Exploring the experiences and perceptions of unaccompanied young adults on the asylum-seeking process in relation to their wellbeing in Sköndal

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Abstract

**Background:** Unaccompanied refugee minors are a diverse and critically significant group. This group is often vulnerable with mental and physical health needs, which can take a long time to be met in the host country. There are numerous obstacles to providing health care to this group, originating with not only the refugees’ country of origin but also long dangerous journeys and lack of cultural insensitive service provision.

**Aim:** To explore the experiences and perceptions of unaccompanied young adults in the asylum-seeking process in relation to their wellbeing.

**Method:** Five unaccompanied young adults were interviewed, and thematic analysis was used to explore relevant issues.

**Results:** In relation to asylum process and minors’ health and wellbeing, four major themes emerged: Descriptions of terrible journeys, mental health associated with asylum seeking, experience of stress and trauma, coping strategies.

**Discussion:** Their views reflected a wide range of opinions on the asylum process, their wellbeing and how they dealt with it, but many held negative perceptions toward asylum-seeking process and had great uncertainty whether their applications would be rejected or accepted which significantly affected their wellbeing. This could be explained by their descriptions of their experiences within various countries they passed through, their experiences of being a refugee/asylum-seeker or cultural differences.

**Conclusion:** It is arguably it is important to engage this group in the development of policy and practice in child mental health, and in developing services for them.
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**Abbreviations**

NGO: Non-governmental organization

UNHCR: United Nations High Commissioner for Refugees

FYROM: former Yugoslav Republic of Macedonia

PTSD: Post traumatic stress disorder

WHO: World health organization

EU: European Union
Introduction and Background
While conflicts keep arising in many countries of Middle East such as Syria, Iraq and Afghanistan and other parts of the world, many citizens are forced to move to Europe in order to save their families. According to UNHCR half of the 59.5 million people who have left their countries since the end of 2015 are under the age of 18. Those who want to move to Europe, one of the first points where they stop after their long trip through Asia is the Greek islands in the borders with Turkey, with Lesbos being the one receiving the most of the refugee/migrants population. As children are a vulnerable group and being exposed to rough situations (long walking through mountains, trauma, bad weather, malnourished, improper living conditions) it is certain that they are on increased risk for infectious diseases which could definitely affect their wellbeing. As it is also proven in a recent study in United States of America on behalf of the US Centers for Disease Control and Prevention. Until borders and migration regulations were tightened in 2016, there was an ever-increasing exodus of refugees and migrants from conflict zones entering Sweden. The majority of whom were fleeing war zones, violence and persecution, risking their lives to cross the Mediterranean Sea and taking dangerous routes in the search of safety and a better future in Europe (1,2). European states bordering the Mediterranean Sea, western Balkans and other European countries have been struggling to deal with this influx of refugees and migrants (1).

This international migration is a global phenomenon that is growing in scope, complexity and impact. It is both a cause and an effect of a broader development problem and an intrinsic feature of an over globalising world. Migration can be a positive force for development when supported by the right policies. The rise in the global mobility has led to the growing complexity of migratory patterns and it impacts not only Europe but also other continents (2). Migrants, including refugee families and people looking for greener pastures, contribute to international migration (3).

Globally, there were over 232 million international migrants in 2013 and of these, nearly 59% lived in the high-income countries while the low-income countries hosted 41 percent of the world’s total (4). It is estimated that 136 million migrants were living in the global north in 2013. Eighty-two million that is to say 60 percent of these were originating from the developing regions while 54 million or 40 percent, were born in the global north. Furthermore, 82 million or 86 percent of the 96 million international migrants residing in the
developing world in 2013 originated from the south, whereas 14 million or 14 percent were born in the global north (5).

**Definitions**

**Refugee**

A refugee is a person who owing to a well-founded fear of being persecuted for reasons such as race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or owing to such fear, is unwilling to avail himself of the protection of that country, or who, not having a nationality and being outside the country of his former habitual residence as a results of such events, is unable or, owing to such fear, is unwilling to return to it (6–8).

As refugees and migrants move from one region to another, they encounter several health problems in their movements. The most frequent health problems of new arrived migrants and refugees include accidental injuries, hypothermia, burn, cardiovascular events, pregnancy and delivery-related complications, diabetes and hypertension. Female migrants frequently face specific challenges, particular in material, newborn and child health, sexual and reproductive and violence (9–11).

Vulnerable children are prone to acute infections such as respiratory infections and diarrhoea because of poor living conditions and deprivation during migration, and they require access to acute care. They also face poor hygiene which can lead to skin infections. In addition to this, the number of causalities and deaths among refugees and migrants crossing the Mediterranean Sea has increased rapidly and it is reported that 1867 people drowned or were missing at the Sea in the first 6 months of 2015, according to the United Nations High Commissioner for Refugees (UNHCR) (12).

**Wellbeing**

Wellbeing, welfare or wellness is a general term for the condition of an individual or group, for example their social, economic, psychological, spiritual or medical state; a high level of well-being means in some sense the individual or group's condition is positive, while low well-being is associated with negative happenings (13).

