COVID-19 IMPACT ON REFUGEES IN SOUTH EAST TURKEY

DRC DANISH REFUGEE COUNCIL

Needs Assessment Report **May 2020**

EXECUTIVE SUMMARY

The present assessment report is based on 4 weeks of data collection (from 5 April – 1 May 2020). The results of this study complete and expand on a first analysis conducted after the first week of data collection. The assessment seeks to explore the socio-economic impact of the COVID-19 crisis on the Syrian refugee population in south-east Turkey, in order to identify humanitarian needs and emerging vulnerabilities. Furthermore, the present assessment seeks to gather data on refugees' level of understanding of, and adherence to, the measures adopted by the government to contain the spread of the virus, including knowledge of COVID-19 services available and access to these.

Methodology

The aim of the present needs assessment is to provide an initial snapshot of the protection risks, vulnerabilities and emerging needs of refugee households in the south-east after the government of Turkey declared the COVID-19 emergency on 11 March 2020. The needs assessment, comprising 117 questions, examined refugee households' socio-economic status and the existence of pre-existing health conditions. The assessment also sought to understand the extent to which refugee households were aware and understood government imposed COVID-19 containment measures and level of adherence to these among households. Finally, the assessment also aimed at assessing the impact of government-imposed restrictions on community and household dynamics and on the psychosocial well-being of affected families. Findings from this report will inform DRC programmatic adjustments to better support refugees during the COVID-19 emergency in Turkey, and will feed into the humanitarian sector's understanding of those needs and its response. Data collection started on 5 April 2020 and was completed by 1 May 2020. During the first week (from 5-10 April), DRC field teams conducted 290 household surveys including 116 in Sanliurfa, 97 in Hatay, 41 in Kilis and 36 in Kahramanmaras. A first analysis of findings from this first week of data collection was produced. This assessment represents an update and follow up on the preliminary observations contained in the first analysis. Between 11 April and 1 May an additional 488 surveys were collected. [1]

Over the course of the entire 4 weeks, a total of 774 surveys were collected, of which 242 in Hatay, 341 in Sanliurfa, 71 in Kahramanmaras, 120 in Kilis.

By surveying household units rather than individuals, DRC aims at obtaining a small but representative age, gender, diversity sample (based on household composition).

1 In the second round a total of 488 new surveys were collected including 145 in Hatay, 35 in Kahramanmaras, 225 in Sanliurfa and 79 in Kilis.

Main Findings

A. **Livelihoods:** The present assessment found a worsening of the economic conditions of refugee households. In all, **74% indicated family finances being depleted because of government-imposed COVID-19 restrictions**. **In this assessment, a greater proportion of households who were previously employed are now out of work (33%) compared to the first study (37%). Furthermore, a greater percentage of households (72%) are now unable to cover basic expenses compared to a few weeks ago (67%).** In line with previous findings, reliance on negative coping strategies remains widespread among households but dependency on certain strategies has increased over the last weeks. In particular, households are borrowing money from family and friends or buying food on credit and are becoming increasingly indebted. Furthermore, there is evidence that households are increasingly cutting on essential expenses including food, medication and hygiene products compared to the first assessment. Findings from the needs assessment confirm that **the livelihoods of the most vulnerable households will be disproportionally affected by COVID-19 government restrictions.** These include households with family members suffering from disabilities and/or chronic conditions, single and women headed households, unregistered families and households with large family units of 6 or more members.

B. **Health: A large proportion of surveyed household present with complex medical conditions**. In total, 25% of households surveyed reported at least 1 family member with a chronic condition and 10% reported at least 1 family member with a disability. However, **44% of surveyed households expressed reluctance to approach a medical center in case they fall ill.** Overwhelmingly, households admitted avoiding hospitals for fear of contracting COVID-19 and being quarantined in a facility outside of home. Further, a significant number of households in all locations held the belief that hospitals were either closed or were only admitting COVID-19 cases.

C. **Knowledge and adherence to GoT COVID-19 measures:** Overall, **refugee households have a good understanding of COVID-19 symptoms and modes of transmission**. High levels of concern about COVID-19 were observed among refugee households and the majority reported limiting unnecessary movements outside their homes and indicated adopting specific hygiene practices to prevent the spread of the virus. However, **information on COVID-19 services available to refugees is limited**. The proportion of refugee households who indicated having limited or no information of COVID-19 related services increased to 72% during this assessment, compared to a previous 67% in the first study. For most refugee households **the main source of information on COVID-19 is the internet and social media**, followed by **community members, friends and family**.

D. **Community and household impact:** Observations of intra and/or inter communal tensions due to the COVID-19 crisis were infrequently reported by survey participants. Wherever tensions were reported, they were for the most part among members of the Syrian community and rarely between Syrians and Turkish citizens. **A rise in domestic tensions and frustration was reported by over half of households.** Routine disruptions, lack of income and uncertainty about the future were prevalent reasons for feelings of stress and anxiety. Although several respondents indicated adopting a number of strategies within the household to deal with increased levels of stress during this time of forced confinement, **a majority of households indicated not enacting any strategies to deal with increased levels of stress.**

E. **Psychosocial impact:** Stigma and shame associated with COVID-19 was not reported by surveyed households. Refugees are also largely unaware of referral systems for people suffering from psychological distress.

Recommendations

1. **Multi-purpose cash assistance and livelihoods**: Though findings suggest a 'blanket approach' of direct cash[2] or voucher assistance would be beneficial, to complement cash support already being delivered through the ESSN. Initial prioritization, based on the findings of this assessment, can cover the following particularly vulnerable groups:
   - Widowed/single and female headed households
   - Households with family members suffering from pre-existing health conditions including persons with disabilities and/or suffering from chronic conditions;
   - Families with six or more members, with one or less working family members during the crisis.
   - Unregistered refugees that may be cut off from governmental services and support programs.

   Given the unprecedented nature of the crisis**, a flexible approach to cash and voucher assistance programming** including flexibility in targeting and in shifting transfer modalities as the situation evolves, will be of paramount importance.

2. **GBV case management** and multi-modality support for GBV survivors, including through **stronger integration with livelihood interventions**, remains crucial. The needs assessment highlighted a rise in household tensions during this period, that could correlate with GBV issues in the longer term, suggesting the need for a continued robust GBV case management response by governmental and non-governmental agencies, as well as widespread dissemination of GBV hotlines and awareness raising on available recourse options, and PSS activities focused on household conflict resolution. In addition to this, it is important to afford particular attention in including GBV survivors in ongoing livelihood programming.
3. **COVID-19 awareness raising/outreach**. There is an acute need for blanket information dissemination on COVID-19 services available. This can be implemented through community based, interactive approaches.
4. **Health and psychosocial support**. Access to healthcare remains a major concern. A database of community-based medical professionals may present a viable link between government run healthcare services and community members. Knowledge of the government-run hotline with Arabic translation option is also important, while a further ease of restrictions on Arabic-speaking professionals to practice by the Government of Turkey would go a long way in alleviating language barriers challenging refugees' access to healthcare services.
5. **There is a need to increase psychosocial support to refugee households (using remote modalities where possible) that are tailored to gender and age.** Such interventions should aim at addressing the psychological distress related to future uncertainty, social isolation and aim at strengthening the psychological resiliency of families. Further it is paramount to scale up psychosocial support to victims of abuse given the proven increase incidence of GBV during times of lockdown and social isolation, while engaging men and boys who, as traditional breadwinners of the family, may feel particularly distressed by the current situation.

2 Challenges with cash transfers without existing financial transfer systems in place suggest that a voucher modality, covering multiple basic needs, may be preferable.

INTRODUCTION

The purpose of this assessment is to explore the socio-economic impact of the COVID-19 crisis on the Syrian refugee population in south-east Turkey and understand protection risks, in order to identify humanitarian needs and emerging vulnerabilities. Furthermore, the present assessment seeks to gather data on refugees' level of understanding of, and adherence to, the measures adopted by the government to contain the spread of the virus, including knowledge of COVID-19 services available and access to these. The results contained in this assessment complete and add to the preliminary observations analyzed in a first assessment based on the first week of data collection.

Turkey officially declared the first case of COVID-19 on 11 March 2020. As of 12 May, there are 139,771 reported cases and 3,841 deaths.[3]

In Early January and February, Turkey adopted containment measures including closing its borders with Iran (one of hardest hit countries by the COVID-19 pandemic) and Syria and interrupting flights from some of the worst-hit countries including China and Italy. Gradually, initial restrictions were tightened with the Government of Turkey (GoT) now having imposed travel bans on all international flights and strict restrictions on domestic travel across provinces. Further, GoT closed all education institutions, non-essential businesses and imposed strict movement restrictions on children and youth below the age of 20 and elderly of 65+ years of age. By late March, Turkey equipped all provinces with COVID-19 testing facilities and took steps to staff hospitals to treat and manage the pandemic.[4] Moreover, as of 10 April 2020, a complete lockdown of 30 provinces was also declared.

Notwithstanding early action to contain the spread of the virus, one of the greatest challenges relates to Turkey's vast refugee and migrant population of over 5 million, of which 3.6 million are Syrian refugees. Social isolation and marginalization alongside language barriers may be preventing many refugees from accessing accurate information on COVID-19 and appropriate prevention measures as well as available COVID-19 related services which may place them at higher risk of contagion.

