategy consents the efficacy of quality of life to be evaluated from various perspectives.

Participants

The research was conducted with 254 Afghan children. Nurse practitioners (n=20) were also contacted in order to capture their reflections of life situations. This study as a fieldwork completed in 12 weeks between February-April 2014 with 20 nurses as home visits at 218 houses in Afghan region in Hatay. Households (1841 people) were considered as study samples. The ones that between 14 and 18 years of age were accepted from each household. Ability to understand/speak Turkish and being developmentally appropriate for age were the inclusion criteria to determine the samples. The target sociodemographic of this study was 0 to 95-year-old Afghan population admitted living in Hatay.

Data Collection

At present study, the sociodemographic questionnaire and SF-36 were utilized as quantitative data. All data were collected by 20 nurses with supervision by researcher (ET). Trained nurses who are 6th semester nursing students as volunteer researchers visited two hundred eighteen houses and informed the persons such as between to 14 from 18 ages in 1841 household, about the quality of life and socio-demographic information. End of the day, nurses diary was noted the knowledge quality of life of migrant children. In this way, qualitative data collected in this study.

Demographic Questionnaire

The demographic questionnaire included such as name-surname, gender, age, relationship with family, education, and occupation, income (9 items) (Table 1). (Insert table 1 here)

Table 1. Socio-demographic data for the household and study sample

Sociodemographic Factors	Household N (%)	Study sample N (%)
Totals	1841 (100)	254 (100)
Sex		
Female	875 (47.5)	171 (67.3)
Male	966 (52.5)	83 (32.6)
Education level		
None	763 (41.4)	
Informal education	186 (10.1)	
Primary	475 (25.8)	10 (3.9)
Secondary	296 (16.1)	229 (90.1)
High school	110 (6.0)	15 (5.9)
University	11 (.6)	
Turkey Citizen for Afgan		
Yes	1648 (89.5)	
No	193 (10.5)	
Relationship with family		
Father	230 (12.5)	
Mother	220 (12.0)	
Son/Dautgher	984 (53.4)	254 (100)
Grandfather/Grantmother	25 (1.4)	
Brother	25 (1.4)	
Mother-in-law/ Father-in-law	9 (.5)	
Son-in-law /Dautgher-in-law	90 (4.9)	
Grandchild	232 (12.6)	
Another person	26 (1.4)	
Job	10 (.5)	
Officer	247 (13.4)	
Worker	557 (30.3)	
Student	839 (45.6)	
Unemployment	188 (10.2)	
Another		
Household income (TL)		
<599 (very bad)	1643 (88.2)	
600-999 (bad)	145 (7.9)	
1000-1999 (fair)	67 (3.6)	
>2000 (good)	6 (.3)	
Income status		
Regular salary	695 (37.8)	
Owner job	56 (3.0)	
Agriculture	31 (1.7)	
Another	1059 (57.6)	

Questionnaires and scaling

SF-36 was found by Ware et al in 1993 to measure the quality of life. SF-36 has been both adapted and translated into the different cultures and languages to compare data about health status globally. (19). It's demonstrated that social factors such as social class and disease status in population surveys and primary care settings were sensitively measured by SF-36. (20). SF-36 use general population between 14 ages and upper. Validation studies of the Turkish version of SF-36 and translation of SF-36 into Turkish were performed in patient groups and urban population in 1999, 2005, 2006 (20-22). The reliability and construct validity of the scale was Cronbach's alpha coefficients surpassed the .70 criterions for all subscales indicating good internal consistency. Results showed that the stability coefficients for subscales of the scale ranged between .81 and .94. Principal components factor analysis with varimax rotation confirmed the Turkish version of the SF-36 is a suitable instrument that could be employed in Turkey (22). The scale included 36 items as a short form questionnaire. There is eight domains that health-related quality of life, such as, social (SF), physical functioning (PF), role limitation due to physical (RP) and emotional problems (RE), energy and vitality (VT), bodily pain (BP), mental (MH) and general health (GH). The scale also includes an item to assess changes in the respondent's health status during the past year. For each item using the standard SF-36 scoring, algorithms were tested, coded, and transformed into a scale from 0 (worst) to 100 (best) (19).