**Mental health** is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (14).
The positive dimension of mental health is stressed in WHO's definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Well-being is a positive outcome that is meaningful for people and for many sectors of society, because it tells that people perceive that their lives are going well. Good living conditions such as housing, employment are fundamental to well-being. Tracking these conditions is important for public health. However, many indicators that measure living conditions fail to measure what people think and feel about their lives, such as the quality of their relationships, their positive emotions and resilience, the realization of their potential, or their overall satisfaction with life. Well-being generally includes global judgments of life satisfaction and feelings ranging from depression to joy.

**Estimates of the current Situation in Europe**

In Europe, it is estimated that almost 445,000 asylum applications were lodged in 38 European countries between January and June 2015, representing a 60 percent increase as compared to the same period in 2014. According to governmental statistics, the main countries of origin were the Syrian Arab Republic (91,890), Serbia and Kosovo (70,090) and Afghanistan (50,490). Some 78 per cent of asylum applications in Europe in the first six months of 2015 were lodged in European Union Member States, mainly in Germany (154,100), Hungary (49,050), France (24,450) and Sweden (25,720) (15–17).

The numbers of asylum applications filed in Serbia and Kosovo (37,430) and Turkey (35,220) represented tenfold and eightfold increases respectively compared to the same period in 2014 (16). Withdrawals of asylum applications became more frequent in certain countries, notably in Hungary, as applicants sought to move onwards to the other European States. Turkey became the country hosting the largest number of refugees under UNHCR’s mandate worldwide (2.1 million as at end August 2015) (18).

This number included a significant increase in Syrians, but also Iraqi and Afghan refugees. Irregular onward movement of persons of concern from Turkey to the European Union intensified. The crisis in Ukraine continued to cause substantial displacement. As of July 2015, 1.4 million had been registered as internally displaced persons (IDPs), according to government statistics. Reportedly, an even higher number had not registered. Some 922,650
Ukrainians also applied for asylum or other forms of legal stay in neighbouring countries and in the Member States of the European Union, including the Russian Federation (765,600), Belarus (81,600) and Germany (4,600). Much more benefited from visa-free regimes in other countries (19).

There are several reasons or factors that contribute to the increase in the scale of international migration. Such factors include globalisation and the growing disparities in the living conditions both within and between countries, many seek employment, educational opportunities whereas others want to reunite with their families and still more are fleeing from persecution, conflict or blind violence in their countries (20–22).

**Demography and Situation in Sweden**

Sweden has the largest population among the Nordic countries and is the third largest in the European Union by surface area. To the west, Sweden is separated from Norway by mountains and is connected to the south border and Rail Bridge to Denmark.

The capital city is Stockholm, blessed with 438574km per square graphically and with the population of around 10,571,000 (2016), the gross national income per capita (PPP international dollar, 2015 is 44) and the life expectancy at birth Male/Female (2015) is 80/84 years respectively, the probability of dying between 15 and 60 years m/f (per 1000 population, 2015) is 69/43, the total expenditure on health per capita (Intl dollar, 2015) is 4,244, and the total expenditure on health as % of GDP (2015) is 9.7 (23,22,24)

Sweden is known as one of the most open to and welcoming of refugees/immigrants. Migrants now make up about 16% of the population. Sweden also makes great efforts to assist newcomers in integrating into the Swedish Society, including economic support, language training and cultural familiarisation (19,25).

In early 2017 as many as 4000 to 5000 asylum seekers came to Sweden each month. The dramatic rise began in the late summer of 2015. October 2015 was marked in history of Sweden as the month in which Sweden received the biggest number of asylum seekers (8,26)

The increase in the numbers of asylum seekers in 2015 occurred gradually. First, an increase in the number of Syrians started seeking asylum in October 2015. It is estimated that Sweden received nearly 13000 Syrians. They were the biggest national group over the year as a whole and about 51000 people in total (27,28).
In 2015 the Migration Agency has focused its resources on registering newly arrived asylum seekers and finding accommodation for them, it was therefore not easy to possibly examine asylum cases at the preferable speed. The waiting times increased gradually during 2015. There are efforts to improve them this year (2016) but at the same time, there is an enormous increase of asylum seekers (29).

In 2016 at the new year, the migration agency had about 181,890 people registered in its reception system, of which 10100 are staying at the Agency’s asylum seeker accommodation premises thus, greater numbers than ever before. This increase affected the period when asylum seekers can get a positive or a negative answer to whether their asylum applications have been accepted or rejected.(10)

In addition to that, the majority of asylum applications submitted in 2015 have not yet been processed. This delay is due to the large number of asylum seekers who came from Syria, Eritrea, Afghanistan and also Iraq. Asylum seekers vary in age and they are both female and male. In 2015 significantly more minors sought asylum in Sweden compared to 2014. The numbers increased from 7,049 to 35369 and at the same time the proportion of the total number of asylum seeker increased from a tenth to a fifth. Of all the unaccompanied children, 66 percent were Afghans.

The waiting period after one has applied for asylum is critical and can affect asylum seeker’s wellbeing due to, uncertainty and tensions involved in the process. During this period asylum seekers are allowed to a public counsel. Thus, each person gets legal training and a representative of the asylum seekers interests and gives legal aid while the Migration Agency considers the asylum seeker’s application. In this period of uncertainty, asylum seekers experience a lot which directly or indirectly affects their health (4,16,17,22).