Registered refugees enjoy access to basic health care in Turkey. At the same time however, public services, in particular state hospitals, are overstretched and under-resourced, which may complicate efforts to contain the spread of the virus. Within this context, an already over-burdened health system urgently needs to be adapted to confront a potential COVID-19 crisis.

Findings from the first assessment already revealed that government-imposed measures to contain the spread of the virus are having a significant impact on the humanitarian situation of refugee communities. For refugees and migrants, most of whom are employed informally, the greatest challenge is going to be economic and protection risks will likely be exacerbated, particularly for the most vulnerable. The loss of income opportunities due to the closure of non-essential businesses and social distancing measures are pushing many vulnerable households deeper into poverty, leading to resort to negative coping mechanisms. Resources and coping strategies families used to rely on are likely to become rapidly exhausted. Accordingly, humanitarian needs are expected to increase as traditional support systems have been partially suspended or have shifted to remote modalities including governmental and INGO services and activities as well as community based protection mechanisms. This may result in those families who were previously heavily reliant on external support to cover basic needs, being cut off from assistance. Ensuing the partial suspension of provincial directorates for migration management (PDMM) as a result of the COVID-19 crisis, refugees are already being curtailed access to certain services and assistance as they are no longer able to renew documentation including TPIDs or ESSN cards. Of particular concern are traditionally at-risk population groups including GBV survivors and persons suffering from disabilities which require specialized support. Studies have already reported an **increase in incidents of gender based violence** in Turkey[5] particularly intimate partner violence, because of the social isolation, scarcity of resources, rapidly changing responsibilities and expectations, and the physical confinement with, often, those initiating the abuse.

3 Al Jazeera. (9 April 2020). Coronavirus: Which countries have confirmed cases? Available at: https://www.aljazeera.com/news/2020/01/countries-confirmed-cases-coronavirus-200125070959786.html

4 Al Jazeera. (28 March 2020). Turkey suspends all international flights, expands restrictions. Available at: https://www.aljazeera.com/news/2020/03/turkey-suspends-international-flights-expands-restrictions-200328055429764.html

5 Al Monitor. (31 March 2020). Turkey's feminicide toll soars amid coronavirus lockdowns. Available at: https://www.al-monitor.com/pulse/originals/2020/03/turkey-women-domestic-violence-soars-coronavirus-lockdowns.html

METHODOLOGY

The needs assessment questionnaire comprises a total 117 questions sub-divided into 8 brief sections that aim at understanding the protection vulnerabilities of refugee community as a result of the COVID-19 containment measures adopted by the Government of Turkey as well as the level of knowledge of government regulations (please refer to the annex for the full questionnaire). The objective is to identify emerging needs that DRC programming can contribute to responding to. The survey sub-sections are as follows:

1. **Demographic information** of households: disaggregated by age, gender and also inquiring on the legal status of household members.
2. **Livelihoods**: This section aims at assessing the type of income sources of refugee households, how this income has been impacted by COVID-19 government-imposed containment measures and what are some of the coping strategies being put in place by households to manage this situation.
3. **Health**: This section aims to assess the prevalence of pre-existing health conditions among refugee households and the level of access to health care services.
4. **Knowledge of COVID-19 government regulations**: This section aims to assess the level of understanding of COVID-19 symptoms/risks and prevention measures among refugee communities
5. **Community impact:** this section aims at understanding the impact of COVID-19 and government containment measures on the communities in particular whether this has resulted in an increase intra/inter-communal tensions among Syrian refugees and among Syrian and Turkish hosts.
6. **Household impact:** This section aims at understanding the impact of COVID-19 containment measures (social isolation, social distancing, not going to work etc) on household dynamics and tensions and which members of the household are worse affected.
7. **Security/safety:** Aims at understanding the perceptions of safety/security of Syrian refugees in accessing services following the coronavirus outbreak.
8. **Psychosocial support:** Aims at understanding whether there is any stigma/shame within refugee communities or between Turkish and Syrian communities that are related to the new coronavirus and whether refugees have knowledge of any referral services available for those who are suffering psychosocial issues as a result of COVID-19.

Data collection started on the 5th of April 2020 and was completed by the 1st of May 2020. During the first week (from 5-10 April), DRC field teams conducted 290 household surveys, and a first analysis of findings was produced. This present assessment report is an update and follow up on the preliminary observations contained in the first analysis. Between 11 April and 1 May an additional 488 surveys were collected.

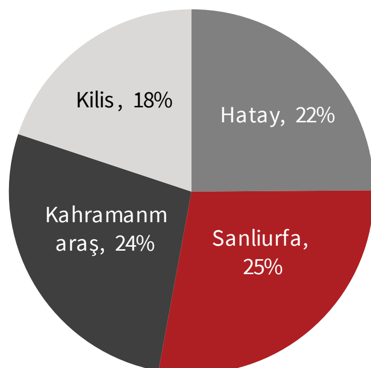
Over the course of the entire 4 weeks, a total of 774 surveys were collect of which 242 in Hatay, 341 in Sanliurfa, 71 in Kahramanmaras, 120 in Kilis.

By surveying household units rather than individuals, DRC aims at obtaining a small but representative age, gender, diversity sample (based on household composition)

To further ensure representativeness, respondents interviewed included a diversity of profiles. More specifically, particular care was afforded to ensuring interviewed participants did not only comprise of household heads so as to ensure a balance of views and perceptions in the responses.

Household identification is conducted by field teams through a snowballing approach where participants are selected from DRC's pool of pre-existing beneficiaries in each area of operation, with further phone numbers of those beneficiaries' social contacts collected at the end of every survey.

% of households surveyed per location

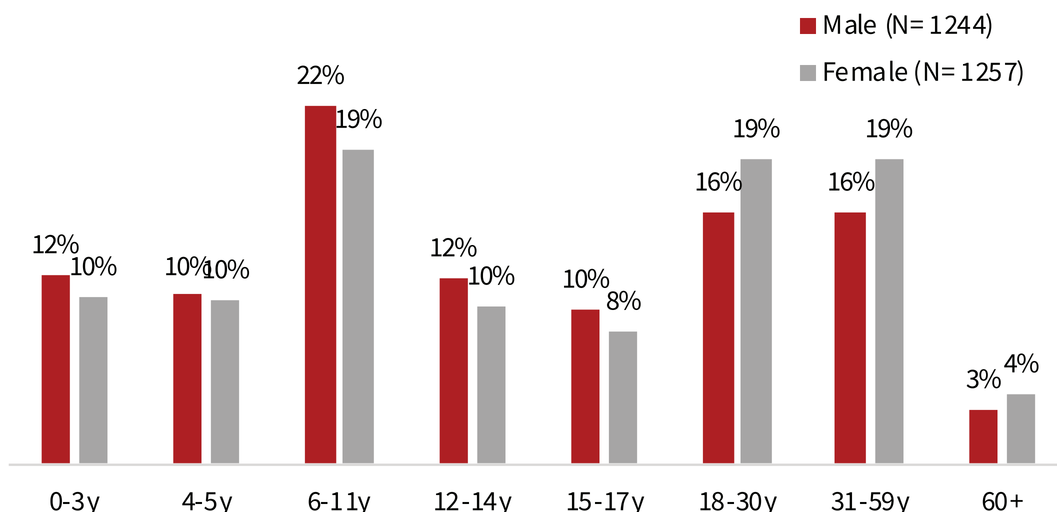


A. DEMOGRAPHIC PROFILES OF REFUGEE HOUSEHOLDS

Finding 1: *Larger family units and single-headed households are likely disproportionally affected by the Government of Turkey response to the COVID-19 emergency.*

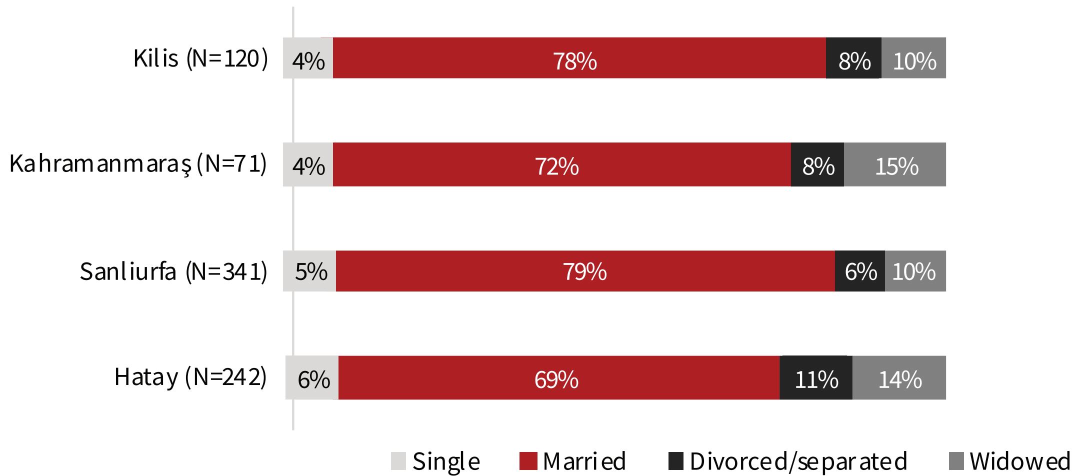
Across all 4 locations, refugee households presented similar profiles. Families were mostly composed of an equal number of male and female members, the majority aged between 18 and 59 or 6 and 11 years (Graph 1).

