

Family networks and refugees' health conditions. A picture from Italian informal settlements

Daria Mendola¹ and Annalisa Busetta²

Abstract

While the relationships between social networks and health are widely acknowledged in the literature, few of these studies have covered the population of refugees living in makeshift camps. In our analysis of a nationally representative Italian survey of individuals living in informal settlements, we find that many had weak family relations: only 10 per cent had one or more family members in their settlement. The paper analyses the effects of individual social network on two measures of health, and finds that the refugees' health conditions were associated with both their personal characteristics and the characteristics of the settlement. The results show that more than 50 per cent of these foreign nationals recently had health problems, and that those with no family members in the settlement had significantly higher chances of both being in bad or very bad health and having experienced a health problem in the last month.

Keywords: *asylum seekers; makeshift camps; self-reported health; social capital; social network*

Refugees' Social Networks, Social Capital, and Health

Health is a popular topic in refugee studies, as it is highly correlated to people's current and future well-being, and it affects nearly all dimensions of human life. Health is a serious concern for refugees living in camps in poor bordering countries, as well for those who have arrived in high-income host countries, and are experiencing marginalisation and deprivation (Paul, 2020). An individual's health status is based on past and current conditions, and it is related to multiple domains of personal experience via relationships that are bidirectional, and that change over time (Karademas et al., 2008).

The healthy immigrant theory – which argues that migrants are positively selected in terms of health compared to non-migrants in their country of origin, and are in better health than natives of the host country – does not apply to refugees. This is mainly because refugees often have prolonged stays in refugee camps, and undergo arduous journeys that undermine their health (Matlin et al., 2018). Indeed, in all phases of their journeys (pre-departure, travel, destination, interception, and return), forced migrants encounter a range of conditions, and are at high risk of experiencing traumatic events (Zimmerman et al., 2011; Mendola et al., 2020).³ Moreover, after reaching their country of destination (the “destination phase”),

¹ Daria Mendola, Department of Psychology, Educational Science and Human Movement (SPPEFF), University of Palermo, Italy. E-mail: daria.mendola@unipa.it.

² Annalisa Busetta, Department of Economics, Business and Statistics (SEAS), University of Palermo, Italy. E-mail: annalisa.busetta@unipa.it.

³ The factors influencing the health conditions of forced migrants differ depending on the phase. The “pre-departure phase” is often characterised by war, famine, environmental, and political factors, as well as by personal circumstances. The modes of travel and transportation are obviously crucial aspects in the “travel phase”, particularly for irregular migrants. The “interception



refugees may feel excluded, and find it difficult to cope with different cultural norms, and with having a different role in society. These feelings can, in turn, make it more likely that refugees will experience identity crises, social marginalisation (Bernier, 1992; Lamba & Krahn, 2003), poverty, and housing problems.

An interesting study by Lamba & Khran (2003) noted that the health of refugees depends in part on whether they can rely on familial and extra-familial ties⁴ (which can be seen as indicators of social capital). The authors pointed out that a “*refugee reporting no one with whom to discuss such issues [economic, personal, or health problems] might be an individual without reliable and trusted contact(s), or in other words someone with a limited stock of social capital*” (*ibidem*: 350).

Particularly in recent years, a growing number of studies have examined the characteristics of refugees' social networks and social capital, and how those characteristics affect their likelihood successfully integrating and remaining in good health (see, e.g., Cheung & Phillimore, 2014). Being able to rely on others for practical and emotional support is of paramount importance for the well-being and resilience of refugees, even after they have arrived at their destination.

Unlike most “voluntary” migrants, “*refugees often have their social and family networks severed in the process of fleeing from persecution*” (Cheung & Phillimore, 2013: 10). Thus, after arriving in the receiving country, refugees have to establish new connections, friendships, and relationships. They also experience the so called “refugee gap” (Connor, 2010; Ortensi & Ambrosetti, 2021) as a condition of lower integration into the labour market, with respect to not-forced migrants. Indeed, these formal and informal social networks may prove to be very helpful in supporting refugees as they deal with financial, employment, personal, or health problems (Lamba & Krahn, 2003); and having shared experiences is often employed as a support-seeking strategy (Simich et al., 2003). Indeed, as Elliott and Yusuf (2014) have pointed out: “*conceptualised as social capital, these relationships provide the invisible glue holding society together*” (*ibidem*: 101).