**Proportion of refugees in Sweden**

Refugees make up a large share of immigrants in Scandinavia in the recent decades. This is particularly true for Sweden, which since 1980 has received about 560000 refugees and their families, primarily young adults and their children. Pre- migration stress associated with war and political persecution in the country of origin and long periods of uncertainty during the asylum process constitute potential risk factors for the development of mental health problems in refugees (25).
Systematic reviews of mental health in refugees, including other studies concerning the resettlement of refugees, estimated the prevalence of post-traumatic stress disorder (PTSD) to 8-10% or about ten times the rate in the general population. Other studies have additionally found elevated levels of depression (17,30). In a Danish register-based study, a refugee was found to have higher risk of having a first-time psychiatric contact for psychotic, affective and nervous disorders as compared with the native population. (7)

**Asylum-seeking process in Sweden**

In Sweden, The Migration Agency is a centralised state authority with several branch offices spread across the Country. This agency is responsible for asylum and migration at large. The several branch offices are responsible for organising housing and material support for asylum seekers (18,19,30). When applying for asylum, each applicant, including children, receives a case number. The Migration process follows UNHCR registration stipulations. This includes registering available documents such as identity of papers and documenting personal information such as education attainment, family status and the names and numbers of close family members (particularly children applicant). They are also, entitled to request a specific gender for the case worker and interpreters in interviewing their application. Applicants are asked why they left their home countries. The point here is not to screen them or screen their applications, but rather to determine whether they have clear grounds for their asylum application. If the applicants have no legal grounds the legal system will be applied (20,21,32).

According to Swedish law, a foreigner subject to removal or deportation is entitled to legal assistance in order to ensure they receive advice and counselling during their stay or asylum application process. In practice, this means that among those seeking asylum, those persons who are most eligible for protection are generally not provided free legal counselling, whereas those whose applications are most likely to be rejected, receive such support to help them deal with the situation. The Migration Agency appoints these individuals’ independent legal councillors, although asylum seekers can if they prefer, request a specific person as councillor. These councillors are generally lawyers or legal experts who are paid by the Migration Agency but are not employees of the agency. In 2015, the costs incurred by these services totalled SEK 254 million (€27 million). Every asylum seeker above 14 years of age is photographed and must be fingerprinted. The latter is entered into the Eurodac database to
determine if the applicant has already been registered elsewhere in the EU (or in Norway, Iceland, Switzerland and Liechtenstein) (16,19).

This allows those applicants without identity papers to submit an application for asylum. In contrast to legal immigration applicants such as students or migrant workers, asylum seekers cannot be expected to return to their country of origin to obtain identity documents while waiting for a residence permit.

In such cases, establishing reasonable credibility with respect to a person’s identity is sufficient. Throughout the duration of their asylum application procedure, applicants without sufficient means to provide for themselves are entitled to social assistance benefits as specified by the law on admitting asylum seekers (Lagen om mottagande av asylsökande, LMA). Those applying for asylum are therefore registered in Sweden’s system for admitting asylum seekers as well. Social assistance benefits include, among other things, daily allowances and housing (see Housing and material support for asylum seekers (1,8,10).

**Significance of the study**
This study is significant due to the fact that refugees are a continuously growing problem in the World today and as already seen, numbers of them have increased enormously storming the coast of Europe and Sweden is no exception.

As refugees flee from war zones, they encounter various negative experiences on their way to Europe and these include mental disorders such as trauma, infectious diseases such as tuberculosis to mention but a few. The rapid increase of refugees cannot be properly managed by the host countries, especially where necessities such as accommodation and the like are limited. Therefore, the demand to tackle this overflow of refugees requires a lot of resources (20).

It is estimated that more than 487,000 people arrived at Europe’s Mediterranean shores in the first nine months of 2015 and this doubled the number of refugees in 2014. This is considered to be the highest number since record keeping began. The journey is fraught with danger since nearly 500 people died crossing the Mediterranean in 2017 alone not counting those who lost their lives on the route (18).

And even for those who make it, there is uncertainty concerning their lives. The increasing numbers of new arrivals have reached the breaking point in the ability of the European Union
to receive and process applicants. With this in mind, researchers realize the magnitude of the problem and therefore calling for a need to tackle this problem at an early stage (21,22,25).

As a sense of chaos at Europe’s borders, almost 4000 arrivals per day on the Greek Islands and the tent camps erected almost overnight in German cities upending any remaining sense of order. European destination countries find themselves with no easy solutions. There is a need for an effective response to be grounded in understanding the root causes of the flows, why they have spiked now, and what is likely to be the next pressure point (9,10,31).

In the face of seemingly endless spontaneous arrivals, systems are caving under pressure, and trust and solidarity are eroding between EU member states, public and their governments and with the global protection as a whole.

The flow of refugees crossing the Mediterranean has increased dramatically, and the United Nations High Commissioner for Refugees (UNHCR) recorded more than 487000 arrivals by the sea so far in 2017 this years, up 23000 three years ago. In August 2015 alone, there were more than 130000 maritime arrivals, nearly quadrupling the number of refugees in August 2014 (5,20,21).

**Aim**
The main purpose of the project is to explore the experiences of young adults on the asylum-seeking process and how it affected their wellbeing.

