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Undocumented migrants' life situations: an exploratory analysis of quality of life and living conditions in a sample of undocumented migrants living in Norway

Running title

Undocumented migrants' quality of life

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Author contribution

Trine Myhrvold is the project leader and manager with the main responsibility for the implementation of the project, for financing, data collection and analysis of the results, formatting of the tables and principle author of the manuscript.

Milada Cvancarova Småstuen has with her statistical expertise contributed to the analysis of results, formatting of the tables and drafting of the manuscript.

Ethical approval

Based on conditions specified in the article, we made an application to the Regional Committees for Medical and Health Research Ethics South-Eastern Norway. The Committee did not raise objections to the project. The reference number is 254735**.**

Aknowledgements

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Conflict of Interest

There are no known conflicts of interest associated with this publication.

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Oslo, 11th of October, 2018

Sign

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ABSTRACT

Aims and objectives

To gather insight in conditions important to an understanding of undocumented migrants' life situations and more specifically to explore undocumented migrants' quality of life and how we can understand the various domains of quality of life related to demographics, living conditions, migration history and inflicted burden.

Background

Undocumented migrants suffer from economic hardship and acculturative stress, limited psychological and social support and at the same time restricted access to health care and social welfare.

Design

An exploratory mixed methods design using primarily quantitative data with a qualitative component was implemented.

Methods

Sosiodemographic data on 90 undocumented migrants were collected and self-report questionnaires on quality of life and psychological distress were completed, supplemented by qualitative data obtained through interviews and additional qualitative questions. The STROBE checklist for cross-sectional studies was used for reporting this study.

Results

Quality of life in our group of undocumented migrants was poor. Leaving their home country because of war or persecution, hunger, having experienced abuse, homelessness and higher

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age were statistically significantly associated with poorer quality of life. Having membership in a local association and having a partner were statistically significantly associated with better quality of life. Qualitative data indicate that marginal living conditions, fear of death and suffering and conditions associated with dependency were the main components comprising the burden to our respondents, reflecting their precarious juridical status as undocumented migrants.

Conclusion

Our respondents' poor quality of life was related to the complex interplay between possible exposures to traumatic experiences before and during flight and post-migration traumatisation in relation to our respondents' experiences of economic, social and acculturative hardship in Norway.

Relevance to Clinical Practice

Responses called for to improve undocumented migrants' quality of life and eliminate barriers to their health care appeal more to nurses as a professional group and to those in positions of authority than each individual nurse on duty.

Keywords

Undocumented migrants, quality of life, World Health Organization Quality of Life- BREF, psychological distress, Hopkins Symptom Checklist-25, social justice

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INTRODUCTION

Undocumented migrants are understood here according to the Platform for International Cooperation on Undocumented Migrants (PICUM) as “migrants without a residence permit authorizing them to regularly stay in the country of destination” (PICUM, 2007, p. 5).

The aftermath of the Western world’s financial crisis and the simultaneous unresolved global refugee problem have caused concern for a number of reasons. First, the situation is reflected in an increasing number of people falling outside of the labour market followed by unsatisfactory living conditions, an increasing number of people suffering from mental health problems, outbreaks of infectious diseases and unmet health care needs in Southern Europe (Karanikolos et al., 2013).

Second, the increasing number of refugees is exerting pressure on the health services and social welfare system in the Western world. Altogether more than 1.5 million additional people have unmet needs for health care since the beginning of the financial crisis (Reeves, Mckee & Stuckler, 2015). Those affected the most are people already in a difficult position. As a consequence, there is increasing polarisation between the need for safety and well-being for the majority/host population and the need for safety and well-being for individuals and groups with precarious juridical status in society, such as asylum seekers and undocumented migrants.

The Nordic countries are small and transparent, characterised as welfare states in which the right to health and social care is considered a human right. We do not have large groups of “working poor”, and there are no large groups of migrants traditionally connected to the black labour market. Additionally, here in Norway, the unresolved global refugee problem has raised questions concerning how much we are willing to pay for various measures for those who immigrate, as well as making them more pressing and relevant. Protection of our

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welfare states is a dominant argument for restricted access to health and social care for undocumented migrants in the Nordic countries.

BACKGROUND

Quality of life in refugee population groups

There is profound knowledge about refugees' cumulative vulnerability to complex mental health problems related to exposure to traumatic experiences before and during flight and experiences of economic, social and acculturative hardships in host countries. The interdependency between an individual's vulnerability and his or her material and psychological security might also explain the importance of satisfactory living and housing conditions, social support and acculturation for quality of life and well-being in refugee populations internationally (Akinyemi, Owoaje, Ige, & Popoola, 2012; Araya, Chotai, Komproe, & de Jong, 2007, 2011; Aziz, Hutchinson, & Maltby, 2014; Goodkind et al., 2014; Sulaiman-Hill & Thompson, 2011) and in the Nordic countries (Buhman et al., 2014; Carlsson, Olsen, Mortensen, & Kastrup, 2006; Teodorescu et al., 2012).

More specifically, poorer quality of life has been associated with unemployment, weak social networks and poor social integration in traumatised refugees in the Nordic countries (Carlsson et al., 2006; Teodorescu et al., 2012), potentially traumatic experiences and human rights violations during childhood among refugees in Norway (Opaas & Varvin, 2015) and poor mental health and weak occupational status compared to professionals among refugees in Nigeria (Akinyemi et al., 2012). Conditions found to improve mental health and ease post - migration stress include social support, acculturation and command of the language for African refugees in the United States (Goodkind et al., 2014). Better living conditions,

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including accommodations making private life possible, and at the same time, protecting them from pests, were reported to improve quality of life in Ethiopia (Araya et al., 2011).

Research on quality of life among undocumented migrants has been sparse. As one might expect, the few previously published studies have shown that satisfactory living conditions and social support also impact quality of life and mental health in undocumented migrants (Coffey, Kaplan, Sampson, & Montagna, 2010; Kuehne, Huschke & Bullinger, 2015). For undocumented migrants, this interplay is related to and reinforced by their precarious juridical status. Their subjective experience of injustice, isolation and hopelessness is in turn a consequence of this status (Coffey et al., 2010).