Only a few previous studies have attempted to provide a comprehensive and systematic enumeration of refugees' social networks, or to describe the specific links between these valuable social ties and health. One of these studies, by Cheung & Phillimore (2013), reported: “*living as part of a family at baseline has clear health benefits with 71% reporting good health [...] while those who lived with friends [were] also healthier but those who had lived in NASS [National Asylum Support Service in the UK] provided accommodation [were] the least healthy*” (*ibidem*: 27). In addition, based on qualitative interviews with service providers and policymakers, Simich et al. (2005) found that “*social support is perceived to play an important role in immigrant settlement and to have a positive impact on immigrant health*” (*ibidem*: 259). Similar findings were reported by Pedersen (2002), who examined the health of people in countries affected by war and political violence (as is often the case for refugees before they start traveling to Europe), and found that

phase” – i.e., the period of temporary detention or interim residence – is particularly important for forced migrants, irregular migrants, and undocumented workers, and is associated with a high risk of developing psychological and/or mental health problems. According to most of the literature on migrant health, the main health risks in the “destination phase” are connected to the socio-economic, living, and working conditions of migrants. The “return phase” refers to the stage when individuals go back to their origin countries, and may involve physical and psychological well-being risks due to the cumulative exposure to unfavourable social environment in the migration process. It has been pointed out that most refugees “*may keep contact with home countries but [...] return is not an option and new communities are built across national boundaries*” (Williams, 2006: 869).

⁴ “Familial ties include spouse or partner and children, as well as extended family members (parents, siblings, and other relatives). Extra-familial ties include: (a) friends; (b) ethnic group ties such as religious and community leaders and members; (c) extra-familial host community ties such as sponsors, service providers, employers, co-workers, teachers, and classmates; and (d) one-self” (Lamba & Krahn, 2003: 350).



“disruption of social networks, low social cohesion and relative isolation from their peers, lack of food and shelter” (*ibidem*: 185) are especially likely to affect the most vulnerable people, such as widows and single mothers.

Against this background, our paper focuses on the importance of family networks for refugees in the “destination phase” of their journey, and, in particular, on how these health risks are connected to the lack of familial and social networks, and to the detrimental living conditions of refugees and asylum-seekers living outside the formal reception system in Italy. In particular, we study the effects of the presence or absence of family networks in Italy, the presence or absence of an ethnic group of the same nationality in the camp, and the level of stability in the settlement on two different indicators of health: self-reported health, and whether the respondent had any health problems in the four weeks prior to the interview. The analysis is based on the results of the first survey of asylum-seekers and refugees in Italy, which included responses from refugees and holders and seekers of international protection status living in informal settlements in Italy (Mendola & Busetta, 2018).

Survey Data and Some Descriptive Statistics

In recent years, there has been a growing and unstable number of makeshift settlements in Italy that host foreign nationals with different juridical statuses (Belloni, 2016; Busetta et al., 2021). These settlements are not organised and are not official refugee camps; they are completely self-managed settlements, although some receive help from humanitarian organisations and local NGOs. In our study, we use data from the MSF-DSEAS Italian survey “Asylum-Seekers and Refugees in Italy: Informal Settlements and Social Marginalisation” (Médecins Sans Frontiers 2016; Mendola & Busetta, 2018). This was a probability survey that covered the whole Italian territory, and focused on medium to large informal settlements⁵ (i.e., with at least 50 inhabitants). These informal settlements were located in eight regions spread across the country. The survey collected information on both the makeshift settlements and the socio-economic and demographic characteristics of their inhabitants, with a special focus on health-related issues. A total of 565 interviews were carried out using a PAPI technique between April and December 2015 on people aged 18 and over (for technical details, see Mendola & Busetta, 2018).

Informal settlements and their inhabitants

In 2015, the MSF-DSEAS researcher team surveyed 27 informal settlements of medium to large size across Italy. About 40 per cent of these settlements were located in the big cities: i.e., in Rome, Turin, Palermo, and Bari. Most of them were occupied buildings (just under 70 per cent), while others were outdoor camps, mixed arrangements, or tent camps. The conditions of these settlements were often very poor, and the services they provided were frequently deficient. Of these 27 settlements, 11 sites were not equipped with running water, 13 lacked electricity, two had no drinking water, 12 lacked showers, and six lacked toilets. NGOs and/or associations provided aid of various kinds in 15 sites. Moreover, health care services were provided in 11 sites, and legal aid services were provided in nine sites. Only two sites had food distribution services, while four sites had clothing distribution, and one site had a literacy training service.