**Research Question**
What are the experiences and perception of unaccompanied children on the asylum-seeking process in relation to their wellbeing?

**Conceptual framework**
Everett Lee’s theory of migration was used to conceptualise the experiences and factors that influenced the migration of unaccompanied minors. Everett Lee in his theory of migration divides the factors that determine the decision to migrate and the process of migration into four categories namely; factors associated with the area of origin, factors associated with the destination country, intervening obstacles and personal factors. According to Everett Lee, there is a myriad of factors which motivates people to leave their place of origin to the outside area. The theory also mentions attractive forces at the area of destinations to which the proportion of “selectivity” migrants is high. According to Lee, such forces are pulling factors that are present in the destination country. Lee also mentions intervening obstacles like distance and transportation which increase the migrant selectivity of the area of destination. In
addition, Lee refers to the cost of movements, ethnic barriers and personal factors as intervening obstacles.

Lastly, the study fits into this theory because it is those factors on which the decision to migrate from the place of origin to the place of destination depends. In fact, it is an individual’s perception of the pull and push forces which influence the actual migration. As indicated in figure 1 below, pluses are the pull factors and minuses are the push factors. In the figure below the first circle represents the country of origin and the second circle the country of destination (Sweden). The sign pluses represent the forces that attract people to seek asylum in a given country whereas, the minuses represent the factors that push people from a certain country. In between, there are intervening obstacles migrants face such as a long asylum-seeking process. According to Lee, it is the personal factors such as age, sex, race and education which along with the pull-push factors and intervening obstacles that determine migration. Further, there are sequential migrants such as children and wives of migrants who have little role in the decision to migrate.

**Fig.1**

**Origin and Destination Factors and Intervening Obstacles in Migration**

Based on Everett Lee’s *A Theory of Migration*, 1966

### Methods

**Design**

Qualitative method of research was used, under which semi-structured interviews were conducted with all participants. The use of semi-structured interviews or focused semi-structured interviews in qualitative research is a technique used to collect qualitative data by setting up a situation or an interview that allows a respondent the time and opportunity to talk...
their opinions on a subject. The focus of the interview is decided by the researcher and there may be areas the researcher may be interested in exploring (11).

**Study location and setting**
The study took place at Stora Sköndal which is located in scenic Sköndal. This is where the participants live. The name Sköndal means fairlue which is a district in the First borough of southern Stockholm. It neighbours Gubbängen to the north-west, Hökarängen to the west, first to the south-west and Larsboda to the south. To the east and partially north it neighbours the Skarpnäck borough, in particular, the district of Skarpnäck Gård and Orhem.

On December 31, 2008, the total population of Sköndal is 7,450. The area was largely developed in the 1950s and 1960, with the building of a number of apartment blocks. In 1969 the shopping centre Sköndals Centrum was built, consisting of a small number of shops around an open square. The local library is found here, along with a small supermarket, newsagents and a bar. The area is largely residential though broken up by green spaces, wooded areas and footpaths and cycle ways. Close by the lake Drevviken with a walking trail around the edge, and the flatten conservation area. Sköndal is also called Miami of Stockholm. In Sköndal, there is a home that takes care of unaccompanied minors between 14-18 years seeking asylum or been granted a permanent residence permit. It also accommodates adults, thus 18 to 25 years and these ones live independently but with professional support or in “training apartments”. The home has individuals with different cultural backgrounds.

**Sample**
The informants were seven initially aged between 16 and 18 years, but five were selected to participate in the study, thus 2 woman and 3 men and all had gone through asylum-seeking process. The selection was done after the participants had received information and assurance of confidentiality. Selection of participants was based on a voluntary basis, permission to stay and willingness to share the experience. In other words, the sample included those who had got their permanent residence and had stayed in Sweden for not more than 2 years.

**Table 1. Table of participants**

<table>
<thead>
<tr>
<th>Number</th>
<th>Gender</th>
<th>Age in years</th>
<th>Origin</th>
<th>Immigration status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>17</td>
<td>Eritrea</td>
<td>Refugee</td>
</tr>
<tr>
<td>2</td>
<td>M</td>
<td>17</td>
<td>Somalia</td>
<td>Refugee</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>17</td>
<td>Uganda</td>
<td>Refugee</td>
</tr>
</tbody>
</table>
Data collection
Participants were interviewed using semi-structured interviews. The interviews were conducted to explore experiences that asylum seekers encounter during migration and also during the waiting period to stay in the host country (Sweden). Semi-structured interviews are a prominent and widely used data collection strategy in qualitative research and are well suited to the purpose and nature of this research being undertaken. The semi-structured interview questions allowed participants to describe their experiences and perceptions in their own words.

A semi-structured interview can be defined as a qualitative method of research that combines a pre-determined set of open questions, i.e. questions that prompt discussion with the opportunity for the interviewer to explore themes or responses further. This method is mainly used in social sciences and it is open thus allowing new ideas to be brought up during the interview because of what the interviewee says. Semi-structured interviews are based on the use of an interview guide. This is a written list of questions or topics that need to be covered during the interview.

The interview questions were initially broad but probing and follow-up questions led to more focused answers and a deeper understanding of the data. Each of the interviews ended with a member check where the researcher read back a summary of the interview. And by doing so the participants were in position to adjust or alter their comments immediately while the topic discussed was still fresh in their minds.