Graph 1: Family composition - by age and gender



Further, the heads of the family were mostly married (for 75% of households on average) and male. Out of 774 surveyed households, 68% were headed by a male versus only 32% headed by a female (Graph 2).

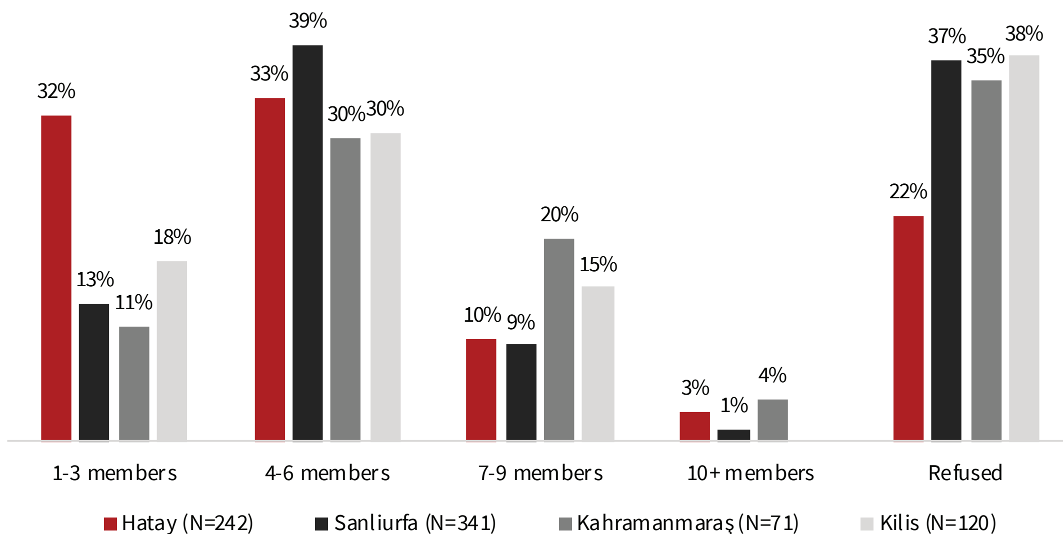
Graph 2: Marital status of household heads- by location



However, differences could be observed across the different locations which could point to specific vulnerabilities of households in these areas. Although most households indicated a family unit ranging between 4 and 6 members (on average 33% of households across locations), in Kahramanmaraş and Kilis larger units of 7 or more members (24% and 15% respectively) were observed (Graph 3). Poverty among refugee households has been extensively documented by DRC's earlier research.[6] Pre-existing conditions of vulnerability are likely to be exacerbated by COVID-19 containment measures imposed by the government as many refugees have been forced out of work.

A second vulnerable category includes single-headed households, whether never married, widowed, divorced/separated from their partner and, among these, single female-headed households in particular. The largest proportion of heads of the household that were not married were observed in Hatay who, along with Kahramanmaraş also reported the largest proportion of female-headed households (43% and 41% of surveyed households respectively, graph 2). These households may face particular challenges in adhering to government-imposed measures of social isolation, as they struggle with competing responsibilities of child-rearing and having to provide for the family with limited or no support.

Graph 3: Family size- by location

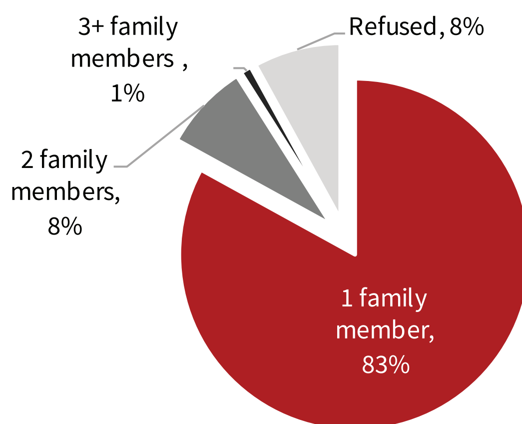


6 DRC Briefing Paper. (December 2019). Protection Risks Review

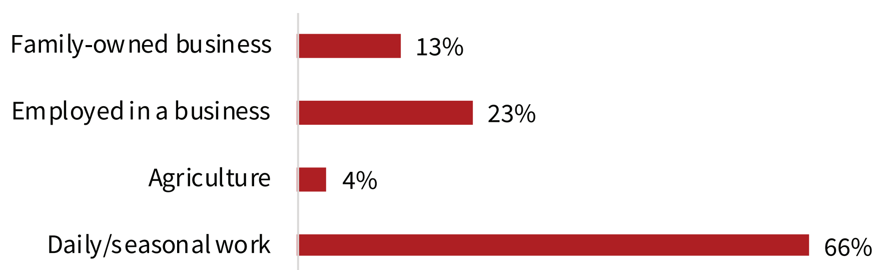
B. LIVELIHOODS

Out of 774 surveyed households, 49% (377) indicated that at least 1 family member was employed prior to the outbreak of the coronavirus crisis. Among the households that agreed to share further details, 83% indicated that only 1 family member was working, 8% had 2 family members working and only 1% indicated having 3 or more family members working (graph 4). In most instances, the head of the household was also the only breadwinner of the family. Among the 377 households that were working prior to the onset of the COVID-19 crisis, 66% did not have a stable income, but rather relied on daily and seasonal jobs. Those few households that reported family-owned businesses, also reported a higher number of family members (3 or more) having a job before the pandemic (graph 5)..

Graph 4: % of surveyed households employed prior to COVID-19- by number of family members employed (N=377)



Graph 5: % of surveyed households employed prior to COVID-19- by type of employment (N=377)



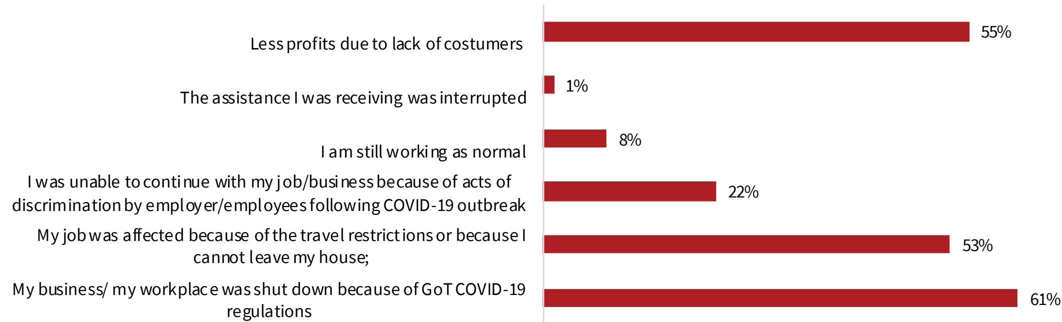
Finding 2: *The majority of households' income sources across all 4 locations were negatively affected by the COVID-19 crisis.*

Out of 774 surveyed households 74% said their income was negatively affected by the COVID-19 crisis. This includes households who were employed prior to the pandemic and households who relied exclusively on humanitarian assistance to cover basic needs while experiencing a reduction of traditional supports owing to the closure or partial suspension of many assistance programs.

Out of the 377 households that indicated being employed prior to the COVID-19 crisis, 84% (315 households) indicated their income having been negatively affected by the government imposed measures to contain the spread of the virus. As shown in graph 6, the closure of many businesses and employment sectors because of COVID-19, as well as government imposed travel restrictions, have significantly disrupted the livelihoods of households previously relying on daily and seasonal work or other forms of part-time employment. Furthermore, containment measures confining youth at home

may have resulted in many households losing their breadwinner. Earlier DRC research has evidenced that refugee households often rely on youth to support family income as it is often easier for younger refugees to find employment in the informal market. Out of 377 households that had a job prior to COVID-19, 8% indicated the breadwinner was a youth between 15 and 25 years old.

Graph 6: How has you or your family's monthly income been affected by the current COVID-19 pandemic? (N=377)



"My son is 19 years old and because of government regulations he cannot leave the house. Now he is staying at home and cannot work so our income has stopped." (Surveyed household, Kahramanmaraş, 7 April 2020)

In particular, out of 377 previously employed households, 69% (259) said they had lost their job because of COVID-19, but salary reductions and other disruptions were also reported among those 31% (118) that had managed to retain their job. Of the 118 households that still had a job, half of them said their workplace registered less profits because of lack of customers. Accordingly, some respondents reported that employers were paying lower salaries or had not paid their full salary since the onset of the COVID-19 crisis, while others indicated being shifted to a part-time modality and working less hours than before.