⁵ Settlements with foreign nationals related to agricultural work were not included in the survey.

Among those who arrived in Italy fewer than three months before the interview, the majority were asylum-seekers, and were waiting to access the host system (about 90 per cent), others had escaped from the official reception centres (Stranges & Wolff, 2018). We found that of the individuals in the settlements who had been in Italy for three or more months, most were foreign nationals who were holders of international and humanitarian protection, but were outside the official reception system, including refugees (just over 20 per cent), holders of subsidiary protection (27.4 per cent), holders of residence permits for humanitarian reasons (22.8 per cent), asylum-seekers (5.7 per cent), individuals without any permit of stay (11.3 per cent), and other typologies (11.2 per cent).

Due to the hard (and sometimes extreme) living conditions, and to the prevalence of men among the irregular immigrants to Italy, most of the people living in these settlements were men (86.3 per cent).⁶ Around 70% of the foreigners were under age 35 (the median age was 30). Almost one-third of the inhabitants had never entered the official reception system or institutional projects (29.3 per cent), while a small share had previously lived in more than two reception centres (3.3 per cent). The survey uncovered a high degree of ethnic concentration across the camps, with more than 75 per cent of these foreign nationals living in settlements in which their nationality was the prevalent one.⁷ When we looked at the distribution of these foreign nationals by the year since their arrival in Italy, we found that a significant proportion (38 per cent) had reached the country before 2011, while only 27.5 per cent had arrived from 2013 onwards. Most of the foreigners we interviewed had a regular permit of residence in the country, but were poorly integrated into the labour market;⁸ 11% of them were not able to read and write. In addition, our observation that most of these foreigners had no family networks in the settlement was a sign of their severe and long-lasting social marginalisation. The survey found that less than 10 per cent of the inhabitants had one or more family members in the settlement, and one-quarter had no family network, even in their home country.

Health conditions of refugees living in informal settlements

The health of the refugees was measured using two indicators: self-reported health status (with the traditional five ordered options) and the reported occurrence of any health problem in the last four weeks. According to the literature (e.g., Burström & Fredlund, 2001; Hernández-Quevedo et al., 2004), these two measures capture different aspects of health. Self-assessed health is generally seen as a reliable general indicator of “true” unobserved health, although it may be affected by self-reporting bias related to socio-economic characteristics and individual lifestyles. The reporting of recent health problems is a measure of an individual’s current health status that is able to capture both major and minor health problems. It is assumed that this indicator is less affected by memory bias or intervening factors, even if it does not allow us to distinguish among different types of health problems (e.g., infectious disease or mental health problems) and their severity.

⁶ This gender unbalance is due also to the fact that women and minors are more likely to find assistance from NGOs, or to be moved to available official shelters.

⁷ Among the 27 settlements, five camps had a prevalence of Nigerians, and four camps had a prevalence of Eritreans. Four camps were occupied mostly by Ghanaians, a further four camps had a prevalence of Somalis, and three camps were occupied mostly by Afghans.

⁸ In general terms, only a quarter of the refugees had a job in Italy. Among those who had arrived in Italy at least three months before, there was still a high degree of social marginalisation: i.e., even among those who arrived before 2011, the percentage who had any employment was below 35 per cent.



The survey uncovered disturbingly high levels of poor health: 86.5 per cent of the refugees who had arrived in the settlement less than three months previously, and 50.6 per cent of those who had been in Italy for at least three months, reported that they had experienced at least one health problem in the last month.

Given the poor health conditions reported by these refugees, their level of access to health care was insufficient.⁹ Among those who had arrived less than three months previously, only two per cent were registered with the NHS (Italian National Health System). Moreover, even for those who had been in Italy longer, the share who were registered did not rise above 70 per cent. Thus, it appears that the health care needs of these refugees were unmet by both formal providers of health assistance (primary care, emergency room, outpatient, public health services dedicated to foreign nationals, private practice, health services in the official reception sites, clinics or services in the settlements, or pharmacists) and informal providers of health assistance (association for assistance to foreign nationals, healers, mediators, family and relatives, employers, Italian friends, or immigrant friends). The survey found that 56 per cent of the refugees who had recently arrived and 28 per cent of those who had been in Italy for longer than three months had not seen any health care provider, despite having health problems.