Theoretical framework

Promotion of health equity for all people, the improvement of daily living conditions, a healthy environment, fair employment and decent work, social protection and access to health care regardless of an individual's status or lack thereof are regarded as necessities according to World Health Organization (WHO) Commission on Social Determinants of Health (WHO, 2008). Undocumented migrants' very status of illegality does not allow for participation in the host society on an equal basis, reducing the likelihood of satisfactory living conditions and preventing rehabilitation and integration.

In the course of our history, some selected groups have been treated as inferior in terms of not being protected by the same moral norms as other groups (Beauchamp & Childress, 2009). Those who are afforded either lower or no moral status have inevitably fewer or no rights (ibid, p. 64). Systematic discrimination based on group affiliation, including in this context the lack of a residence permit, when at the same time there are

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existing resources that could relieve the situation, represents social injustice regardless of the characteristics or traits of the person that cause the restrictions (Power & Faden, 2006). Undocumented migrants' precarious juridical status therefore seems to be fundamental for their poor health and well-being, exacerbated by limited access to care (Kuenhe et al., 2015; Myhrvold & Småstuen, 2017).

The complex interdependency between individuals' vulnerability and economic, social and cultural conditions mediated by the wider socioeconomic and cultural environment is important for our understanding of public health (Dahlgren & Whitehead, 2007). Social inequality in health is a vital concern in public health efforts. Thus, improving public health must benefit the least advantaged in society (ibid). Such an understanding is in agreement with nurses' fundamental responsibilities included in the International Council of Nurses' Code of Ethics for Nurses: to promote health, to prevent illness, to restore health and to alleviate suffering (International Council of Nurses, 2012). Moreover, the Code further states that " nurses share with the society the responsibility for initiating and supporting action to meet *the health and social needs* of the public, *in particular those of vulnerable people*" and the responsibility to advocate "for *equity and social justice* in resource allocation, *access to health care* and other *social and economic services*" (ibid, our italics).

The ambition to achieve health equity therefore raises questions regarding the issues that should be included in the discussion of the ethical foundations of public health. Social justice is concerned with conditions of importance to individuals' well-being necessary for a decent life for everyone, regardless of group affiliation, of time and space, and personal preferences and ambitions, as reported by Power and Faden (2006). In addition to health, conditions of importance include personal security, reasoning, respect, attachment, and self-

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determination (ibid). These dimensions cannot be accounted for thoroughly here. What is important is that each individual is respected as a moral equal, such as being granted access to health and social care, living without threats against one's own physical and psychological integrity, having the opportunity to learn the necessary skills to be able to support oneself and one's family wherever one is living, having self-respect and respect for others, experiencing a sense of belonging, and having a certain degree of influence over one's own life.

In summary, these conditions reflect the dimensions of life that, when absent, might initiate flight and migration and that are missing or threatened for undocumented migrants. In addition, undocumented migrants experience restricted access to health and social care. In Norway, access to health and social care is, with few exceptions, restricted to emergency health care services, although the United Nations' International Covenant on Economic, Social and Cultural Rights (ICESCR) was included in the law on Human Rights, which took precedence over other Norwegian laws in 1999.

The restrictions on access to health and social care have been criticised by the United Nations' Committee on Economic, Social and Cultural Rights (2013). The committee recommended "that the State party take steps to ensure that irregular migrants have access to all the necessary health-care services, and reminds the State party that health facilities, goods and services should be accessible to everyone without discrimination", in line with the right to health of the United Nations' ICESCR (1996).

To deprive certain groups, in this context undocumented migrants, of their opportunity to meet their basic needs not only breaches fundamental human rights understood as each individual's rights without exception, but it also breaches the understanding that the

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protection of human rights is first and foremost relevant for vulnerable individuals and groups (Larchanché, 2012; Viladrich, 2012). We can therefore conclude that restrictions related to the health care provided to undocumented migrants infringe on the duties of health professionals to provide health care based on needs (Larchanché 2012; Myhrvold & Eick, 2010; Viladrich 2012).

In this paper, a second part of the study "Undocumented migrants' mental health, quality of life and living conditions" is discussed. The first part of this study, exploring the respondents' mental health care needs, revealed that our group of undocumented migrants suffered from extremely high levels of psychological distress, indicating a need for additional diagnostic evaluations and mental health care and living conditions so marginal that their day-to-day existence was threatened (Myhrvold & Småstuen, 2017). To broaden our understanding of circumstances of significance to their lives, the second part of this study explores how our group of undocumented migrants perceives its quality of life and how we can understand the various domains of quality of life related to salient features in these people's environment.

Quality of life is understood here according to the definition provided by the World Health Organization Quality of Life Group (WHOQOL Group) as "individuals' perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations, standards and concerns" (WHOQOL Group 1996, p. 4).

Necessities for a decent life, as described above, are in agreement with facets such as reasoning, level of independency, personal security and access to health and social care incorporated within either of the quality of life domains of physical health, psychological

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health, social relationships or environment included in the quality of life concept by the WHOQOL Group (Power & Kuyken, 1998, p. 1570).

Embedded in a cultural, social and environmental context, perceived quality of life is a means of measuring the effects of circumstances of significance for respondents' lives (WHOQOL Group 1996). In our opinion, perceived quality of life is therefore an important phenomenon to assess in our efforts to attain a deeper understanding of undocumented migrants' life situations. Our knowledge of undocumented migrants' quality of life is, however, strikingly sparse.

Aims and objectives

The overall purpose of this paper is to gather insight into the conditions important to understanding undocumented migrants' life situations. More specifically, the aims are to explore undocumented migrants' quality of life, determine how we can understand the various domains of quality of life related to salient features in their environment and shed light on the circumstances of significance regarding why our respondents continue to stay in Norway.

METHODS

Design

A mixed methods approach using primarily quantitative data with a qualitative component was implemented. The STROBE checklist for cross-sectional studies was used for reporting this study (see Supplementary File 1).

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Setting and participants

The respondents were recruited, and the study was conducted at the Health Centre for Undocumented Immigrants in Oslo (HC), a place that represented security and help for the respondents. Informational letters with a presentation of the project and the project leader, including *inter alia*, contact information, were available in the waiting room and were also placed on the information board at the HC for as long as the study was in progress.