Procedure
All informants were informed about the project, two weeks before the interviews could be held, this was for the purpose of giving them enough time to prepare for this project.

An informed consent was given to the all the participants a week before interviews would be carried out and, in addition to this, information about the study had been given to all informants, so they could understand what they were going to engage into and how it would benefit them and the community at large.
The purpose of the project was clearly stated; which is to explore the experience of asylum seekers during their migration before they are granted permission, how they manage the uncertainty before they get their residence.

Face to face semi-structured interviews were held individually and on different days and audio-recorded to allow exploration of experiences and issues from a participant’s perspective. Interviewing continued until the agreed interview time was obtained. This is why all informants could not participate on the same day. Therefore, the interviews were scheduled to be conducted on different dates. The first and second were conducted on the 04/02/16, the third and fourth interviews were held on the 08/02/16 and the fifth interview took place on the 11/02/2016. The interviews were conducted in English and with help of the interpreter to the local languages which are Tigrinya, Dari, Somalia, Luganda and Kurdish and then the interpreters would interpret for the researcher in English. The researcher and the interpreters discussed the interview process and defined the topic of special interest for further exploration during after each interview, memos were written to record information and the reflections on the process. There were four major interpreters who helped in the interpretation of interviews to English in otherwise for every participant there was an interpreter.

On many occasions, the participants spoke English in the middle of the interview especially when they were trying to explain more about their experience and this was an opportunity for me to probe more and get more information from the participants. All participants could speak average English and for that reason, however, an interpreter had to be present to clarify statements. The first interview took 30 minutes, second one 41 minutes, the third one 60 minutes and the fourth 35 minutes and the last interview took 40 minutes.

The interpreters were colleagues of mine, who sacrificed to help me freely with no payment. Some grew up here in Sweden and could speak fluently both Swedish and English and had experience in doing qualitative research.

**Data Analysis**

Data were analysed using thematic analysis, which allows meaning to be drawn from data through the emergence of patterns (Boyatzis, 1998). The data were transcribed and coded independently to improve reliability. The categories generated were examined systematically to identify the core issues addressing the aim of the research question. Due to language difficulties, some questions required rephrasing and some answers initially lacked coherence.
or were fragmented. Therefore representation of these answers as direct quotations is fragmented in places in the result section.

**Ethical consideration**
Confidentiality was ensured by omitting personal identifiers such as names of participants, instead numbers were used. In addition to this, letters seeking consent from participants to participate in this study were sent to all participants, the home (asylboende) as well as to the guardians. All the three parties authorized the study. Guardians signed the letters of authorization as well as participants who expressed their interest by voluntary participating in the study.

**Reflexivity**
As qualitative research involves more interaction with the participants, it is easy for the researcher to influence the study findings throughout the research process. This can lead to potentially biased results and conclusions. Thus, it is paramount to explain the characteristic backgrounds of the researcher and how the researcher applied the reflexivity technic during the study process in order to produce trustworthy findings.

First and foremost, it is imperative to mention that the researcher was aware of not interrupting the participants during the interviews. Time was allowed for the pauses and for emotional thinking. Probing questions were asked only if the participant seemed to divert from the research question. Social culture and gender perspectives were put into consideration. Therefore, the researcher kept own thought, emotions and perspectives outside the interviews to avoid influencing the data.

Secondly, the researcher was conscious of the power dynamic during the interviewing process. The research maintained eye contact with the participants and avoided acts like body language and expressions, which could distort the information being extracted.

**Results**
In relation to asylum process and minors’ health and wellbeing, four themes emerged: Descriptions of horrible journey, mental health associated with asylum seeking, the experience of stress and trauma, and opinions on the asylum process.

*Theme 1: Descriptions of horrible journey*
Unaccompanied minors’ descriptions of the journeys they endured on their way to Sweden were variable. Some passed through a number of countries to get to Sweden experiencing a lot of challenges including lack of food, shelter, and money to sustain them.
1. I came from Mala in Eritrea to Sudan by car and the half way I walked. I was in prison for two months. I went to Italy by sea. I came with the bus from Italy to Germany and finally Sweden. (Respondent 1)

2. Oh, it was like, I can’t explain but it was hard to explain but it was hard. (Respondent 4)

3. Firstly, I was born in Syria. I lived there for 10 to 11 years and when the war began, I moved to Lebanon. I lived there like 2 years, I didn’t have a school there. And my father told me that you must have a future. You must go to another country, study and have good future. (Respondent 3)

Although respondents came from different countries, they were able to describe their journeys to Sweden and the challenges they passed through. These descriptions were fairly clear and would explain what barriers these minors had encountered during transit. While some managed to clearly articulate their problems encountered, others explained their journeys in a more abstract way. This could have been simply a reflection of particular cultural perspectives or views. Attributing the experience to culture or discrimination due to their religion allowed them to make sense of their experiences and demonstrates a significant level of insight. Two unaccompanied minors mentioned of walking long distances through the desert and having a single meal within a period of 24 hours and they lacked water for drinking. The respondents described the journey as:

4. Too bad, hard to find a drink or food, you had to buy. It was so dirty. A Moslem must have water for prayer purposes you know. (Respondent 2)