Modelling the Relationship Between Availability of A Social Network and Health Outcomes

Our paper offers some insights on how the refugees' ability to rely on their own social networks shaped their probability of reporting being in poor health, even in an extreme context such as that of an informal settlement.

To compare the associations of a set of covariates with the two selected health outcomes, we decided to code self-reported health as a dichotomous variable, with very bad and bad health making up one category. This approach allowed us to model both health outcomes using binomial logit models. Table 1 displays the survey weighted estimates from two logit models for the two poor health outcomes, which refer, respectively, to general perceived health and the occurrence of recent health problems.¹⁰

The regressors are the same for both models. The regressors of interest for this study are those that can tell us, directly and indirectly, about the availability of social networks that refugees could rely on in case of need. Based on the thematic literature and on the constraints of the available information and the parsimony criterion, we selected three indicators of the presence of a social network: a) whether the refugee had any family member in the settlement (such as father, mother, cousins, sons/daughters, brothers, sisters, ...); b) the duration of the refugee's residence in the settlement; and c) whether the refugee belonged to one of the predominant nationalities in the settlement. While our choice of (a) should not require further

⁹ Evidence of unmet needs was also provided by Busetta et al. (2018), who documented that there were considerable disparities in access to medical care, both between citizens and non-citizens, and between regular and irregular immigrants in Italy. It has also been reported in the literature (e.g., Fiorillo 2020) that among refugees, there is an interplay between the lack of family networks and unmet medical needs. Unfortunately, we do not have room here to deal with this additional health outcome.

¹⁰ Estimates are presented as odds ratios: an estimated odds ratio greater than one tells us that the chances (odds) of being in bad health was greater for those respondents in a particular category of the explanatory variable than for those respondents in the reference category of the same explanatory variable (this corresponds to a positive value of the corresponding beta coefficient). Conversely, an odds ratio of less than one means that being in that specific category of the explanatory variable is better than being in the reference category, as it lowers the odds of reporting bad health.

explanation, we should make clear that (b) and (c) can be used as proxies for the refugees' available social capital. In particular, we assume that the longer a refugee stayed in the settlement, the greater the likelihood that s/he would establish new trusting and mutually supportive relationships with other settlement inhabitants, and, when present, with NGO representatives supporting the settlement. Moreover, we assume that it was an advantage for individuals to have the option to stay connected to a broad community of people from the same country, who likely had similar life experiences and religion (Rödlach, 2019). Indeed, as Belloni (2016: 509) pointed out, this kind of communal living can foster integration via easier access to “*useful information to navigate the new environment and by facilitating access to crucial economic and social resources*”, such as information on acquiring accommodation and employment, and a range of community benefits, including friendship and marital prospects.

The two models shown in Table 1 also include some control variables referring to the personal characteristics of the refugees (sex, age, years since migration in Italy, and literacy level) and to site-specific characteristics (access to water and electricity, options to shelter from bad weather, size of the settlement, geographical location of the settlement).¹¹

The presence of family members in the settlements was found to be a strong protective factor that reduced the probability of reporting being in bad or very bad health. This result is clearly consistent with the main literature on migrants and refugees (see, among others, Cacioppo et al., 2002; Kim, 1999). The survey showed that not having relatives in the settlement increased the odds of reporting being in bad or very bad health currently by about 23 times. By contrast, the other two indicators of social network availability were not shown to have any statistically significant effect.

Among the other covariates in model 1, living in a medium-sized settlement was found to be associated with a higher propensity to report being in bad health than living in a large settlement. Specifically, the survey found that living in a smaller settlement increased the odds of reporting being in bad health by about two times. This was likely because these settlements had lower visibility (they were often in rural areas), and thus received less support from NGOs or civic associations.

The foreigners who reported being healthier were disproportionately younger¹² and male. None of the other covariates were found to have significant effects on the propensity to report being in bad health.