Included in the study were adult undocumented migrants with the competency to provide their consent. The largest language groups at the HC, in addition to Norwegian and English, were selected in advance. These languages were Pashto, Mongolian, Farsi, Amharic and Somali. One-third of our respondents completed the questionnaires in Norwegian or English. Excluded from the study were minors and patients with problems of such a nature that their competency to provide consent could be questioned. Completion of the forms took approximately one hour. It took approximately one additional hour to gather supplementary qualitative data. In total, 90 patients consented. The sample was one of convenience.

Some respondents chose to skip selected questions. The total number of respondents per item is indicated in the tables.

Data collection was performed from January to March 2013.

Measures

Demographics, living conditions, migration history and inflicted burden

The self-reported questionnaire on sociodemographic characteristics, migration history and inflicted burden was based on a quantitative questionnaire designed by the International

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Centre for Migration and Health in Geneva and was prepared for use in Norway by the Norwegian Centre for Minority Health Research, and it was kindly made available by these research centres upon request.

World Health Organization Quality of Life-BREF (WHOQOL-BREF)

The WHOQOL-BREF is an abbreviated 26-item version of the World Health Organization's Quality of Life-100 (WHOQOL-100). The WHOQOL-BREF contains one general question about quality of life, one general question about how satisfied respondents are with their own health and 24 questions related to four domains; physical health, psychological health, social relationships and environment (WHOQOL Group 1996).

The WHOQOL-BREF was developed as a cross-cultural instrument and is considered to have high validity and reliability (ibid). The WHOQOL-BREF was chosen because it is considered to express the individual's subjective experience and to provide a general assessment of the individual's life situation.

The items are rated on a five-point Likert scale using the following possible responses: "Not at all-Completely", "Very poor-Very good", "Very dissatisfied-Very satisfied", "Not at all-An extreme amount", and "Never-Always". Higher scores indicate better quality of life. Cronbach's alpha for the WHOQOL-BREF in the present study was 0.904 for the total scale, 0.784 for physical health (domain 1), 0.775 for psychological health (domain 2), 0.693 for social relationships (domain 3), and 0.708 for environment (domain 4).

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Originally the WHOQOL-100 consisted of two more domains: one domain related to independence and one related to spirituality. These domains are particularly relevant for undocumented migrants who suffer from powerlessness, dependency and acculturative stress.

However, the domain related to independence consists only of four questions and the spirituality domain of only one question in the WHOQOL-BREF. In addition, there are already a limited number of three questions related to the social domain in the WHOQOL-BREF. Moreover, during the development of the WHOQOL-BREF, empirical evidence showed that the independence and spirituality domains were associated with the physical and psychological domains, respectively (Skevington, Lofty, & O'Connell, 2004). The research relevant for this study used only four domains in their analyses; therefore, doing otherwise would make it even more difficult to compare our results with the available literature. Based on the above considerations, we concluded that further division into six domains would not be expedient, and we present the results based on the WHOQOL-BREF by four domains.

Hopkins Symptom Checklist-25

The Hopkins Symptom Checklist-25 (HSCL-25) measures symptoms of anxiety (10 items) and depression (15 items). The instrument has been found to have good validity and reliability in refugee population groups internationally (Kleijn, Hovens, & Rodenburg, 2001; Miller, et al., 2009; Mollica, Mc.Donald, Massagli, & Silove, 2004) and in Norway (Jakobsen, Thoresen & Eide Johansen, 2011; Lavik, Laake, Hauff, & Solberg, 1999). The respondents answer how much they are negatively affected by these conditions on a scale from 1 to 4 using the following possible responses "Not at all", "A little", "Quite a bit" and "Extremely". Respondents with scores greater than the cut-off score of 1.75 are considered to be in a state of requiring additional diagnostic evaluation and eventually mental health care. Cronbach's

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alpha for the HSCL-25 in our study was 0.943 for the total scale, 0.877 for HSCL - anxiety, and 0.924 for HSCL - depression (Myhrvold & Småstuen 2017).

The short versions of the WHOQOL-BREF and HSCL-25 instruments were chosen because it is reasonable to assume that very comprehensive questionnaires would be exhausting to complete for our respondents.

Additional qualitative data

Three open-ended questions were added: Which is actually your greatest worry in life? What is stopping you from returning to your home country? If you mean there are important concerns which have not been included in this survey, will you be so kind as to describe them here? For all practical reasons, these questions were only asked in the Norwegian and English versions of the questionnaires used by 31 of the respondents. All of them answered the questions regarding their greatest worry and what they considered important hindrances to returning to their home countries, and most of them offered a few sentences to express their concerns. Six of the respondents also elaborated upon these particular themes in the interviews.

The respondents were given room to elaborate upon themes in the questionnaires and to eventually express their associations, views and experiences related to important aspects in life. This was dependent on the respondents' wish to elaborate on their answers and their ability to express their views to some degree in English or Norwegian, regardless of which language they used in the questionnaires. Approximately two-thirds of the respondents did actually elaborate on their answers, most of them with a few sentences to express their

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feelings. Notes were taken during the interviews, immediately after the interviews and at the end of the day.

Ethical considerations and human safety precautions

Due to our respondents' vulnerable life situations, both as undocumented migrants and as patients, it was of the utmost importance to avoid exploitation and to strengthen confidentiality. The respondents were not offered any money or other goods, except for two respondents who wanted to finish completing the questionnaires at home and were given travel money to be able to make an additional trip to HC to return the questionnaires. Moreover, our respondents were registered with participant numbers only, and they were not asked to provide their addresses or the municipalities to which they belong. The information sheet did not need to be signed, and the eventual informed consent to participate was confirmed by marking an X in the box for "yes". The interviews were not tape recorded.

Based on these conditions, specified in the application to the Regional Committees for Medical and Health Research Ethics in Norway, the Committee approved the project.

Data analyses

Data are described with means, standard deviations (SDs) and ranges for continuous data and with counts and percentages for categorical data.

Associations between quality of life and selected variables were analysed using multivariate linear regression. The results are presented as point estimates of the regression coefficients with 95% CIs (confidence intervals). Given the relatively small sample size and small subgroups, we chose to fit models with at most five variables to avoid overfitting. P-values <0.05 were considered statistically significant. All of the analyses were performed using SPSS software, version 20.0.