"My husband is working in a restaurant but the owner hasn't paid his full salary since the coronavirus crisis started. Now there are less customers and they are not making enough money." (Surveyed household, Sanliurfa, 10 April 2020)

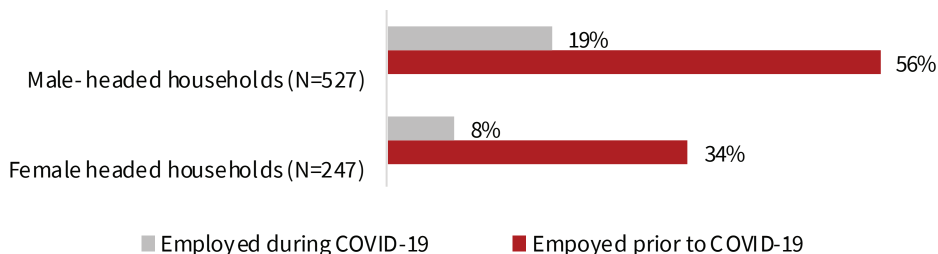
Comparing present data with that collected during the first round, a worsening of economic conditions of refugees can be observed. Out of 488 new surveys gathered during this last round, 239 households indicated being employed prior to the outbreak of COVID-19. Of these, only 33% (79) were able to retain their job, representing a 4-percentage point drop compared to the first assessment analyzed in April. During the first round, out of 290 surveys collected, 158 households indicated having a job prior to the outbreak of COVID-19, of which 37% (58) were able to keep their job into the crisis. Related to this, a greater percentage of the 488 refugee households surveyed in this round indicated being unable to cover expenses (85%, 415) compared to the first round (79% of the 290 surveyed households). It is possible that previously available negative coping mechanisms are becoming rapidly exhausted pushing families deeper into poverty. In particular, data analysis found that households who are indebted because of borrowing money from family or friends, or buying food on credit, increased to 82% from a previous 80%. Moreover, a larger proportion of households during this round indicated cutting on expenses (69%) including food, medication and hygiene products compared to the first round (65%).

Finding 3: *Most affected households included at risk population groups such as households with family members suffering from disabilities and/or chronic conditions as well as women- headed and single-headed households.*

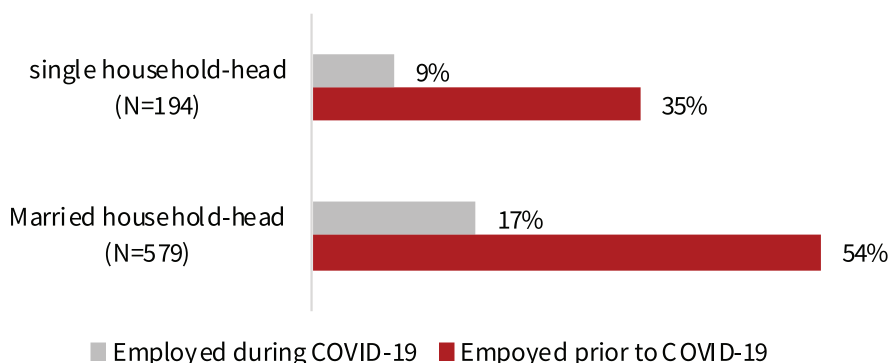
As mentioned earlier in this report, disproportionally affected by COVID-19 containment measures were female headed households. According to the data (graph 7), surveyed households headed by women (247) were less likely to have been employed prior to the COVID-19 crisis (34% of women headed households versus 56% of male-headed households). Furthermore, only 8% of female-headed households remained employed with the onset of the COVID-19 crisis, an over fourfold drop compared

to the pre-pandemic period. This compares to 19% of male-headed households that remained employed during the crisis. Similar results were observed when triangulating the data on the marital status of the household head (graph 8). Those household heads who were single - whether because divorced, separated from their partner, widowed or never married (these in most cases coincided with being female heads) - were less likely to have been employed prior to COVID-19 crisis compared to married household heads. Once again, out of 35% of surveyed single household heads who were employed prior to COVID-19, 9% remained employed with the onset of the crisis, compared to 17% of household heads who are married.

Graph 7: Employment - by gender of household head

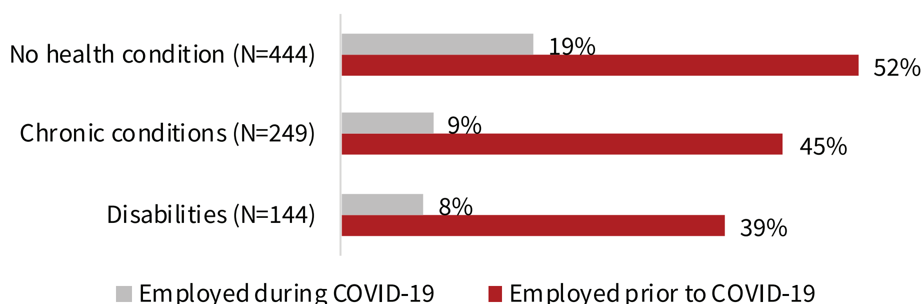


Graph 8: Employment- by marital status of household head



A second at-risk population group includes households who have family members suffering from a disability (whether physical or mental) or a chronic condition (graph 9). Households with pre-existing health conditions had higher unemployment rates than households without health conditions.
In particular, 61% of the 144 households reporting members with disabilities and 55% of the 249 households with members suffering from a chronic condition were unemployed prior to COVID-19. In both cases, employment rates dropped to less than 10% with the onset of the pandemic. This compares with 48% of households without health conditions who were employed prior to COVID-19.

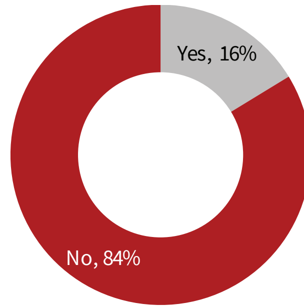
Graph 9: Employment-by pre-existing health conditions



Finding 4: *Reliance on negative coping strategies is widespread among households, most of whom are unable to cover basic expenses.*

In all, 84% of surveyed households are unable to cover monthly expenses during COVID-19 (graph 10). Prime concerns include inability to cover rent costs and utility bills (cited by 89% and 79% of the 643 households who cannot cover expenses) while access to food is an issue for 44% of households.

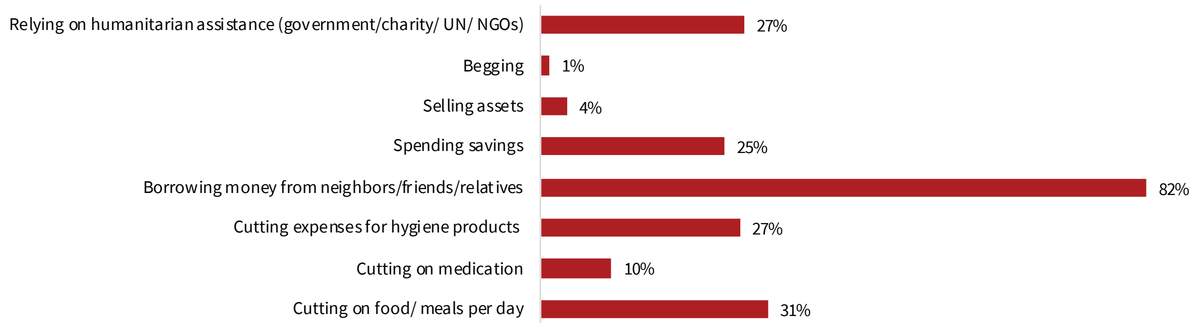
Graph 10: Are you able to cover monthly expenses following these cuts (rent, food, bills)? (N=774)



Furthermore, 82% of households surveyed admitted adopting 1 or more negative coping strategies to ease financial burdens. Although most households indicated relying on between 1 and 3 negative coping strategies, the heaviest reliance on these was observed among households in Kilis and Hatay with 17% of households in Hatay and 10% of households in Kilis enacting 4 or more potentially harmful mechanisms to cover expenses.

The most common such coping strategies included borrowing money from relatives and friends (cited by 82% of respondents), or buying food on credit at the market, indicating that many refugee families will sink deeper into poverty as they become increasingly indebted. Other common coping strategies mentioned included cutting on food consumed per day (cited by 31% of respondents) and spending savings (cited by a quarter of respondents, graph 11).

Graph 11: Type of coping strategies employed by households (N=637 *the total number of households who reported adopting negative coping strategies)

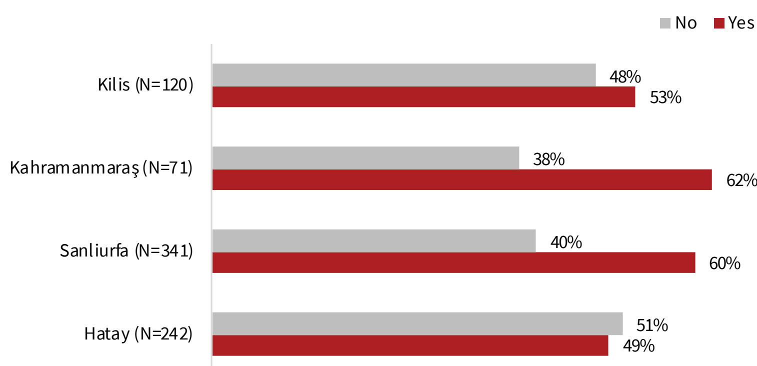


It can be assumed that households had been enacting some of these coping strategies prior to the outbreak of COVID-19, given the fairly recent imposition of government restrictions, which were first introduced on 11 March 2020. However, the widespread reliance on such strategies represents an alarming indication that households lack resources and social protections to sustain living expenses without a regular source of income. It is therefore likely that reliance on harmful coping strategies will increase in the next months, and limited resources available will become rapidly exhausted pushing many refugee households deeper into poverty.

Finding 5: *The partial suspension of PDMM activities due to COVID-19 containment measures, may restrict access to assistance for some refugees.*

Overall, reliance on humanitarian assistance was high among surveyed households across all 4 locations. On average, over half of interviewed households in all locations indicated being an ESSN beneficiary, with the highest proportion in Sanliurfa (60%) and Kahramanmaraş (62%, graph 12).