The results of model 2 (on the occurrence of health problems in the last four weeks), which are displayed in Table 1, tell a very similar story. In line with the findings reported above, the analysis showed that having relatives in the settlement decreased the odds of reporting health problems in last four weeks by about eight times, which further confirms that having a family network had a positive impact on health (see also Kim, 1999; Ponizovsky & Ritsnerb, 2004). In addition, the model found there were non-significant effects for belonging to one of the three main ethnic communities in the settlement. Each increase of one year in the age of the respondent increased the odds of reporting health problems by about four per cent. Furthermore, being unable to write and read (even in the native language) nearly doubled the odds of reporting recent health problems. When we look at the settlement characteristics, we find that living in a settlement with poor endowments (namely, a lack of access to water and

¹¹ This control was introduced because in Italy, the national health care system is arranged on a regional basis.

¹² No quadratic effect of age was detected.



electricity) increased the refugees' odds of having recent health problems by more than five times.

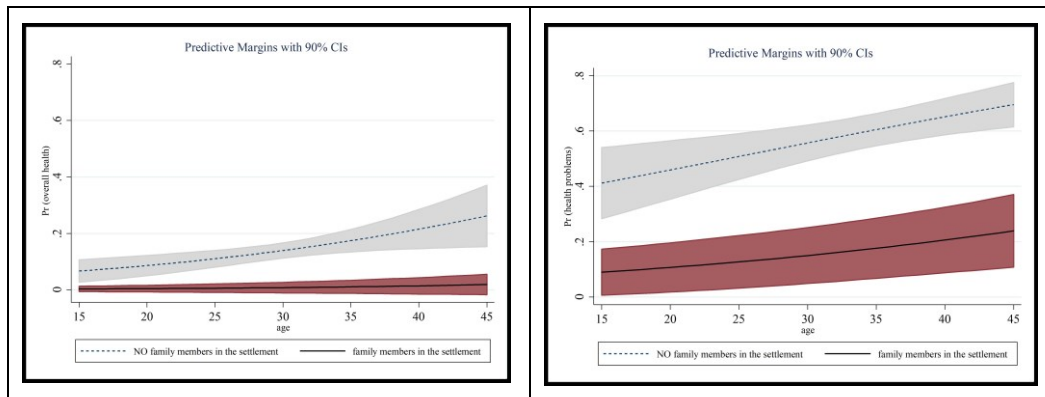
Table 1. Determinants of bad health conditions (odds ratios; survey estimates)

	Model 1 (overall health)	Model 2 (health problems)
SOCIAL NETWORK		
Having family members in the settlements	0.044**	0.115***
Belonging to the predominant nationality of the settlement	1.039	1.297
Long residence in the settlement (ref. 0-3 months)	0.901	0.815
PERSONAL CHARACTERISTICS		
Male	3.252*	1.195
Age	1.061**	1.044**
Illiterate	1.090	1.712*
Years since arrival in Italy	0.971	0.971
SETTLEMENT CHARACTERISTICS		
Poor shelter	1.009	0.951
Lack of water/electricity	1.425	5.233***
Medium-sized settlement (ref. large)	2.324**	0.996
Area (ref. North of Italy)		
Centre of Italy	0.369	1.453
South of Italy	0.590	0.794
Constant	0.012***	0.254*
No. of obs	466	498
* $p < 0.10$ ** $p < 0.05$ *** $p < 0.01$	F (12, 454) = 4.93 Prob (F>f) = 0.000	F (12, 486) = 5.33 Prob (F>f) = 0.00

Figure 1 shows that the average marginal effect (AME)¹³ of having bad health increased with the age of the respondent. Not having family members in the settlement increased significantly the odds of reporting both being in bad or very bad health and having experienced a recent health problem for the respondents aged 15 to 45 (who made up around 95 per cent of our sample). Moreover, we found that the lack of social networks mainly affected the objective indicator.

¹³ AME expresses the effect of a change of an explanatory categorical variable x_1 from one category to another, or the effect of an infinitesimal increase for a continuous variable, averaged across the values of the other covariates introduced in the model, on each modality of the ordinal response variable (see also Cameron and Trivedi, 2005).