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The qualitative data were analysed by the interviewer in five steps using a method of qualitative meaning condensation (Brinkmann & Kvale, 2015). First, the texts were read as a whole to attain a sense of the content in full (step 1). Next, our respondents' feelings and concerns were described in short sentences to identify natural meaning units (step 2). Third, these meaning units were restated as central themes (step 3). Moreover, the central themes were discussed in light of earlier research and theoretical perspectives on quality of life and public health ethics to provide a deeper understanding of the conditions important to our respondents (step 4). Finally, descriptive statements of the themes were written, and quotes from the original texts were selected to illustrate the results emerging from the statistical analyses and to shed light on the circumstances of significance to our responders' experiences as undocumented migrants (step 5). The analytical process was circular. The texts were read several times to validate and eventually refine the natural meaning units and the themes to ensure that important matters to our respondents' life situations were included. The content of the data was discussed with colleagues and the research group members**.** See Table 1 for examples of natural meaning units and central themes.

Nine respondents answered the third open-ended question regarding important concerns not included in this survey. Except for one respondent who emphasised the importance of questioning the "ethics of professionalism towards the case of human rights", the other eight respondents answering this particular question took the opportunity to provide a complementary description of the questions regarding their greatest worries and reasons for not returning to their country of origin. The answers to all three questions were to a great degree overlapping, and we therefore chose to analyse them together: for example, the fear of being imprisoned if they returned to their home countries represents both their greatest worry and the main reason for not returning.

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RESULTS

Demographics, living conditions, migration history and inflicted burden

As displayed in Table 2, most of the respondents were men (57%), and the majority were 30-39 years of age (43%), were single (43%), had no children (52%), and had completed either lower or upper secondary school (53%). The majority had someone dependent on them financially (61%), had a living place (75%) and worked or were employed (64%). The largest groups were from Mongolia (20%), Ethiopia (14.5%), Afghanistan (13%) and Iran (11%). The majority left because of war or persecution (53.5%), did not know anyone in Norway before arrival (68%), went to bed hungry at least once a month (60%), and missed their families (64%). Many (41.5%) confirmed at least one incident of sexual abuse, violence or harassment.

As displayed in Table 3, the mean scores for quality of life by domain in our group of undocumented migrants were 40.14 for physical health, 46.50 for psychological health, 43.39 for social relationships and 30.53 for environment.

Multivariate regression analysis of demographics affecting quality of life revealed that "higher age" was statistically significantly associated with the reduction in the quality of life domain of psychological health. Moreover, "having a partner" and "having a higher level of education" were statistically significantly associated with higher levels in the quality of life domain of physical health (see Table 4A).

As displayed in Table 4B, multivariate regression analysis of living conditions affecting quality of life outcomes, adjusted for gender, age, civil status and level of education, revealed that "left because of war or persecution" and "hunger" were statistically significantly associated with reductions in all of the quality of life domains. Further, "having experienced at least one incident of sexual or other harassment" was statistically significantly associated with the reduction in the domains of psychological health and social relationships, and

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"homelessness" was statistically significantly associated with the reduction in the domains of social relationships and environment.

Moreover, membership in a "local association" was associated with a higher level in the quality of life domain of environment. Neither "work affiliation" nor "financial dependency" seemed to have a noticeable impact on quality of life. Finally, we found that respondents from Mongolia (N= 18) had significantly higher levels of quality of life than the other analysed groups. The respondents from Mongolia consisted mainly of women, 13 held bachelor's degrees, and 13 were employed. The size of the subgroups and the high variation in the results related to country of origin and to the level of education rendered it difficult to draw firm conclusions apart from the observation of Mongolia being distinct from the other countries in the study.

Associations between quality of life and psychological distress

Multivariate regression analysis of psychological distress (by total, anxiety and depression) on quality of life domains revealed that all three variables were statistically significantly associated with all four domains of quality of life (see Table 5).

Qualitative data

The qualitative questions regarding the respondents' greatest worries and important hindrances to returning to their countries of origin revealed that four central themes were crucial to our responders: fear for one's own life if returning, limited possibilities to live in accordance with one's values and beliefs, marginal living conditions and limited perspectives for the future. Our respondents also emphasised these conditions during the interviews. Many reported a feeling of having no choice, neither with respect to leaving their home countries nor regarding their decisions to stay in Norway. Other central themes revealed from the

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interviews were that our group of undocumented migrants did not feel that they were able to make decisions on their own and experienced double acculturative stress and limited possibilities to establish good relations with others on equal terms, all of which have the potential to result in subsequent loss of self-worth.

In light of the results of the statistical analyses, as well as earlier research and theoretical perspectives on quality of life and public health ethics, we found that fear of death and suffering and marginal living conditions were of major concern to how our group of undocumented migrants experienced their life situations. Further, we associated central themes, such as their feeling of having no choice, of not being able to make decisions on their own and of acculturative stress, with dependency, which was a major concern regarding how our responders experienced their life situations (see Table 1 for examples of natural meaning units and central themes).

DISCUSSION

Quality of life in our group of undocumented migrants indicated poor quality of life in all four domains, compared with international mean scores obtained by the WHOQOL Group (Skevington et al., 2004). Moreover, our respondents had lower or comparable levels of quality of life, compared with the levels of quality of life seen in refugees living in Iraq (Aziz et al., 2014), Nigeria (Akinyemi et al., 2012) and Ethiopia (Araya et al., 2011). Further, mean scores in the quality of life domains of physical health and psychological health in our group were higher than the results from studies of quality of life in traumatised refugees in Norway (Opaas & Varvin, 2015, Teodorescu et al., 2012) and were approximately as high as levels found in tortured refugees in Denmark (Carlsson et al., 2006).

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Next, the mean score in the domain of social relationships was higher in our group of undocumented migrants and in traumatised refugees in Norway and Denmark (Carlsson et al., 2006; Teodorescu et al., 2012) than it was in adults who had experienced traumatic experiences and human rights violations in childhood (Opaas & Varvin, 2015). Finally, we found that the mean score in the domain of environment was significantly poorer for our group of undocumented migrants than the scores found in studies of traumatised refugee groups living in the Nordic countries cited here, which is an issue associated with marginal living conditions due to our respondents' precarious juridical status. In summary, our results are in line with comparable results from studies of quality of life in refugee population groups.