Graph 12: Are you a beneficiary of ESSN or other forms of cash/food assistance? - by location



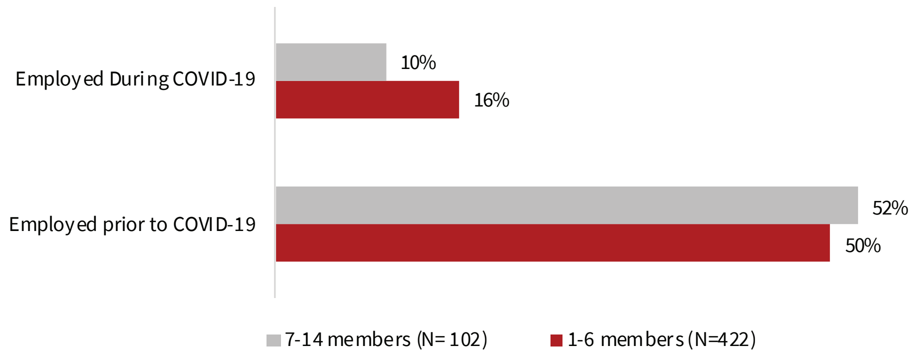
Furthermore, almost a quarter of households across all 4 locations reported receiving other forms of humanitarian assistance.

At present, however, many humanitarian organizations that have traditionally supported refugees have shifted to remote modalities. This may impact such organizations ability to assist refugees and provide crucial services for some of the already highly marginalized groups, forcing those to use scant resources to fend for their own needs. Furthermore, the partial suspension of services of provincial directorates for migration management (PDMMs) may also restrict access to assistance to some refugees. As part of government imposed containment measures, PDMMs have suspended registration for anyone except newborns. This is resulting in refugees who are unregistered or do not have valid documentation being cut off from government assistance programs. This was reported by one surveyed household in Hatay who was cut off from ESSN assistance as they were unable to register their new home address at the PDMM:

"The ESSN card has stopped because I was not able to register my new address due to the suspension of governmental activities"(Surveyed household, Hatay, 3 April 2020)

As confirmed by the data, at-**risk population groups may be disproportionally affected by any disruption of assistance programs**. These include in particular refugee households with family members suffering from disabilities and/or chronic conditions, as well as women-headed households who, as mentioned earlier, were less likely to have an income source prior to the COVID-19 crisis and relied almost exclusively on humanitarian assistance to cover needs. A final potential indicator of economic vulnerability is family size. Households with the largest family units of 7 or more family members are less likely to have retained their source of income and employment during the COVID-19 crisis compared to smaller sized units. The graph 13 shows that prior to the outset of COVID-19 in Turkey about half of surveyed households in each group were employed. Yet, only 10% of the larger family sizes reported being still employed during the crisis versus 16% of smaller sized family units. Adding to this, and within the group of large family sizes, the largest families of 10 or more members reported the lowest employment rates prior to the COVID-19 crisis, whereby 71% of them were unemployed prior to the COVID-19 crisis compared to 50% of households of smaller family units.

Graph 13: Employment status - by family size

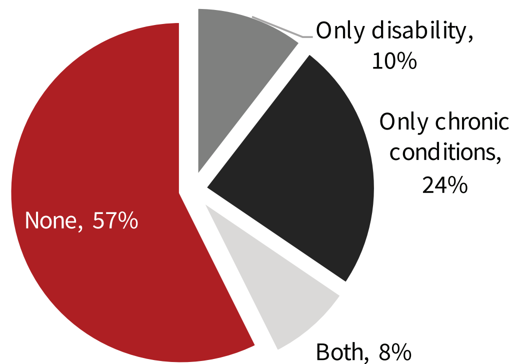


C. HEALTH

Finding 4: *Pre-existing health issues including disabilities and chronic conditions were reported by a large number of surveyed households across all 4 locations. Comorbidity between disabilities and chronic conditions was also common.*

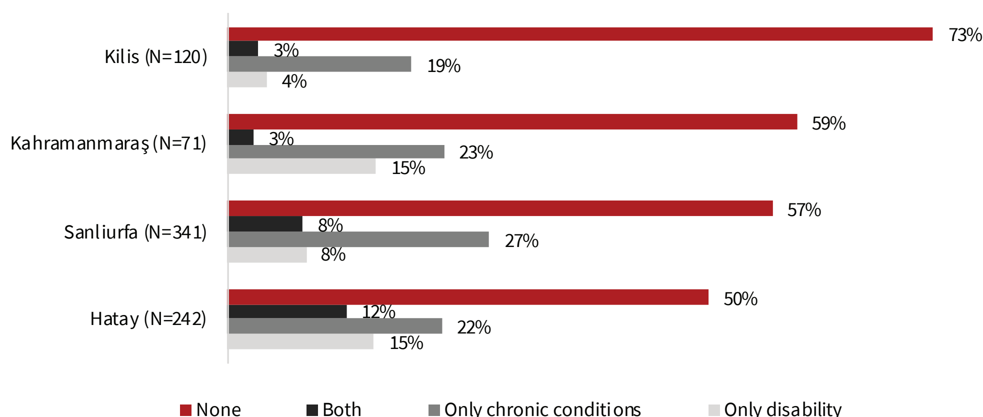
Out of 774 surveyed households, a quarter reported having at least 1 family member suffering from a chronic condition. These ranged from heart disease, hyper/hypotension, cancer, pulmonary diseases and kidney diseases. In addition, 10% of households had at least one family member suffering from a disability. This included both a physical disability such as leg/back injury or hearing impairment, or a mental disability, the most commonly reported included autism and depression. Importantly, comorbidity between the two conditions was frequently reported, and accounted for 8% of the total households surveyed (graph 14).

Graph 14: % of households with pre-existing health conditions . (N=774)



In analyzing the data disaggregated by locations some differences could be observed in the prevalence of pre-existing health conditions among households. As shown in graph 15, chronic conditions were most frequently reported in Sanliurfa (comprising 27% of interviewed households) and Kahramanmaraş (23%), representing almost a quarter of surveyed households in this area. It must be noted that some of these households, particularly in Sanliurfa, reported family members suffering from multiple chronic conditions.

Graph 15: % of surveyed households with pre-existing health conditons

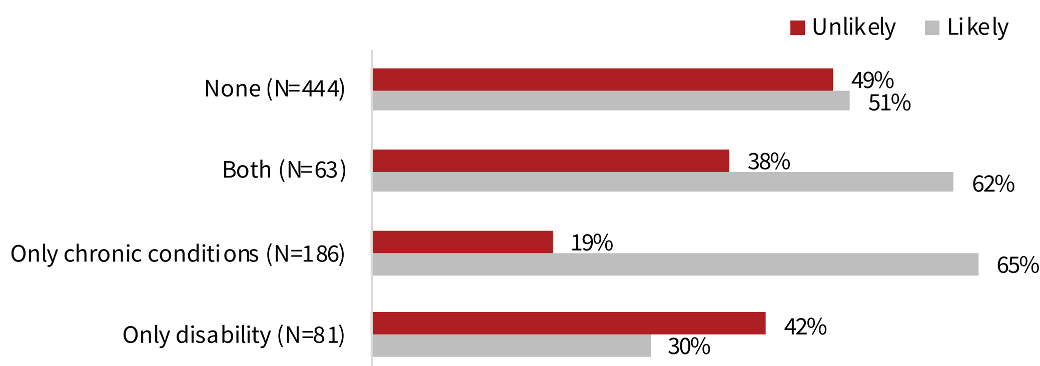


Furthermore, Kahramanmaraş and Hatay also presented the largest number of households with members suffering from disabilities, both physical and mental (accounting for a further 15% of surveyed households in each location). Important vulnerabilities also emerged in Hatay, which presented the highest percentage of comorbidity between chronic conditions and disabilities among households (12%) followed by Sanliurfa (8%,). Kilis, on the other hand, presented the lowest prevalence of health conditions among surveyed households and the highest number of healthy families.

Finding 5: *Refugee households across all 4 locations expressed reluctance to approach a medical center in case they fall ill. In particular, concerns were widely expressed among households with members suffering from disabilities and chronic illnesses.*

In all, 44% of surveyed households (342) indicated being reluctant to approach a hospital or medical center in case a family member falls ill. Among these, 342 (82%) expressed concerns associated with reaching out for treatment. Highest levels of distrust were observed among households in Hatay and Kahramanmaraş where over half (51% in each location) said they were unlikely to approach a hospital in case of illness.