Figure 1. Average marginal effects of having family members in the settlement on the probability of reporting being in bad or very bad health (left panel) and of reporting experiencing health problems in the last four weeks (right panel) by age



Discussion

Our aim in this contribution was to add to the debate on the relationship between refugees' health and their own social capital, with social capital being defined as being able to rely on familial networks in the usual place of residence; having a long-lasting, stable presence in the settlement (and thus the ability to establish new relationships with other settlement inhabitants, and, eventually, with NGO representatives supporting the settlement); and being a member of one of the three larger national groups in the settlements. To the best of our knowledge, this is the first attempt to assess this relationship among refugees living outside the official reception systems and in extreme living conditions, such as those of informal settlements.

The analysis was carried out on a sample of foreign nationals, applicants, and beneficiaries of international protection who were living in informal settlements in Italy. Although most of these foreign nationals were young, more than 50 per cent had recently experienced health problems, and their poor health was found to be strongly associated with the lack of family networks in the settlement, even controlling for both personal and settlements characteristics.

Moreover, we found that even for those refugees who belonged to one of the three main ethnic groups in the settlements, the community networks did not protect them from having bad health. Interestingly, our results are consistent with those from a report from the Nuffield Foundation - University of Birmingham (Cheung et al., 2013) on refugees in UK, which highlighted that "*between the different types of network or capital refugees most valued, friends and then family were more important than religious, co-national and co-ethnic and other groups*"; and that rights to family reunion are rated higher than other kinds of social networks or capital, "*perhaps emphasising the level of importance placed on family for those who had none in the UK*" (*ibidem*: 10).

The settlement characteristics were also shown to matter. Living in a smaller settlement (generally, smaller settlements had worse living conditions and no services for foreigners) increased the probability of being in bad health, whereas the lack of access to water and electricity increased the probability of having experienced a health problem in the last four weeks.



Naturally, this study has limitations. First, little information was available on the family networks of the foreign nationals in their destination countries and their countries of origin, and no information was available on the sizes and the characteristics of the social networks they had in Italy. Moreover, we had no information on the quality and quantity of the contacts among the foreigners and their social networks. Having access to such information would enable us to better understand the relationships at the centre of this study.

Second, for economic and ethical reasons, we were not able to accurately assess the health status of the respondents, and we acknowledge that self-reported health might be affected by some reporting biases.¹⁴ We recognise that “*individuals report health differently depending upon conceptions of health in general, expectations for own health, financial incentives to report ill health and comprehension of the survey questions*” (Bago D’Uva et al., 2008: 351). Unfortunately, we were not able to optimally control for these confounding factors.

Third, this paper did not provide causal explanations of the effects of social networks on bad health outcomes for several reasons. In particular, we were unable to control for some key explanatory variables (such as real medical conditions, mental health, and the effects of victimisation during the journey), and for the refugees’ initial conditions (such as their health status at the time of their arrival in Italy or at the time of migration). Finally, we were constrained by the small sample size, and had to be careful to avoid over-parameterising the model.

We are, however, confident that our results can contribute to the knowledge about a phenomenon that has certainly grown in importance in recent years, and that remains critical: namely, that of the health of refugee populations.

Acknowledgments

The survey “Asylum-Seekers and Refugees in Italy: Informal Settlements and Social Marginalisation” was designed by Daria Mendola and Annalisa Busetta in collaboration with Giuseppe De Mola from Médecins Sans Frontières - MSF- Italian Section, under the scientific collaboration agreement (prot. n. 2936 on 16/11/2015) between the Department of Economics, Business and Statistics (SEAS) of the University of Palermo and MSF Italy, Rome.

The views expressed here are those of the authors and do not necessarily reflect those of SEAS, SPPEFF, and MSF.

References

- Bago D’Uva, T., Van Doorslaer, E., Lindeboom, M. and O’Donnell, O. (2008). “Does reporting heterogeneity bias the measurement of health disparities?”. *Health Economics*, 17: 351–375. <https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.1269>
- Belloni, M. (2016). “Learning How to Squat: Cooperation and Conflict between Refugees and Natives in Rome”. *Journal of Refugee Studies*, 29 (4): 506–527. <https://academic.oup.com/jrs/article-abstract/29/4/506/2572053>

¹⁴Karademas et al. (2008) highlighted that “the way a person understands his/her own health is influenced not only by health-related perceptions and experience, but also by general cognitions about the self and the world. An implication of this finding is that health-related interventions (preventive or therapeutic) should also consider a person’s broader perceptions” (ibidem: 36). For more on this topic, see Hernández-Quevedo et al. (2004).