Leaving their countries of origin because of war or persecution, hunger, having experienced abuse and homelessness were all statistically significantly associated with the reduction of quality of life in two or more domains. These particular questionnaire items were the same as those that revealed the strongest associations with higher levels of psychological distress in our sample (Myhrvold & Småstuen, 2017). Refugees' mental health problems and mental health conditions were found to be significant to individuals' perceived quality of life (Araya et al., 2007; Teodorescu et al., 2012). We assume that the conditions associated with traumatisation are of particular relevance to why our analyses of psychological distress by total, anxiety and depression affecting quality of life domains revealed that all three factors were statistically significantly associated with all four domains of quality of life (see Table 5).

Most important to our respondents' poor quality of life were conditions associated with traumatisation, marginal living conditions, and conditions associated with dependency.

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Fear of death and suffering

The majority of our group of undocumented migrants left their countries of origin because of war or persecution (53.5%), and this particular questionnaire item was statistically significantly associated with reduction in all of the quality of life domains (see Table 4B). How necessary their flight had been was further emphasised by our respondents in the interviews. They escaped war, persecution and economic insecurity and placed everything into the hands of smugglers, even their lives, and they experienced denial of their applications for asylum as if "*the flight continues",* as one of our respondents expressed it.

Fear of death and suffering is also essential to why they considered returning to their home countries impossible despite very difficult living conditions in Norway. Thirteen of the 31 respondents who answered the qualitative questions reported fear for their own lives as either the main reason for not going back or their greatest worry. Our respondents linked the fear to the risk of being imprisoned, being executed or living in destitution. "*There is no way back – I will be hanged if I return"*, one of our respondents wrote. Another respondent drew a gallows during the interview.

Six of our respondents related the fear for their own lives to their families in the countries of origin and not the political authorities. Their flight was initially generated by a breach with the family values related to religion or one's sexuality and represented the main reason why they did not return to their home countries. The women stated the risk of forced marriages or having children outside of marriage as specific reasons for this fear. The men stated sexual orientation or religious affiliation as decisive factors. Common factors were that they could not rely on their families' support if they returned. The consequences of being excluded from the family were explained as the risk of a life in destitution with further threats to their physical and psychological integrity. As one of our respondents said, "*I have nothing*

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to return to. Me and my child don't have a home anymore. My only option would be to beg on the streets".

The political situation, human rights violations and very difficult living conditions in the countries of origin, a reality for the majority of our respondents, render the fear credible. Except for Mongolia, the largest groups were from Afghanistan, Iran and Ethiopia. Other countries of origin included Iraq, Eritrea, Somalia, South Sudan and Palestine. Several of our respondents emphasised during the interviews that their applications for asylum were justified due to previous political activity, work related to human rights, or breaches with norms or laws in their home countries related to the views of women, sexuality or religion.

Many of our respondents' experiences of inflicted burdens in Norway, such as hunger, abuse and homelessness, also represented threats to physical and psychological integrity, which could be associated with post-migration traumatisation (see Table 2). As displayed in Table 4B, "hunger" was statistically significantly associated with reductions in all of the quality of life domains, "having experienced at least one incident of sexual or other harassment" was statistically significantly associated with reductions in the domains of psychological health and social relationships, and "being homeless" was statistically significantly associated with reductions in the quality of life domains of social relationships and environment.

It is impossible "to live a decent life if one is in constant fear of physical or psychological abuse", Power and Faden emphasised (2006, p. 19). Physical safety and security are also among the many important facets within the quality of life domain of environment of particular relevance to our group of undocumented migrants. In summary, it is difficult to understand our results in any other way than that our responders perceived their personal security as even more threatened in their countries of origin than how it was experienced in Norway.

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Marginal living conditions

Future opportunities for people who have experienced exposures to traumatic experiences and suffered severe losses depend on them being able to live with their pasts and their ability to look ahead to establish new lives including building new relations (Myhrvold, 2006). Our respondents' precarious juridical status prevented rehabilitation and integration. Undocumented migrants are largely excluded from opportunities that can contribute to providing them with material and psychological safety and the social support important to quality of life. Our respondents were excluded from regular employment, which in turn made them vulnerable to exploitation and poor working conditions, and their living conditions were so marginal that their day-to-day existence was threatened (for details, see Myhrvold & Småstuen, 2017).

We assume that the above could explain why work affiliation did not seem to noticeably impact any of the quality of life domains and that higher age was associated with poorer quality of life. The answers to the qualitative questions further confirmed that living conditions were important. Twenty of the 31 respondents who answered the additional qualitative questions reported marginal living conditions and/or limited perspectives for the future as their greatest worries, and these conditions corresponded to terms often used by the respondents in the interviews to express their life situations.

Indeed, having a place to live provides protection against the elements and the many dangers of a life on the streets. As expected, homelessness was associated with the reduction in the quality of life domains of both environment, which includes physical safety and security, and social relationships, which include personal relations, sex and support (see Table 4B). However, many of our respondents who actually had a living place also considered their housing to be poor. What emerged from the interviews was that they had to move often and to share houses with (many) people to whom they did not have any close relations. Having to

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share a home due to poverty, with strangers living in the same marginalised situations as themselves, was experienced as a form of forced communality, depriving them of privacy and the possibility of establishing good relations with others, which was underscored as important to refugees' quality of life by Araya and colleagues (2011). This situation, in turn, impacts our respondents' opportunities to meet others on more equal terms and to make their own decisions.

Dependency

Despite the above concerns, none of our respondents gave the impression in the interviews that returning to their home country was an alternative. In contrast, many reported in the interviews a feeling of having no choice; neither related to the conditions in the home country that led to the flight or the conditions during the flight, nor regarding their decisions to stay in Norway even when they in fact failed to attain asylum here and suffered from living conditions so marginal that their day-to-day existence was threatened. The experience of being captured in an impossible situation is one that dominates. A statement from one of our respondents captured the essence of this quandary: "*You have nothing to do, and still there is no time to do constructive things. You are both overtired and without sleep. You are lost*".

Regardless of the reason for breaching norms or legislation in the home country, a smaller group of our responders emphasised in the interviews that their expectations for a life in Norway were related to the idea that here they could "become who they really are". As they represented a minority in their home country, they eventually regarded themselves as a minority within a minority in Norway, a position that can be associated with double acculturative stress (Tingvold et al., 2015). Those with whom they shared housing could have the same attitudes as those from whom they fled, and they did not feel that they were in a

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position in which they could investigate these attitudes more closely. In the struggle between "fitting in" and being themselves, "fitting in" was a pragmatic solution that might be easier even when the collective notions represent a breach of one's own ideals or values.