Ethical Considerations

Verbal information was provided to the children and the permissions of participating were obtained. Moreover, nurses who were the important part of this study by providing their experience of the process also gave their consent to participate in this study. Mustafa Kemal University Ethics Committee provided ethical approval for this study (Ethical approval number: 10.11.2014/205).

Data Analysis

The quantitative data were entered and analyzed in SPSS 15 windows packet program. Test of homogeneity of variances is acknowledged normal according to skewness and kurtosis (-2/+2) values (23). Variables data as a sex, age, education were examined Independent t-test, ANOVA and Tukey test. We set the alpha level of significance for .05. The qualitative data was content analyzed by two independent researchers using thematic analysis.

RESULTS

Sociodemographic data collected the study for 218 houses as 1841 Afghans people who were between to 0 from 95 ages; and 254 study samples for eligible people, i.e. 14-18 years old and 67.3% girl. The mean age of the household was 22±18.47 and 47.5% were women. There was a complex relationship between household as extended family in the house such, grandfather/ grandmother, mother-in-law/father-in-law, son-in-law/ daughter-in-law, grandchild and 1.4% another person (see detail Table 1). The mean people of the household per each house were 8.44±3.73 (min=3, max=26). There were 2 schools that are primary and secondary in the Afghan region. Most of the study sample graduated from secondary school (90.1%). The majority of the household were none education (41.4%), unemployed (45.6%), with unstable income (57.6%) and their income as 'very bad' (88.2%).

Study sample data were obtained PF scores (72.17±1.45), SF scores (71.80±1.27), RP scores (78.46±2.36), RE scores (82.28±2.13), MH (67.10±.84), energy and VT scores (56.34±.97), BP scores (70.62±1.39), and GH scores (56.25 ±.87). Study sample scores were well below indices observed in the Turkish general population (20).

Afghans girl showed poorer health when compared with men for all quality of life variables (Table 2). A significant difference was observed at PF scores (t (252):7.61, p=.014), RE scores (t (252):10.209, p=.025), VT scores (t (252):5.88, p=.004), MH scores (t (252):4.91, p=.006), BP scores (t (252):6.86, p=.021) and GH scores (t (252):3.91, p=.036) in favour of Afghans boy. There were no significant differences SF scores (t (252): 4.08, p = .134) and RP scores (t (252):9.19, p=.06) for Afghans children sex. (Insert Table 2 Here)

Table 3 showed mean (SD) values of SF-36 variables by age groups. There was no significant difference between age groups at SF-36 domains with Post- hoc analysis including Tukey and ANOVA tests. Similarities were identified in education levels of Afhgans children. As seen in Table 3, while there was no significant difference between education level at SF-36 domains with statistical analyzes. (Insert Table 3 here)

Table 2 . Mean (SD) scores for eight variables of SF-36 for sex

Variables (N)	Girl (n = 171) Mean ± SD	Boy (n=83) Mean ± SD	P*
SF (254)	70.47±20.4	74.55±19.9	.134
PF (254)	69.68±23.9	77.29±20.4	.014*
RP (254)	75.45±39.7	84.65±32.6	.068
RE (254)	78.95±36.3	89.16±27.6	.025*
VT (254)	54.42±15.4	60.30±14.9	.004*
MH (254)	65.50±13.1	70.41±13.6	.006*
BP (254)	68.38±22.4	75.24±21.3	.021*
GH (254)	54.97±14.2	58.89±12.9	.036*

*Independent t-test (.05)