- Bernier, D. (1992). Indochinese refugees: A perspective from various stress theories. In: A.S. Ryan (ed.), *Social work with immigrants and refugees*. New York: Haworth.
- Burström, B. and Fredlund, P. (2001). "Self rated health: Is it as good a predictor of subsequent mortality among adults in lower as well as in higher social classes?". *Journal of Epidemiology & Community Health*, 55 (11): 836–840. <https://jech.bmj.com/content/55/11/836.short>
- Busetta, A., Cetorelli, V., & Wilson, B. (2018). "A universal health care system? Unmet need for medical care among regular and irregular immigrants in Italy". *Journal of Immigrant and Minority Health*, 20 (2): 416–421.
- Busetta, A., Mendola, D., Wilson, B., & Cetorelli, V. (2021). "Measuring vulnerability of asylum seekers and refugees in Italy". *Journal of Ethnic and Migration Studies*, 47 (3): 596–615.
- Cacioppo, J.T., Hawkley, L.C., Crawford, L.E., Ernst, J.M., Burleson, M.H., Kowalewski, R.B., Malarkey, W.B., Van Cauter, E., & Berntson, G. (2002). "Loneliness and Health: Potential Mechanisms". *Psychosomatic Medicine*, 64 (3): 407–417. <https://journals.lww.com/psychosomaticmedicine/toc/2002/05000>
- Cameron, A.C., & Trivedi, P.K. (2005). *Microeconometrics: methods and applications*. Cambridge University Press.
- Cheung S.Y., & Phillimore, J. (2013). *Social networks, social capital and refugee integration*. Research Report for Nuffield Foundation. Cardiff: Nuffield Foundation.
- Cheung, S. Y., & Phillimore, J. (2014). Refugees, social capital, and labour market integration in the UK. *Sociology*, 48 (3): 518–536. <https://journals.sagepub.com/doi/10.1177/0038038513491467>
- Connor, P. (2010). "Explaining the refugee gap: economic outcomes of refugees versus other immigrants". *Journal of Refugee Studies*, 23 (3): 377–397. <https://doi.org/10.1093/jrs/feq025>
- Elliott, S., & Yusuf, I. (2014). "‘Yes, we can; but together’: social capital and refugee resettlement". *Kotuitui: New Zealand Journal of Social Sciences Online*, 9 (2): 101–110. <https://www.tandfonline.com/doi/full/10.1080/1177083X.2014.951662>
- Fiorillo, D. (2020). "Reasons for unmet needs for health care: the role of social capital and social support in some western EU countries". *International Journal of Health Economics and Management*, 20 (1): 79–98. <https://link.springer.com/article/10.1007/s10754-019-09271-0/>
- Hernández-Quevedo, C., Jones, A. M., & Rice, N. (2004). "Reporting bias and heterogeneity in self assessed health. Evidence from the British Household Panel Survey". *Health, Econometrics and Data Group (HEDG) Working Paper*, 05/04. https://www.york.ac.uk/media/economics/documents/herc/wp/05_04.pdf
- Karademas, E. C., Sideridis, G.D., & Kafetsios, K. (2008). Health-related Information Processing and Recent Health Problems. Evidence from a Modified Stroop Task. *Journal of Health Psychology*, 13 (1): 28–38. <https://journals.sagepub.com/doi/10.1177/1359105307084309>
- Kim, O. (1999). "Mediation effect of social support between ethnic attachment and loneliness in older Korean immigrants". *Research in Nursing & Health*, 22: 169–175. [https://onlinelibrary.wiley.com/doi/10.1002/\(SICI\)1098-240X\(199904\)22:2%3C169::AID-NUR8%3E3.0.CO;2-F](https://onlinelibrary.wiley.com/doi/10.1002/(SICI)1098-240X(199904)22:2%3C169::AID-NUR8%3E3.0.CO;2-F)
- Lamba, N.K., & Krahn, H. (2003). "Social capital and refugee resettlement: The social networks of refugees in Canada". *Journal of International Migration and Integration/Revue de l'integration et de la migration internationale*, 4 (3): 335–360. <https://link.springer.com/article/10.1007%2Fs12134-003-1025-z>
- Matlin, S. A., Depoux, A., Schütte, S., Flahault, A., and Saso, L. (2018). "Migrants' and refugees' health: towards an agenda of solutions". *Public Health Reviews*, 39(1): 1-55. <https://doi.org/10.1186/s40985-018-0104-9>.
- Médecins Sans Frontières (MSF) (2016). *Out of sight. Asylum seekers and refugees in Italy: informal settlements and social marginalization*. Rome: MSF. Available at: https://www.aerzte-ohne-grenzen.de/sites/germany/files/attachments/aerzte_ohne_grenzen_out_of_sight_report.pdf.
- Mendola, D., & Busetta, A. (2018). "Health and living conditions of refugees and asylum seekers: a survey of informal settlements in Italy". *Refugee Survey Quarterly*, 37 (4): 477–505. <https://academic.oup.com/rsq/article-abstract/37/4/477/5208894>
- Mendola, D., Parroco, A.M., & Li Donni, P. (2020). "Accounting for Interdependent Risks in Vulnerability Assessment of Refugees". In: A. Pollice, N. Salvati, & F. Schirippa Spagnolo (eds.) *Book of short papers SIS 2020*, Rome: Pearson 1418-1423. ISBN: 9788891910776.
- Ortensi, L.E., & Ambrosetti, E. (2021). "Even worse than the undocumented? Assessing the refugees' integration in the labour market of Lombardy (Italy) in 2001–2014". *International Migration*. <https://onlinelibrary.wiley.com/doi/10.1111/imig.12884>