Altogether, our respondents' limited opportunities to be an autonomous self with independent decision-making power could thus be said to reduce the level of independence, a key concept in understanding quality of life according to the WHOQOL Group (Power & Kuyken, 1998, p. 1570). In such a situation, both individuals and organisations can play roles that at least might partially explain why "having a partner" and having membership in a "local association" were positively associated with the physical and environment domains, respectively (see Table 4A and 4B). We therefore assume that a steady partner was a person on whom they could rely in their everyday lives, which is important for a feeling of belonging and for a certain degree of independence.

The need for identification papers and payment is likely to limit the associations available to undocumented migrants to join and that they dare to approach. Denominations also emphasise charity work and provide food and clothing. To draw firm conclusions on why our respondents sought these different associations in Norway is therefore difficult. Given these limitations, we assume nevertheless that these areas were arenas in which the respondents had chosen to be in compliance with their own set of values and interests and that could contribute to recreation, leisure, information and skills. Participation in such arenas could perhaps also provide room and opportunities to meet others on more equal terms and to experience that something in life, at least to a certain extent, is shaped by one's own choices, which could result in a certain feeling of attachment to others and society.

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Limitations

Our study was limited by its reliance on self-report measures. Self-report measures on quality of life, psychological distress and living conditions were, however, supplemented by qualitative data obtained through additional open-ended questions and the respondents' varied comments on life as undocumented migrants obtained through interviews. Our findings were, however, based primarily on quantitative data. The magnitude of the qualitative data was therefore smaller than it is common for qualitative interviews. Moreover, the main author's and the respondents' language barriers made it difficult to perform an ongoing interpretation with confirmation or disconfirmation during the interviews. Due to our respondents' unstable life situations, reinterviewing was not possible.

The study also has limited statistical power due to a relatively small sample size and small subgroups. The size of the sample and the high variation in living conditions of the different countries and economic resources available for health care and aid provided to refugee population groups made it difficult to compare our results with the results of studies of quality of life in other refugee population groups. Such comparisons must therefore be interpreted with caution.

The study had sample bias because the respondents were recruited at the HC and thus were already patients.

The sample was also biased regarding language, culture and background.

CONCLUSION

Our group of undocumented migrants suffered from poor quality of life. Conditions found to be most important to our respondents' poor quality of life were leaving their countries of origin because of war or persecution, hunger, having experienced abuse and homelessness.

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Conditions associated with traumatisation and marginal living conditions were of particular importance regarding why our respondents fled their home countries in the first place and why they continued to stay in Norway despite an altogether extremely difficult life situation here. Many gave the impression of being in constant fear of death and suffering and a feeling of having no choice, in turn rendering them even more dependent on others concerning work and a place to live, with a subsequent feeling of not being able to live according to their values. Relations to others on more equal terms and having a sense of belonging to others and to society could therefore provide an explanation for why having a partner and having membership in a local association appeared to have positive influences on quality of life.

We understand this outcome to be a cumulative vulnerability related to the complex interplay between possible exposures to traumatic experiences before and during flight and post-migration traumatisation, such as hunger and abuse, in relation to our respondents' experiences of economic, social and acculturative hardship in Norway.

Our findings are in line with the increasing recognition of the impact of satisfactory living conditions and social support on quality of life in refugee population groups internationally and in the Nordic countries. For undocumented migrants, however, their suffering of multiple vulnerabilities is further reinforced by their precarious juridical status since they are, to a large extent, excluded from opportunities that could contribute to providing them with the material and psychological safety and social support important to quality of life and mental health, all of which are exacerbated by limited access to care.

We therefore presume that our respondents' poor quality of life and mental health indicate to a greater extent that conditions in the home country that led to flight and life as it appears in Norway represent multiple vulnerabilities, rather than that they as individuals are particularly vulnerable. Given other possibilities in either their countries of origin or in

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Norway, they might have scored significantly higher on quality of life and lower on psychological distress.

Thus, our respondents' poor perceived quality of life can be understood as a result of the rejection of the application for asylum and that they have not been able to establish what Power and Faden (2006) considered important to an individual's well-being necessary for a decent life in Norway. Poor quality of life therefore might be said to pose challenges to social justice. Responding to social needs and paying certain attention to individuals and groups facing marginalisation are in line with a human rights approach to quality of life.

In our opinion, perceived quality of life is an important phenomenon to assess in our efforts to gain a deeper understanding of undocumented migrants' life situations.

RELEVANCE TO CLINICAL PRACTICE

With the point of departure in the ongoing discussion concerning our professional and moral responsibility for those who are not equally included in the health and welfare system, nurses are challenged on (at least) two levels: in meeting with patients to whom we cannot provide sufficient care and on a more overall, political level.

Although little can be done to change refugees' possible traumatic experiences before and during flight, public policies in the host country can contribute to mitigating the negative concequences for health and social welfare associated with precarious juridical status. Access to universal health care and social welfare in accordance with the recommendations of the United Nations' Committee on Economic, Social and Cultural Rights (2013) is therefore important.

Responses called for to improve undocumented migrants' quality of life and mental health and to eliminate barriers to their health care appeal more to nurses as a professional group and to those in positions of authority than each individual nurse on duty. In our opinion,

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including juridical status in those conditions to which nursing care should be respectful and unrestricted by in the International Council of Nurses' Code of Ethics for Nurses could contribute to having us play a role in enhancing the conditions that promote health and minimising the conditions that lead to health risks.

Thus, there is a need to sensitise nurses to the importance of social, economic and cultural dimensions of quality of life and health, to human rights and discrepancies between human rights and national laws, to our professional and moral responsibilities in accordance with our Code of Ethics, and to the resources availaible to individuals and groups facing marginalisation. When meeting undocumented migrants as patients, we must use this opportunity to compensate for marginal living conditions and to provide a refuge from fear and judgement and a moment of repose.

For the time being, there is a need to protect charity-based health centres and health professionals' obligation of confidentiality. In a society with limited economic resources or restricted access to health and social care, cooperation between the ordinary system of help and charity-based health services is also important.