Graph 16: How likely are you to report and visit a health centre? - by pre-existing health condition

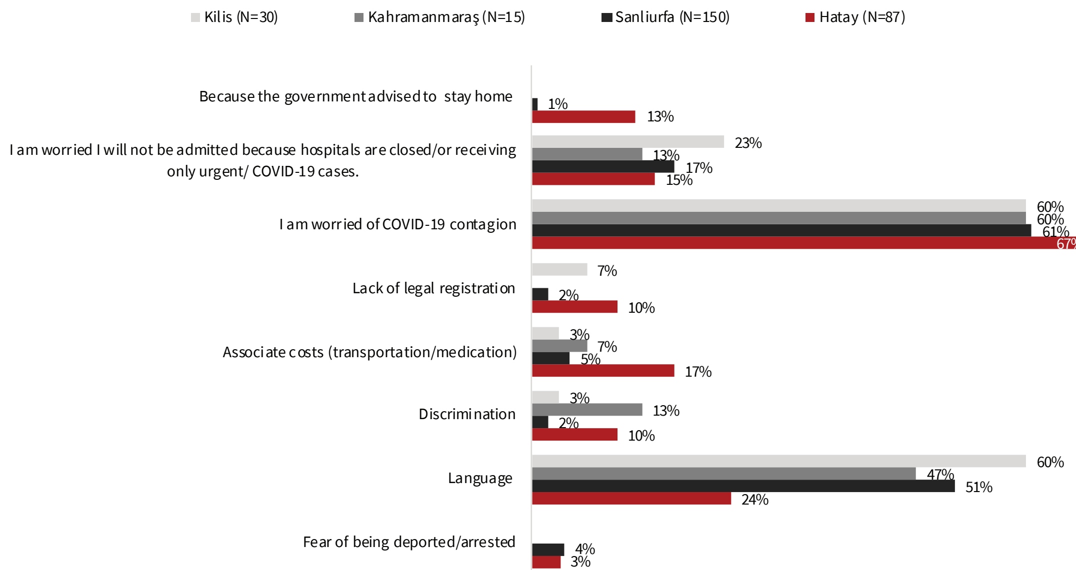


Among the main concerns expressed by households, not being able to communicate in Turkish was a common discouraging factor across all 4 locations. Overwhelmingly however, households expressed fears of catching COVID-19 in hospitals in all locations. Further, a significant number of households in all locations held the belief, not necessarily true, that hospitals were either closed or were only admitting COVID-19 cases and therefore other medical conditions would not be able to be admitted to treatment (Graph 17). This is an alarming finding possibly indicating that refugees with complex medical conditions may not be seeking the required and urgently needed care, which in turn could cause significant deteriorations of their symptoms making future treatment more difficult and costly. Such assumption seems to be partially confirmed by the data. Graph 16 shows that households with at least 1 family

member suffering from a disability are least likely to approach a medical center during COVID-19 in addition to 38% of households with complex medical conditions with members suffering from both chronic illnesses and disabilities.

Graph 17: "If you fall ill, are there any specific concerns /difficulties you may have to approach a medical center?" - by location

(Percentages are out of the subset of households (282 households) who identified concerns in approaching medical centers).



"**The hospitals and health centers are closed because of COVID-19 and they are not treating people anymore**." (Household survey, Kilis, 7 April 2020)

Differences in concerns were also observed across locations. For instance, households in Sanliurfa and Hatay expressed the greatest fears of being arrested and deported should they approach a hospital. Accordingly, these two locations were also the most concerned about following the government's regulations/advisory to stay at home. Also related, households in Sanliurfa and Hatay were reluctant to approach hospitals because of legal registration issues. On the other hand, concerns about discriminatory treatment in hospitals and medical centers were most commonly reported in Sanliurfa and Kahramanmaraş.

"**I am afraid of going to the hospital because I may be deported because I do not have a TPID**." (Household survey, Hatay, 7 April 2020)

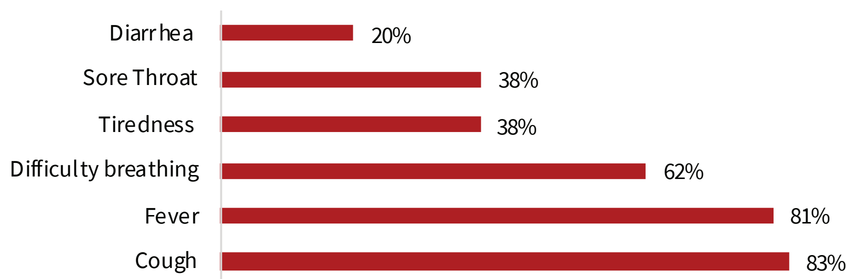
These findings were further confirmed when households were asked whether they felt safe in accessing health services since the outbreak of the Covid-19 pandemic. Overall, 35% (276 households) said they either felt unsafe or somewhat safe. Among these, 89% indicated being afraid of contracting the virus in the hospitals while a further 7% were unsure about whether they would be admitted to the hospital. Among these several respondents expressed the belief that hospitals were 'closed' or that they were unsure which hospitals they could access, indicating a certain degree of misinformation among refugees of the level of services that are presently available to them.

D. KNOWLEDGE OF COVID19- AND ADHERENCE TO GOVERNMENT GUIDELINES

Finding 6: *Overall refugee households have a good understanding of COVID-19 symptoms and modes of transmission.*

All surveyed households had some knowledge of COVID-19 and a good level of main symptoms and modes of transmission (Graph 18). Cough and fever were identified as the main symptoms by 83% and 81% of the 774 surveyed households, followed by respiratory problems identified by 62% of households. Other symptoms identified by respondents included headaches and the loss of the sense of taste and smell. Furthermore, 89% indicated the virus can be transmitted from person to person while 77% acknowledged the virus could be transmitted by touching infected surfaces.

Graph 18: What are the symptoms of the new corona virus according to your knowledge? (N=774)

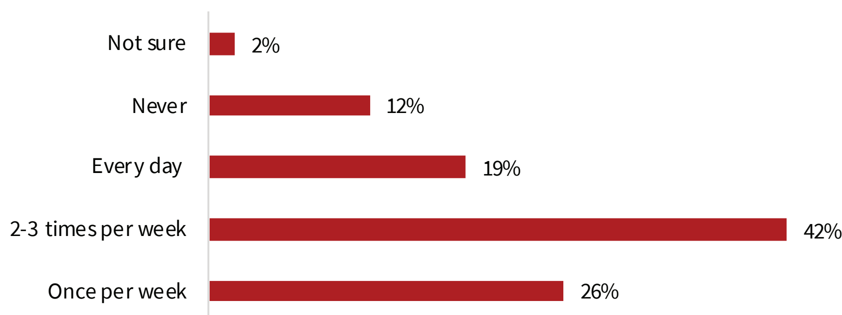


Finding 6: *High levels of concern about COVID-19 was observed among refugee households who widely practiced social distancing and specific hygiene measures to prevent infection.*

In an attempt to understand adherence to GoT guidelines following the outbreak of COVID-19 in Turkey, surveyed households were asked how frequently they left their homes during the week.

The majority of households indicated attempts to limit unnecessary movements during the week with only 19% reporting leaving the house every day. A higher percentage of households (42%) indicated leaving the house on average 2-3 times per week while a further 38% indicated either leaving the house once per week or never (graph 19).

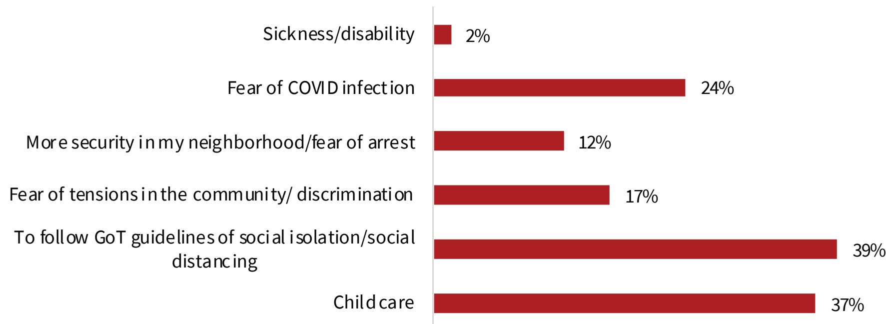
Graph 19: How often do you leave the house? (N=774)



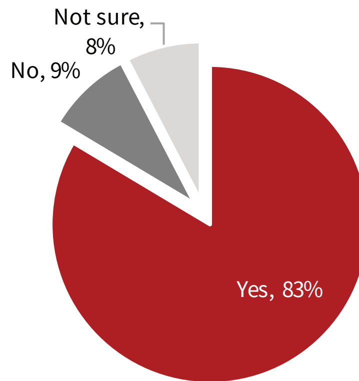
For most households the prime reasons for leaving the house were to buy groceries (61%) or to attend urgent matters (35%) while only 7% reported leaving the house to socialize with family or friends. Some 17% of households also indicated members leaving the house in order to go to work.

Among the 289 households who indicated leaving the house once per week or never, a quarter explained not leaving the house for fear of contracting COVID-19 and 39% didn't leave the house in order to adhere to the GoT's social isolation and social distancing recommendations, this included adhering to quarantine regulations for elderly and youth below the age of 20 (Graph 20). Another important impediment to leaving the house included child rearing responsibilities cited by 37% of respondents and likely to become an increasingly prevalent factor for single parents, particularly in the context of school closures and quarantine rules.