- Paul, S. (2020). "Characteristics of migrants coming to Europe: A survey among asylum seekers and refugees in Germany about their journey". *Migration Letters*, 17 (6): 825–835. <https://journals.tplondon.com/ml/article/view/1007>
- Pedersen, D. (2002). "Political violence, ethnic conflict, and contemporary wars: broad implications for health and social well-being". *Social Science & Medicine*, 55 (2): 175–190. <https://www.sciencedirect.com/science/article/abs/pii/S0277953601002611?via%3Dihub>
- Ponizovsky, A.M., & Ritsnerb, M.S. (2004). "Patterns of loneliness in an immigrant population". *Comprehensive Psychiatry*, 45 (5): 408–414. <https://pubmed.ncbi.nlm.nih.gov/15332205/>
- Rödlach, A. (2019). "Refugee health and religion: Karenni Catholics in Omaha, United States". *Migration Letters*, 16 (3): 389–397. <https://journals.tplondon.com/ml/article/view/636>
- Simich, L., Beiser, M., & Mawani, F.N. (2003). "Social Support and the Significance of Shared Experience in Refugee Migration and Resettlement". *Western Journal of Nursing Research*, 25 (7): 872 – 891. <https://journals.sagepub.com/doi/10.1177/0193945903256705>
- Simich, L., Beiser, M., Stewart, M., & Mwakarimba, E. (2005). "Providing Social Support for Immigrants and Refugees in Canada: Challenges and Directions". *Journal of Immigrant and Minority Health*, 7 (4), 259–268. <https://link.springer.com/article/10.1007%252Fs10903-005-5123-1>
- Stranges, M., & Wolff, F.-C. (2018). "From hell to heaven? Evidence of migration trajectories from an Italian refugee centre". *Demographic Research*, 39: 963–990. <https://www.demographic-research.org/volumes/vol39/36/39-36.pdf>
- Williams, L. (2006). "Social Networks of Refugees in the United Kingdom: Tradition, Tactics and New Community Spaces". *Journal of Ethnic and Migration Studies*, 32 (5): 865–879. <https://www.tandfonline.com/doi/abs/10.1080/13691830600704446>
- Zimmerman, C., Kiss, L., & Hossain, M. (2011). "Migration and health: a framework for 21st century policy-making". *PLoS Med*, 8 (5), e1001034. <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001034>



TÜRKİYE SINIRI VE SINIRÖTESİ KENTLERDE GÖÇ HAREKETLİLİĞİ VE KENTSEL YAŞANABİLİRLİK
Afrin ve Çevresi Gözlem Araştırması
by Zeynep Banu Dalaman ve Hüseyin Murat Lehimler
Yayın Tarihi: 09.09.2021