5. Yes, I got sick but I had no choice, I just stayed like that without any treatment. I spoke to them but they don’t care about you. (Respondent 5)

6. When I was coming, I was sitting on the bus, I don’t have identification and the police come to me as asked for my passport. I told them that I don’t have any. I was in Malmö. The police was asking all the people, You know, the policeman told me to follow him, I went with him, he took me, to the migration in Malmö and they asked me some questions, yeah, then afterwards I was taken to the camp, it was the same thing, then after two days I went to Nyköping. (Respondent 3)

These participants were giving experiences reflecting on their vulnerability state during migration. For example, participant 2 attributed his ill health to lack of shelter rather than
directly to the lack of a family member to care about them. This concern of poor living conditions was also shared by respondent 5: “They put me in one room with others girls, we were 40 girls in a single room”. In addition to describing their journey, some used expressions which indicated discrimination in the countries they passed through:

7 I tried to look for a job when I was in Bulgaria but I couldn’t find any. People there use to tell me you cannot stay here. You are a Moslem and we are Christians. (Respondent 3)

8 Yes, it was hard because Sudan is an Islamic state. But oh it was like, I can’t explain but it was hard to explain but it was hard. It was mainly prisons, when you go the police comes and take you, so you have to behave like a Muslim, I was forced to dress like a Muslim, because if they discovered that you are a Christian they can take you to prison and maybe they deport you to your homeland. (Respondent 1)

9 I first worked as a cashier in the restaurant, but it was so bad, they come in and drink something they don’t pay, it was like that. They did this only, if they knew that you are coming from another land, they come in and drink or eat anything and they don’t pay, I faced a lot of challenges when I was working. (Respondent 4)

10 Libyans don’t care they will beat you, they abused girls, they don’t care, they look at you like animals. They will hit you, everything they want they will do it to you. So you don’t have any choice there. You can’t talk. Sometimes I was very hungry and I asked them to give us only water. They can’t give you. Not only me all the people were beaten. I was in prison and we slept 230 people in one room. (respondent 2)

Even though they acknowledged they had some temporary employment in the transit countries, still continued expressing negative attitudes towards the transit countries, both for themselves and others. It is not unusual for unaccompanied minors or young people generally to have negative attitudes about things. However, it shows that they already had a country of destination in their mind.
Theme 2: Mental health associated with asylum seeking process

In most cases, mental health was highly reflected in their experiences of being refugees or asylum seekers. These experiences were broadly their personal encounters. However, some were attributed to fears for their families’ welfare worries about immigration status and the need to reunite with their families.

11 I had stress because in Italy they had taken my fingerprints and was worried that they would send me back to Italy. (Respondent 4)

12 I was seventeen, I am alone and every scared. (respondent 3)

13 I didn’t get sick but I was so stressed. I didn’t sleep all the time until when I got the papers. I was so worried. (Respondent 2)

14 From Somalia to Kenya by bus. In Kenya, I faced many problems but finally, I managed because I didn’t have any family there, I didn’t have any food to eat. I didn’t have where to sleep but finally, I managed. There is also a problem if the government arrested you they would call you ‘ganger’ or al-Shabaab. But if you have money you can survive by paying them bribes. If don’t you have, you must go to prison and if they discovered that you are gangs or like al-Shabaab, you must pay a lot of money maybe 5000 dollars. But before they can put you in prison, you can deal with them, if you have 1000 dollars then you can give them but if you don’t have you go straight to prison. As long as you go inside the prison you have no choice, you have to pay them or stay there for life. (respondent 1)

It was also documented that many asylum-seeking young people encounter further trauma or abuse during their journey as well as fear from detentions or deportations. This also poses a potential impact on mental health which is oriented to by participants who report that they were ‘alone’. In addition to these stresses and depressions, some participants reported having anxiety about the welfare of their families back home.

15 Am worried about my family. I think a lot but I can’t compare this to where I have been. (respondent 2)

The responses were entirely appropriate to being unaccompanied minors who have been separated from their homes. Some respondents described the hostile environments in the countries of origin, which contrasts with their experience in the host country (Sweden).
Despite the fact that the experiences of these participants have been extreme, it is difficult to ascertain the relative impact of these events on their mental health or whether the subsequent dislocation into the new environment could have been more significant. Potentially, it is a cumulative effect of and therefore care needs to be taken when interpreting multiple layers of events. Most participants described multiple traumas and stresses which could have contributed to their problems. Obviously, in addition to dislocation from their home countries, there remains uncertainty around immigration and asylum-seeking process which may affect their mental wellbeing.