Undocumented migrants' restricted access to care makes it difficult for the nurses to provide sufficient health care and work out the relevant research questions. Both issues in turn, have consequences for opportunities for professional development to establish sufficient knowledge both about what this group needs regarding help and about the possible positive measures in accordance with nurses' fundamental responsibilities as they are formulated in our Code of Ethics for Nurses, cited above.

Improving resilience in individuals and groups facing marginalisation, in this context undocumented migrants, indicates that our attention is focused on both an outcome of interactions between individuals and their environments and the process that contributes to these outcomes, according to Ungar (Ungar, 2012). At the HC, there are organised group

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activities that aim to strengthen each individual undocumented migrant's resilience (Nãsholm, 2014a), and undocumented migrants are included in voluntary work (Nãsholm, 2014b). Based on a psychoeducational approach, the aims are to improve patients' understanding of the challenges that they are facing and their internal and external resources, to alleviate loneliness and fear, to contribute to social affinity and support and to sustain a certain influence over one's own life and a sense of positive self-worth. Such an approach is particularly important in contexts of adversity (Ungar, 2012).

There is, however, a need to perform evaluation studies to assess the actual effects on mental health and quality of life of such interventions. Such studies could be done by means of performing follow-ups. We hope that our exploratory analysis and measures described briefly here could contribute to the discussion of how to improve quality of life and mental health among undocumented migrants and could inspire further research.

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What does this paper contribute to the wider global clinical community?

- Assessing quality of life could be a useful way to understand who need greater attention in our efforts to improve public health.
- A mixed methods design enables us to detangle multiple vulnerabilities in our efforts to gain a deeper understanding of undocumented migrants' life situations.
- As long as the ordinary system of care does not provide everyone with adequate health and social care, responding to social needs and paying certain attention to individuals and groups facing marginalisation are in line with a human rights approach to quality of life.

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Table 1 Examples of natural meaning units and central themes

Natural meaning units	Central themes
- I was forced-married at a young age and escaped my husband, and therefore had to flee. Later I had a child and I cannot return to my home country as both my child and me then would be killed - My village was in the middle of the war, very many died. I escaped, but what was I supposed to do? Going back means to be killed (from notes) -Persecution, lack of freedom, fear of degradation, social instability, human rights violation (from answers to additional qualitative questions)	Fear of death and suffering
-Having no money means I do not have any possibility to provide for my family with what they need. Thanks to God I had travel money today because there was a ticket control on the bus (from notes) -I have no money for apartment, nothing left for food and transport. No money – no job – no place to live in short -Don't have money to start from somewhere, lack of jobs in home country, everyone being disappointed with me, haven't paid my dept (from answers to additional qualitative questions)	Marginal living conditions
-I cannot make any suggestion or any protest against my working conditions, cannot even ask questions if there are things I don't understand, cannot make any decision regarding my everyday life (from notes) -I do not have possibilities to make decisions on my own. How to stand of my own, not to be dependent on someone before I reach to my needs is my greatest worry and not being able to do anything meaningful with my life, zero choice (from answers to additional qualitative questions)	Not being able to make decisions on their own
-I am gay and do not believe in the right God and that is like being in hell, I must hide who I am because I am sharing accommodation with people from my home country who believe in the right God (from notes) -Bullying, cultural differences? clash of cultures, I am a woman - I want to decide for myself who I am and to be myself which I were not able to do back in my home country and it seems I cannot decide for myself in Norway either (from answers to additional qualitative questions)	Double acculturative stress

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Table 2 Demographics, living conditions, migration history and inflicted burden

	Number	Valid Percent
Gender (N=90)		
Female	39	43
Male	51	57
Age (N=84)		
18-29	27	32
30-39	36	43
40+	21	25
Marital status (N=90)		
Single	39	43
Married/Steady partner	33	37
Divorced, separated or widowed	18	20
At least one child (N=88)		
Yes	42	48
No	46	52
Educational background (N=87)		
No formal education	7	8
Primary school	9	10
Lower secondary school	23	26.5
Upper secondary school	23	26.5
Degree from university/college	25	29
Economic conditions		
Financial dependence (N=90)		
Yes	55	61
No	35	39
Debt (N=79)		
No	40	51
Would not answer	9	11
Yes	30	38
Housing conditions (N=87)		
Homeless		
Yes	22	25
No	65	75
Live alone	6	7
Number of co-habitants (N=78)		
1-2	23	29.5
3-4	35	45
5-6	8	10.3
7-8	3	3.8
More than 8	4	5
Not relevant	5	6.4
Social conditions (N=88)		
Current employment status		
Never worked in Norway	32	36
Work affiliation	56	64
Company with at least one family member in Norway		
Yes	53	60
No	35	40
Member in associations in Norway (N=84) *		
None	51	61
At least one	33	39
Church or other religion community	14	
Sport association	8	

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Others as e.g. cultural associations	18	
Country of origin (N=90)		
Mongolia	18	20
Ethiopia	13	14.5
Afghanistan	12	13.3
Iran	10	11.1
Somalia	3	3.3
18 more countries	34	37.8
Reasons for leaving country of origin (N=90)		
War	25	28
Persecution	23	25.5
Economic insecurity	20	22
Access to health care	0	0
Other reasons (as e.g. search for better education)	22	24.5
Did you know anyone in Norway prior to your arrival (N=90)		
Yes	29	32
No	61	68
Go to bed hungry at least once a month (N=85)		
No	34	40
Yes	51	60
Incidents of sexual abuse, violence and harassment (N=89)		
Never experienced any such incident	40	45
Would not answer	12	13.5
At least one incident	37	41.5
Hit by spouse/partner	7	
Sexually abused by spouse/partner	2	
Hit by others	7	
Sexually abused by others	4	
Sexually abused at their workplace	2	
Harassed at their workplace	12	
Missing	3	
Missing most (N=87) *		
Nothing	7	
Family	56	64
Friends	17	19.5
My own child/children	16	18.4
Climate/nature	17	19.5
Food	12	
My house	10	
Other things	17	

*Multiple choice was possible

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Table 3 Descriptive statistics of Quality of Life domains

	Total	Domain 1 Physical health	Domain 2 Psychological health	Domain 3 Social relationships	Domain 4 Environment
Mean	41.27	40.14	46.50	43.39	30.53
Median	40.33	39.29	45.83	41.67	28.12
SD	14.39	14.21	17.03	25.07	16.58
Minimum	4.17	0.00	4.17	0.00	0.00
Maximum	77.53	75.00	83.33	100.00	75.00
Cronbach's Alpha	0.904	0.784	0.775	0.693	0.708