Graph 20: What is stopping you from leaving the house every day? (N=289)



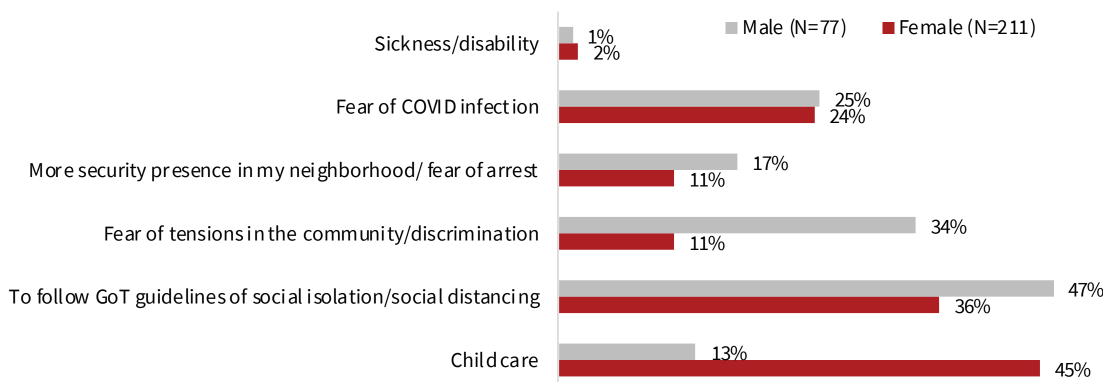
Graph 21: Are you applying any specific hygiene precautions in response to COVID-19? (N=774)



Graph 22: Are you applying any specific hygiene precautions in response to COVID-19? (N=774)

Related to this, and when analyzing the data through a gender lens, differences in motivations emerge (Graph 23). Among the 289 surveyed respondents who rarely left their house (selecting either 'never' or 'once per week'), 73% were women.

Graph 23: 'What is stopping you from leaving the house every day? - by gender



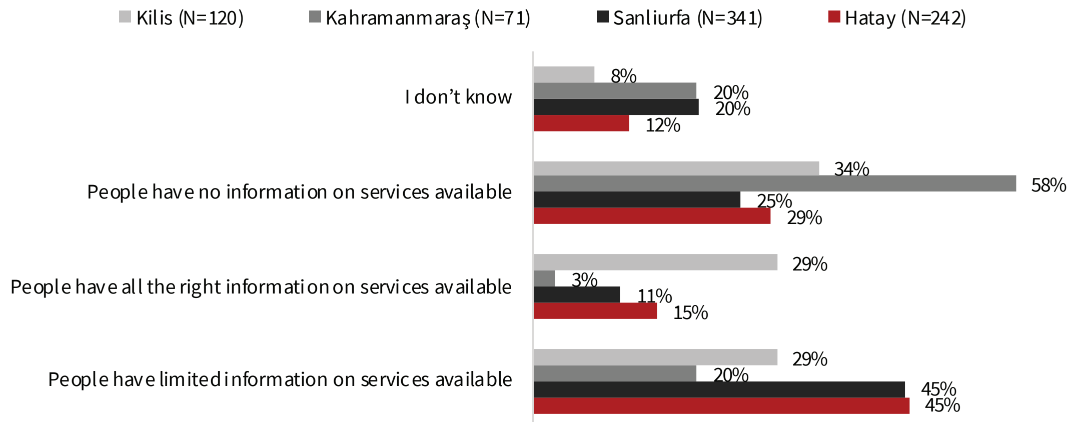
When asked about the reasons, women respondents were more likely to mention child rearing responsibilities (cited by 45% of the 211 women respondents). However, men were more concerned about following the government's regulations on social distancing/ isolation 47%. Men respondents were also more fearful of being arrest and of increased security in their neighbourhood (34%) and related to this, of community tensions and discrimination.

In addition to social distancing measures, the majority of refugee households across all 4 locations indicated adopting specific hygiene practices to prevent the spread of the virus (graphs 21 and 22). The most commonly mentioned practices included frequent handwashing and showering (74%), covering nose and mouth when leaving the house and wearing gloves (59%) and disinfecting the house and touched surfaces (50%). Several other households also indicated changing and washing clothes upon returning home.

Finding 7: *Information on COVID-19 services available to refugees is limited across all 4 surveyed locations. For most refugee households the main source of information on COVID-19 is the internet and social media as well as other community members which may contribute to exposing refugees to fake or inaccurate information on COVID-19.*

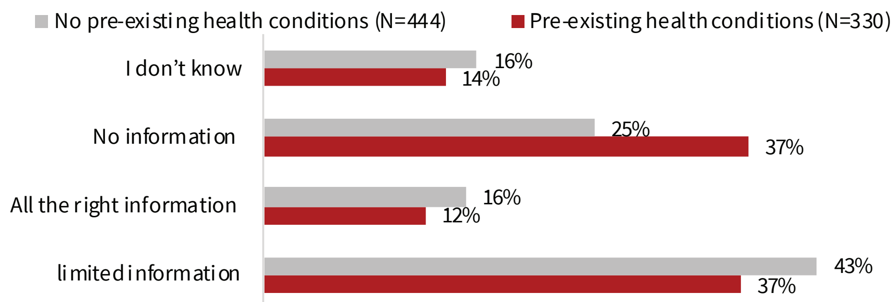
Overall, households reported having either partial or no information on services available for COVID-19 (Graph 24). Across locations, the least informed were households surveyed in Kahramanmaraş where 58% indicated reported having no information and 20% partial information. Widespread lack of knowledge on services available was also observed among households in Kilis, 29% of which indicated having no information on services available and 34% having only partial information. Some level of information on services was reported by households in Hatay (45%) and Sanliurfa (45%), but a large proportion of households also indicated not having any information in these same locations. In all, knowledge about available services showed consistent gaps across all locations. Compared to the first round of data collection, the percentage of households with limited or no knowledge of COVID-19 related services increased. Out of 488 new surveys collected during this round, 72% (351 households) indicated having no or partial knowledge of available services, compared to 67% of the 290 households surveyed during the first round.

Graph 24: In your opinion, how much do you and other people in this community know about the services available for people suffering from COVID19?

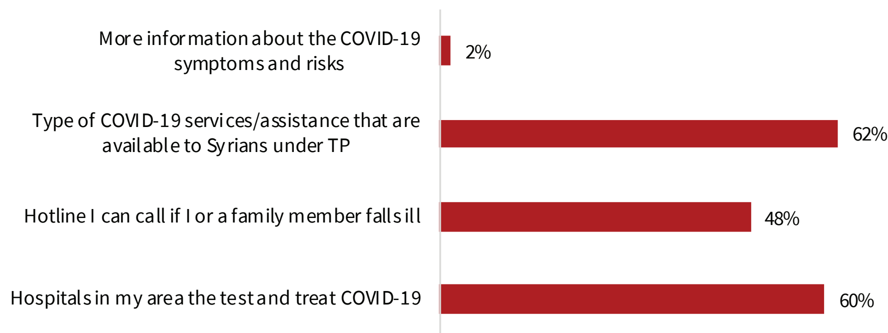


In particular, refugee households with members suffering from a disability, chronic condition or both, were more likely to report not having any information on COVID-19 services available, than households without pre-existing health issues (Graph 25). Out of 330 such households, 37% indicated being unaware of information on available COVID-19 services, compared to 25% of the 444 households that had no pre-existing health conditions.

Graph 25: Households' knoweldge on COVID-19 services available



Graph 26: What information on services would you like to know more about? (N=774)

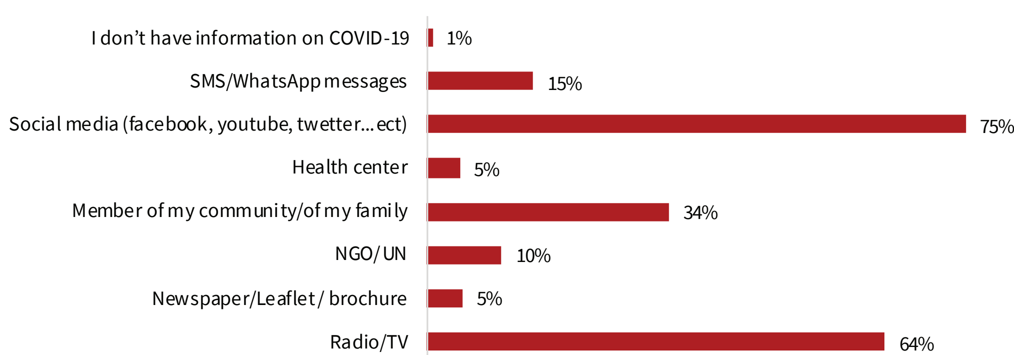


Mostly, surveyed households indicated needing more information on hospitals in respective areas that test or treat COVID-19 (cited by 60% of households) and the type of services that are available to Syrians under TP (62%, graph 26). Almost half of respondents were also interested in knowing the numbers of hotlines to call if a member of the family falls ill (mentioned by 62% of households) while a minority expressed interest in receiving general information about COVID-19, symptoms and risks (2%). Reflecting

these findings, a large proportion of surveyed households (40%) did not know whom to report or refer suspected cases to, while an additional 28% were unsure.

Overwhelmingly, households indicated social media, including Facebook and the internet in general, as the main source of information on COVID-19, followed by TV and the radio, while only 10% of surveyed households mentioned having received information on COVID-19 by the UN or NGOs (graph 27). Such heavy reliance on social media for information may expose a sizeable proportion of refugee households to fake or inaccurate information on this issue. Another important source of information are community members, friends and family (cited by 34% of surveyed households) which could also expose refugees to inaccurate news on this issue if such a community is not well informed. At the same time however, this points to the existence of tight social networks which can play an important role in disseminating knowledge and raising awareness while dispelling myths on COVID-19.