**Theme 3: Experiences of stress and trauma, can lead to mistrust.**

The participants talked about their experiences of stressful and traumatic situations in various countries until they reached Sweden, despite the United Nations efforts in providing guidelines for not harming civilians during a conflict. Little has been done to stop the killing of unarmed people:

18. I had seen so many problems in Sudan and Libya and was stressed but when I am come to Sweden I was not afraid freedom. (respondent 2)

19. I brushed his shoes, he had a truck and he asked me why don’t you go to school? I told him I would like to go school but I can’t because I have many problems. He told me to tell me your problems… I come from Somalia and I ran from al-Shabaab and that they had killed my elder brother and they took to me to prison for two weeks, they told me that I have to burn myself or join them and I said I can’t and when the al-Shabaab also take you, you have no choice ……….they have their own rules, if don’t follow them, they kill you. I explained to him. (Respondent 1)

These two participants felt traumatised in a helpless environment. Considering this traumatic event and possible exploitation of these young people, mistrust among them should be entirely understandable. They use it as a protective mechanism. However, this is a huge
barrier for adequate integration of these unaccompanied minors. Mistrust can also translate into feeling “not safe”. Integration officers themselves are trustworthy, but trust is clearly an important issue for unaccompanied minors.

20. …., I had no freedom, they would tell us that keep quiet or you will die. (respondent 2)

21. In those three times the money I got I gave it to the police because I didn’t have any identity card, if you don’t have an ID …., you are nothing, so I gave the money to the police, the police will tell you that if you don’t have, your money is the ID. (Respondent 1)

This can be problematic for providing services in the host country who try to provide protection and promoting mental well-being for this group of refugees. This is further compounded by the feeling that services providers fail in their duty to provide help for these children. Understandably, mental and health care sensitivity need to be taken into consideration when working with these young people to promote their wellbeing, as their views about mental health services may only worsen if they feel their problems are becoming more intense. These young people have responded in a negative way to what is seen in contemporary practice which includes a full assessment and clarification of their experiences in detail. This by definition requires a great deal of questioning and characterising what kind of interventions are appropriate for them.

22. I appreciate that am in Sweden. I must thank God. (Respondent 4)

23. When I came to Sweden, I went for check up in the hospital and they discovered that I had TB. They gave me medicine. I have taken it for a month and it’s just one month left. (Respondent 2)

This does, however, have to be contextualised against the rest of the narratives in these interviews where the individuals particularly participant 5, denied having any mental health difficulty with the asylum-seeking process but appears very thankful he has been helped. There are clearly some contradictions in their accounts of their experiences and perceptions of the asylum process. However, to contextualise the experiences within Sweden health services, it is paramount to explore their experiences in the country of origin. The respondents were able to describe what their experiences or perceptions of mental health services were in their home countries. In general, the minors described health services as limited or absent. There
was also distrust of the professionals involved in these services, which may partially account for the limited trust of refugee services.

**Theme 4: Perspectives of participants on the asylum-seeking process**

In addition to the views expressed regarding the cultural background and experiences in Sweden, the unaccompanied minors did have views on the actual asylum-seeking process and the way they were received. The general treatment was viewed as good here in Sweden compared to other countries they passed through.

24. .....I stood in the line, they were calling one by one, when my turn came I went in and they asked where are you from, I answered................, how old are you, am 16 years old. Before that they asked me do you know English, I said yes, have you come to apply for asylum, yes then they gave a piece of paper and told sit there someone is going to come meet you and ask you some questions. Then I sat somewhere, a guy came and asked are your (.)? And I said yes and I followed him to his office and then he asked me some the reasons why I came to Sweden. (Respondent)

**Discussion**

Conflict in many parts of the world has led to an increase in refugees (13,15,18,22). Increased recognition that refugees have significant physical, social and mental health needs has meant a development of different services for them to improve their wellbeing in various host countries. The experiences of these young adults have elaborated the need to be appropriate to the requirements of this population and recognise their specific requirements. The voices of unaccompanied minors need to be acknowledged in these developments as they are a particularly vulnerable group.

An understanding of the concept of wellbeing is often essential in ensuring engagement with social support and integration (32). These concepts integration and social support were unfamiliar to some of these participants, and the majority reported strong negative views of wellbeing and mental health. Nonetheless, their negative perceptions of wellbeing are not entirely different from children living in western cultures (O’Reilly et al., 2009). These minors either denied them or reconstituted them as physical problems. The participant’s understanding did appear to be concomitant with their age; however, there were a number of influences upon this. This may be a reflection of their cultural differences (Lustig et al.,
may be an echo of the cultural attitudes of their home environment (Lynch, 2001) or their experiences of situations back home.

Describing wellbeing is notoriously difficult, and most minors typically think in terms of mental illness, rather than being physically, socially or mentally healthy (Svirydzenka et al., 2014). These adolescents appeared cautious of integration services for several reasons, including professionals identified as representatives of the government, and/or fear of deportation et al., 2011). Consequently, wellbeing and legal issues can be perceived as intertwined, despite the differences being explained to them. In my sample, the level of trust did not appear dependent upon their immigration status (33). However, this was a limited cross-section of this group. Thus, the mistrust of strangers could be viewed as protective, originating from their adverse experiences or culture (34). Trust is inherently a relational concept, which lies between people and events, people and organisations, and people (Gilson, 2003). Ultimately, therefore, trust involves a degree of risk derived from the individual’s uncertainty about the intentions, motives and future actions of others on whom they are dependent (Kramer, 1999).