Table 3. Mean (SD) scores for eight variables of SF-36 for age and education

Groups (N)	SF Mean (SD)	PF Mean (SD)	RP Mean (SD)	RE Mean (SD)	VT Mean (SD)	MH Mean (SD)	BP Mean (SD)	GH Mean (SD)
14	70.83 (23.5)	67.29 (28.3)	71.88 (43.8)	73.61 (40.5)	50.63 (16.1)	64.00 (14.)	66.15 (25.3)	51.04 (15.5)
15	70.38 (20.6)	69.78 (25.2)	74.46 (38.5)	76.81 (35.7)	56.30 (17.0)	68.00 (13.)	69.78 (25.4)	56.52 (15.3)
16	72.60 (16.6)	75.67 (18.7)	85.59 (30.6)	86.54 (30.4)	57.98 (16.8)	67.85 (13.3)	74.28 (18.8)	59.21 (12.9)
17	75.89 (18.8)	75.93 (20.9)	83.25 (35.)	89.05 (28.2)	57.36 (13.)	66.00 (14.4)	74.68 (20.9)	56.49 (11.9)
18	67.94 (22.9)	68.63 (24.4)	72.58 (42.1)	78.49 (37.7)	56.05 (15.5)	68.26 (12.8)	65.32 (21.8)	55.31 (14.8)
14-18	71.80 (20.3)	72.17 (23.1)	78.46 (37.7)	82.28 (34.)	56.34 (14.)	67.10 (13.4)	70.62 (22.2)	56.25 (13.9)
P*	.352	.397	.426	.203	.173	.576	.273	.677
Primary	81.25 (22.2)	78.5 (19.3)	70.00 (42.1)	83.33 (36.)	57.00 (19.8)	69.6. (16.7)	75.25 (23.2)	54.17 (14.5)
Secondary	71.51 (20.4)	72.14 (23.3)	78.72 (37.4)	82.24 (33.8)	56.29 (15.4)	67.07 (13.4)	70.64 (22.4)	56.42 (14.)
High School	70.00 (17.5)	68.33 (22.9)	80.00 (41.4)	82.22 (37.5)	56.67 (14.7)	65.87 (11.9)	67.17 (20.1)	55.00 (13.3)
P*	.231	.397	.714	.995	.990	.693	.532	.882

*Post Hoc=Tukey Alpha (.05)

Qualitative Results

Nurses' diaries were gathered in-depth feedback on Afghan populations' conditions of lives in Hatay. Four main themes were identified, these are: 'Difficulties about fieldwork', 'Cultural practices and especially girls' cultural obstacles', 'Genetic diseases and harmful habits prevalence', 'Low living conditions including education, play activities, social restrict, job obtain'.

Difficulties about fieldwork: Nurses felt uncertain about home visits, cultural differences, concern to meet their personal needs. The fear of the "unknown" that comes with moving to a new and unfamiliar area was the main problem for them. But then they started to get used to working with Afghan families and their culture with the day a day.

This is the first time we have undergone training out of the hospital. When we first went there, it took us a lot of time to get used to it, because it was a very different place. But now we are happy to be here (OKK, Nurse).

I've seen real happiness with the help of this project. I'm honored and proud to be on this project. Thank God, I'm in this Project (SC, Nurse).

Cultural practices and especially girls' cultural obstacles: Cultural differences were also perceived as challenges that should be considered in the equality of life for Afghans girl. Nurses noted many of the traditional practices harmful to health which was applied to children. Nevertheless, the reason for the effectiveness of nurses in calming the anxieties of the Afghans may be that they are sensitive to potential cultural differences. Nurses tried to make the children feel comfortable by establishing eye contact, sitting with them and even playing games with them. To meet the many needs of migrants' population there was strong social support and knowledge the traditional harmful practices from the nurses for children.

The heart of a person can be warmed by the smile of a child… If you enter children's home, you really understand them. I really think we've touched the girl children's lives (SK, Nurse).

It really has taught me lots of things. I've learned about children from different cultural and traditional habits. I worried about girls but they can get happiness out of very small things (ÇA, Nurse).

Genetic diseases and harmful habits prevalence: Cost and access to health services were the significant problems of health care. Not only individuals could afford to see a health care provider, but also there was to afford the medication for treatment. Nurses have indicated high the harmful habits prevalence between Afghans adolescent. Nurses suggested Afghans migrant that it would be beneficial for them to learn what programs and support services were eligible to them rather than feeling as though they are leaving them isolated.

I don't believe in this health situation. There is a lot of diseases. I amazed high prevalence substance use between Afghans adolescent. I think they have huge free time but there is nothing in there (RK, Nurse).