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Table 4 Associations between demographic variables and domains of Quality of Life (QoL)

All statistically significant associations are highlighted in bold (p<0.05)

A Demographics

	Domain 1 Physical health			Domain 2 Psychological health			Domain 3 Social relationships			Domain 4 Environment		
Variable	B	95%CI	p-value	B	95%CI	p-value	B	95%CI	p-value	B	95%CI	p-value
Age (in 3 categories, ref the youngest)	-0.10	[-0.37,0.17]	0.459	**-0.35**	**[-0.64,-0.06]**	**0.020**	-0.30	[-0.65,0.05]	0.095	-0.10	[-0.32,0.12]	0.359
Gender (2 categories, ref males)	-0.02	[-0.39,0.35]	0.926	-0.16	[-0.56,0.24]	0.425	0.12	[-0.36,0.61]	0.613	-0.18	[-0.47,0.12]	0.239
Civil status (2 categories, ref not having a partner)	**0.53**	**[0.12,0.94]**	**0.011**	0.20	[-0.24,0.63]	0.368	-0.115	[-0.64,0.41]	0.666	0.23	[-0.09,0.56]	0.155
At least one child (2 categories, ref no children)	0.27	[-0.16,0.69]	0.215	0.32	[-0.13,0.78]	0.156	0.00	[-0.55,0.55]	0.998	0.16	[-0.18,0.49]	0.364
Education (3 categories, ref the lowest)	**0.31**	**[0.04,0.58]**	**0.026**	0.20	[-0.09,0.49]	0.173	0.21	[-0.14,0.57]	0.234	0.16	[-0.06,0.38]	0.140

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B **Associations between selected variables on Quality of Lie domains 1, 2, 3, and 4.**

	Domain 1 Physical health			Domain 2 Psychological health			Domain 3 Social relationships			Domain 4 Environment		
Variable	**B**	**95%CI**	**p-value**	**B**	**95%CI**	**p-value**	**B**	**95%CI**	**p-value**	**B**	**95%CI**	**p-value**
Financially dependent (ref not dependent)	0.01	[-0.40,0.42]	0.960	-0.39	[-0.80,0.02]	0.062	-0.12	[-0.62,0.39]	0.650	0.07	[-0.25,0.38]	0.671
Homeless (ref not homeless)	0.28	[0.18, 0.74]	0.229	0.41	[0.05, 0.88]	0.079	**0.79**	**[0.25, 1.33]**	**0.005**	**0.39**	**[0.04, 0.73]**	**0.029**
Work affiliation (ref no)	-0.13	[-0.53,0.27]	0.516	0.07	[-0.35,0.48]	0.753	-0.13	[-0.62,0.37]	0.609	0.05	[-0.26,0.360]	0.731
Family member (ref no family member)	0.06	[-0.35, 0.47]	0.758	-0.09	[-0.53, 0.36]	0.701	-0.48	[-1.00, 0.03]	0.066	-0.10	[-0.42, 0.23]	0.555
Association membership (ref no association)	0.17	[-0.26, 0.60]	0.428	0.27	[-0.16,0.71]	0.214	-0.24	[-0.76,0.29]	0.369	**0.37**	**[0.06,0.68]**	**0.020**
Left because of war or persecution (ref not because of war or persecution)	**-0.59**	**[-1.02, -0.16]**	**0.009**	**-0.90**	**[-1.33, -0.48]**	**<0.001**	**-0.83**	**[-1.37, -0.30]**	**0.003**	**-0.43**	**[-0.77, -0.90]**	**0.013**
Country of origin												
Mongolia vs other	**0.56**	**[0.09,1.03]**	**0.021**	**0.54**	**[0.06,1.02]**	**0.036**	**0.65**	**[0.04,1.27]**	**0.038**	**0.40**	**[0.03,0.77]**	**0.035**
Iran, Iraq, Afghanistan vs other	-0.16	[-0.57,0.25]	0.428	**-0.44**	**[-0.86,-0.03]**	**0.036**	-0.11	[-0.64,0.42]	0.686	-0.19	[-0.51,0.13]	0.243
Knew someone prior to arrival (ref knew no one)	0.05	[-0.37,0.47]	0.815	0.08	[-0.36, 0.52]	0.711	0.15	[-0.38, 0.67]	0.573	0.12	[-0.21,0.47]	0.473
Hungry to bed (ref not hungry to bed)	**0.51**	**[0.13,0.88]**	**0.009**	**0.48**	**[0.09,0.87]**	**0.016**	**0.64**	**[0.17,1.11]**	**0.009**	**0.50**	**[0.21,0.78]**	**0.001**
At least one incident of sexual or other harassment (ref no incident)	-0.18	[-0.57, 0.21]	0.366	**-0.46**	**[-0.86,- 0.07]**	**0.021**	**-0.78**	**[-1.23, -0.32]**	**0.001**	-0.07	[-0.35, 0.22]	0.640

*All models are adjusted for age (in categories), gender, civil status and education (in categories)

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Table 5: Association between Hopkins Symptom Checklist (HSCL) and domains of Quality of Life (QoL) adjusted for age, gender, civil status and level of education

Variable	Domain 1 Physical health			Domain 2 Psychological health			Domain 3 Social relationships			Domain 4 Environment		
	B	95% CI	p-value	B	95% CI	p-value	B	95% CI	p-value	B	95% CI	p-value
Total HSCL	-1.80	[-2.45,-1.14]	<0.001	-2.00	[-2.81,-1.19]	<0.001	-3.39	[-4.63,-2.16]	<0.001	-2.18	[-2.95,-1.40]	<0.001
Anxiety HSCL	-1.42	[-2.10,-0.77]	<0.001	-1.42	[-2.25,-0.60]	0.001	-2.80	[-4.03,-1.57]	<0.001	-1.87	[-2.64,-1.11]	<0.001
Depression HSCL	-1.67	[-2.27,-1.07]	<0.001	-1.92	[-2.66,-1.18]	<0.001	-3.09	[-4.22,-1.95]	<0.001	-1.93	[-2.65,-1.21]	<0.001

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