Respondents reported finding the host country (Sweden) unfamiliar, which can affect trust, thus creating a further impediment to engagement. Furthermore, the unfamiliar language and limited independent communication may have had some effect. In many cultures, there is a mistrust of people outside of the family unit, and their current situation precludes them from accessing the support of their families, which they may have accessed if distressed in their home country. Although not universal, some adolescents in Western cultures have also been shown to lack trust in services which would support or enhance their wellbeing (Flisher et al., 1997; Wilson & Deane, 2001). The views of the unaccompanied minors should be seen in this context; however, their mistrust does seem to be to a greater degree. In child health and child wellbeing, the predominant modality of treatment remains the ‘talking’ therapies, and alongside these modalities has been an increased use of medication, despite their effectiveness not being fully evaluated (Lustig et al., 2004). Many of the respondents found engaging with integration difficult. This may reflect cultural experiences, where health care was limited or absent and treatment was different or a different understanding of illness. Explanatory models
of illness have a very strong cultural basis, and while integration has a well-established framework within a Westernised healthcare system, this is not universal globally.

Integration process can also be challenging, due to linguistic limitations (even when using interpreters) due to the loss of the subtle nuances of communication. Consequently, integration intervention may be deferred until their language has improved (Huemer & Vostanis, 2010). Wellbeing cannot be fully achieved when these minors have not seen their family for a long time. Staying away from family which they left in a war zone is hard for them to comprehend. This is a decision that needs to be balanced against the risk. Even with appropriate intervention, some respondents lacked clarity regarding their wellbeing (35). This does raise concerns around informed consent as they should understand the best coping strategies.

Although all the unaccompanied minors had refugee status, they had been within Sweden for different lengths of time, but they had all attended integration activities for at least 2 times. It is difficult to quantify the effects of acculturation (the process of cultural change), assimilation (adoption of cultural attitudes of the prevailing group) and peer group influences on these young people and therefore whether this process had influenced their understanding of the Western health culture (36). This variability does obviously pose challenges for their wellbeing, which supports the need for specialist clinicians who understand these needs. Fortunately, in this situation, they got the assessments and were provided by such professionals. The findings from this study have implications for ethics. Services should have the flexibility and accessibility to engage the child, and wellbeing input should always be integrated with welfare, education and physical health services, thus encouraging consistency and acknowledging the ‘integration’ role of those involved. Their access and engagement can be also improved by utilising the mediation of people who have already gained their trust (Davies & Webb, 2000).

Importantly, in addition to the history of trauma, the impact of the current psychosocial adjustment and uncertainty over the future are also considerations. Ideally, foster carers would need specific training on the issues facing these minors or if possible have a shared cultural background; however, finding foster placements or group accommodation which can meet
these needs is difficult, and this was reflected in the interviews (26). Ultimately, professionals still have the power to decide what services will be accessible particularly for those who actively choose to actively participate in integration activities. Young people can feel that their voice is not given due credence (LeFrançois, 2007), and this is particularly problematic for unaccompanied asylum-seeking/refugee minors. They may prefer to resist the indigenous pathways to care and health norms, or may view the service as intrinsic to their refugee application, rather than as a wellbeing or integration intervention. It is important to strike a balance between respecting their rights to make decisions and protecting them from long-term health consequences.

**Limitations**

This population remains under-represented in research, and there are inherent difficulties in accessing them. The sample itself is ostensibly small but is nonetheless representative of the population and reflects the quality criteria for sampling adequacy for the method (O’Reilly & Parker, 2013). The representative group is in the 16- to 18-years range and is potentially selected by the participants’ ability to endure the refugee process unaccompanied.

Although there were linguistic difficulties, the minors were able to express pertinent views from which to draw conclusions. Future research may focus on younger children or consider a wider sample from different countries of origin to obtain a broader range of perspectives and understanding (37). It may also be useful to obtain data from other localities within Sweden, but my data has transferability. At present, there is limited published literature on the experiences and perceptions of wellbeing in Swedish minors, particularly in relation to issues such as trust, and further work would be beneficial (1). Larger quantitative studies may help to inform service design or government policy with the aim of developing interventions which will facilitate care.
Conclusion
This study revealed inductive results of experiences of unaccompanied children on asylum-seeking process. It is evident that minors who migrate from conflict zones undergo through a number of challenges which put their wellbeing at a high risk and they are emotionally burdened for a lifetime. The results of the study indicated that unaccompanied refugee minors are in a highly vulnerable situation. High levels of emotional and behavioural problems may be present among unaccompanied refugee children. Experiences of post-migratory stresses faced by unaccompanied asylum seekers may interact and exacerbate their emotional symptoms. Therefore, it is most likely that the same kinds of problems are present in all countries, which are receiving or received unaccompanied children. A high level of healthcare and social security is paramount for unaccompanied minors.

The journey that refugee/migrants follow in order to reach the Europe is undoubtedly continuing. The possibilities of refugee children becoming unwell, physically, socially and mentally have been reflected on in this study. The leading reasons that the refugee children seek help from the healthcare providers are to improve their wellbeing. Other factors such as respiratory and gastrointestinal tract infections, poor hygiene, lack of vaccination and medication in chronic diseases are important factors that affect their wellbeing. Mental health is also a big issue concerning the sensitivity of their living conditions in refugee camps and detention centres, missing a safe environment to develop. Therefore, institutions with the mandate to pass policies and actions specifically targeting improving asylum seekers wellbeing need to act more to tackle this problem. This particular view of childhood wellbeing is a high cultural question and will need further research during the coming years.

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