Low living conditions including education, play activities, social restrict, and job obtain: Nurses practitioners were clearly not happy with their employment and financial situation of the Afghan population. There were low levels of family relationships satisfaction, household members' number, and social activity for children. It's reported that home visiting sessions were critically important for examined QOL.

It's [to access health care] not easy. There is income, no education, no job. There is nothing I can do (BA, Nurse).

I'm 22 years old and I live in the same city with Afghani girl. I don't know this there life…I am lucky but not there. …I worry about it? (SS, Nurse).

As a result of observing the selves and Afghans population, and reflecting on them by diaries, the nurse practitioners have raised plenty of concerns about their condition of life and faced with many cultural difficulties.

DISCUSSION

In a recent survey, Afghan migrants were shown to have a complex relationship within and among families. There were so many people in the same house with a maximum of 26 people and now new people continue to join the Afghan family. It will say this situation affected negatively the quality of life among household who were no regular income and job. On the contrary, Crabtree, 2010 indicated that when refugees live with more family members it may enhance their ability to cope, positively affecting their QOL. The study showed that migrant children have no high education and social activities that they need good development (6). Studies also reported that education, cultural domains, life satisfaction, quality of situation in the house, household income and local health services quality were also critically associated with child quality of life (4,5,24,25).

The quality of life of Afghan migrants in Hatay is of particularly interesting because the region has a lower quality of life than other parts of Turkey (6,20). Our study was unique in that it is the first paper about the quality of life utilization patterns among Afghans migrant between 14-18 ages in Turkey. In addition, although it was more difficult to assess children's quality of life than adults, our study has also supported this data with nurses' theme such as 'Low living conditions including education, play activities, social restrict, job obtain' (26). The study (27) indicated these values and perspectives that social events are based on culture and, as such, resistant to changes. Social standards' inequalities and cultural domains occurred among migrant, may cause to low their health and quality of life (2,5,7,16,27).

In recent research, Afghan girls reported being having lower health compared to boys for all parameters in quality of life and supported qualitative data as a theme 'Cultural practices and especially girls' cultural barriers. Culturally congruent researches are required to clearly understand the health needs or QOL of migrants (5,10, 13). The study (5) highlights the need for social and mental health services based on culture. Similar findings of gender were showed from research on the Malaysian and Turkish migrants, where females result lower than males in the measured QOL scales (3). But another study not supported relationship of QOL with gender (16,17).

Last research demonstrated that migrant population has had a lot disease including genetic disease, hepatitis B, posttraumatic stress, sexual infections, maternal and child health issues (4,8,10). Health-related life quality was based on the way patients and parents provided treatment options and their access (28). In additional migrant population used the traditional approach in health (5,10,18). Understanding how migrants' express life may need to be revealed culturally. In our study is very clearly between QOL data with cultural context. A sum that cultural contention, difficulties of understanding a new language, lack of awareness of available services and lack of health provider which is not understanding of the complex health needs of migrants can all lead to inhibited access to healthcare.

The recent research has multidimensional aspects. The study used a mixed-method design for evaluating the quality of life which provided both breadth and depth of evidence. Mixed method approaches are a frequently used method in recent years (29,30). This study was performed in the Afghans town where fieldwork resources are limited. This study concurs with the literature that used method is feasible and effective.

The study is the first study on this subject in Turkey. The study showed Afghan migrants' different aspect to life also. There is need to a lot of researches for the migrant life in different regions.

Limitation of the Study

This study has limitations. Our sample is Afghan migrants in Hatay. Nevertheless, SF-36 scores should not be interpreted in comparison to the population-based means; but rather, they should be interpreted according to 14-18 ages. A final limitation is that results may not be generalized to all immigrant groups.

CONCLUSION

In conclusion, this study shows that the quality of life of Afghan immigrants in Hatay is low and the quality of life is determined by a number of factors such as having cultural and social resources. We hope that the data obtained from this study will indicate health policies towards Afghans at greatest risk of health and QOL. We recommend further studies to include other factors that play a role in the QOL of migrants, especially ethnic differences, coping with the new environment and job and financial security.

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