Graph 27: Where have you obtained information on COVID-19? (N=774)

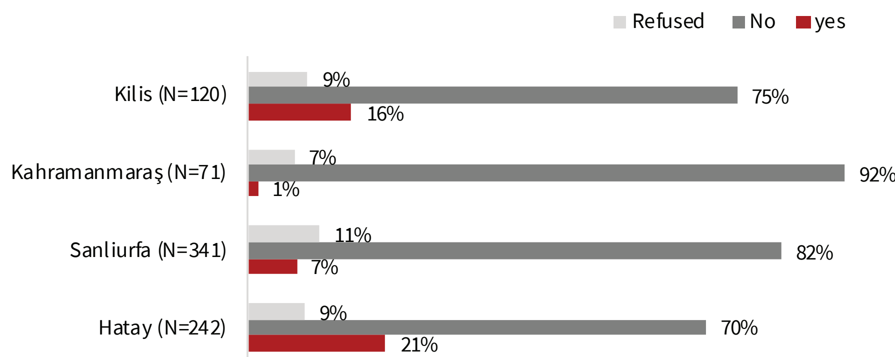


E. COMMUNITY IMPACT AND HOUSEHOLD IMPACT

Finding 8: *Intra and inter community tensions because of COVID-19 crisis remain limited. Social tension was mostly observed within the Syrian community due to the loss of jobs and fears of COVID-19 infection.*

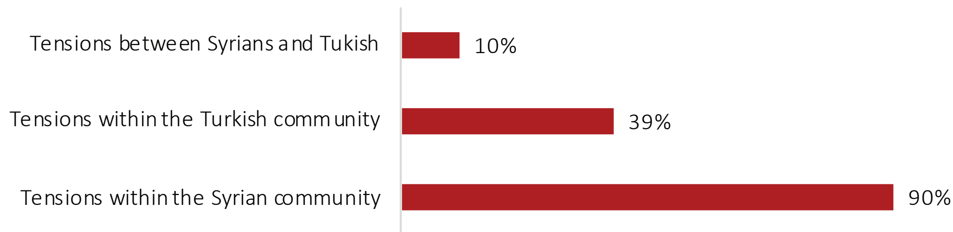
Observations of intra and/or inter communal tensions due to the COVID-19 crisis and containment measures were infrequently reported by survey participants (Graph 28). Only 12% (96) of the 774 respondents interviewed mentioned encountering incidents of social tension. These were mostly reported by households in Hatay (21%) and Kilis (16%).

Graph 28: "Have you experienced or witnessed any tensions in your community since the corona virus outbreak?" - by location



Interestingly and as shown in graph 29, tensions were for the most part observed among members of the Syrian community and rarely between Syrians and Turkish citizens. This could be attributed to the social confinement and isolation imposed by the COVID-19 government response which may have also had the effect of reducing the level of interaction between the two communities. This can be worrying as it portends a disruption in what is typically the first line of community based protection mechanisms including neighbors and friends.

Graph 29: "Have you experienced or witnessed any tensions in your community since the corona virus outbreak?" (N=96)

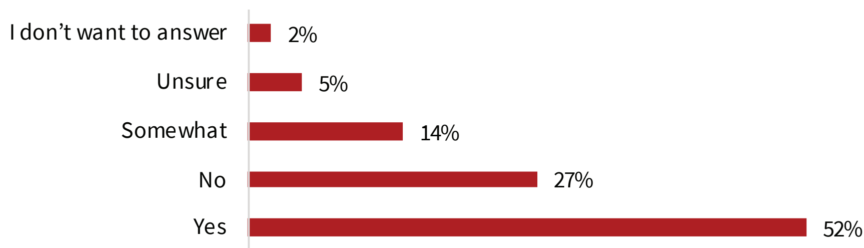


Respondents describe a generally tense situation where refugees are fearful of catching the virus and at the same time concerned for the economic situation and the lack of job opportunities due to government imposed containment measures. Tensions between Syrians and Turkish citizens mostly resulted from overcrowding in marketplaces that resulted in long queues and inability to respect social distancing rules as well as some isolated instances of discrimination. Overall, discrimination incidents due to COVID-19 were rare, accounting for 2% of 774 surveyed households.

Finding 9: *High levels of domestic tensions and frustrations were reported by the majority of households. Disruptions in the daily routine, lack of income and uncertainty about the future were prevalent reasons for feelings of stress and anxiety. However, most households do not seem to enact specific strategies to manage these feelings.*

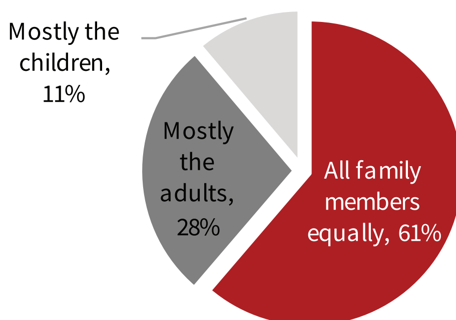
Over half of the 774 surveyed households reported greater stress, frustration and anger within the domestic sphere since the outbreak of the crisis. An additional 14% said tensions between family members were somewhat higher since the outbreak of the crisis (Graph 30).

Graph 30: Do you feel you are experiencing more tension (stress, anger, anxiety, frustration) at home following the coronavirus outbreak? (N=774)



Out of the 511 households that indicated higher or somewhat higher levels of stress within the family following the COVID-19 outbreak, 61% of surveyed respondents acknowledged that all family members were equally affected by household tensions while 28% indicated adults in the family were the worst affected (Graph 31).

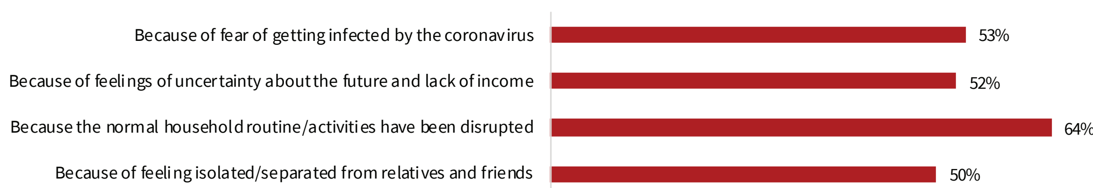
Graph 31: How is mostly affected by the tension im the family? (N=511)



The majority of households attributed the source of domestic tensions to the disruption of the normal household routine because of government-imposed COVID-19 containment measures, as well as feelings of uncertainty about the future (Graph 32). Anxiety was also expressed over the loss of income opportunities. Although the present survey did not directly ask questions on domestic violence, several respondents made an indirect mention to it, highlighting that the rise of tension in the domestic sphere because of the abovementioned reasons can give rise to violence and abuse in some cases:

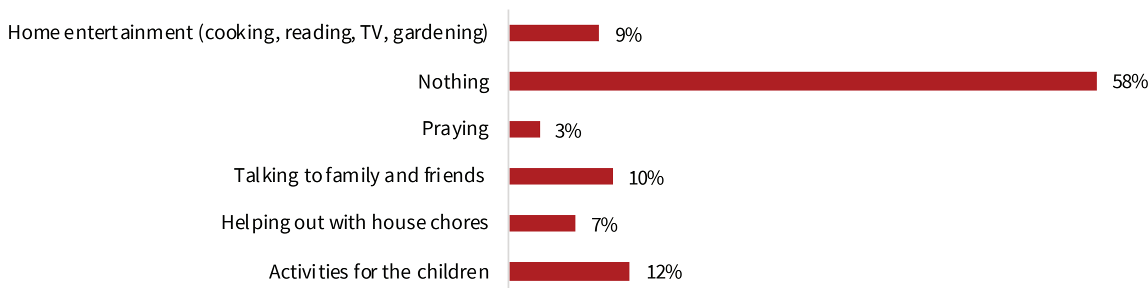
"**The lack of money in the family results in domestic violence and psychosocial problems between them**." (Household survey, Hatay, 7 April 2020)

Graph 32: Why do you feel you are experiencing more tension (stress, anger, anxiety, frustration) at home following the coronavirus outbreak? (N=511)



A sizeable percentage of households mentioned tensions emerged out of fears of getting infected and perhaps not knowing where to seek out treatment in case of need. Almost a third of households also mentioned feeling frustrated and anxious from being unable to visit relatives and friends, possibly indicating the negative impact of the COVID-19 crisis on the psychosocial condition of many refugees in the longer term.

Graph 33: "How are you coping with the confinement? "(N=166)



Respondents also indicated adopting a number of positive strategies within the household to deal with increased levels of stress and overcrowding during this time of forced confinement (Graph 33 Out of 166 households who provided a response to this survey question, a significant proportion indicated organizing activities for the children who are not allowed to leave the house, which may include

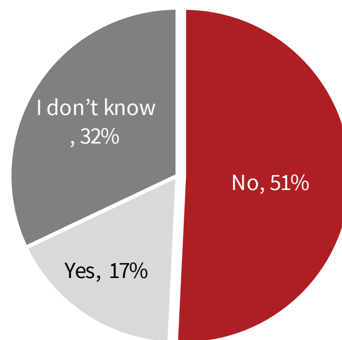
recreational activities as well as allowing children to participate in the house chores. Many also indicated dedicating time to hobbies such as reading, cooking, gardening as well as watching TV, sleeping, or talking more with family, friends and relatives over the phone. Several households specifically described engaging in more open dialogue with family members and endeavoring to practice patience and self-control during times of tension. For some, praying was also an important coping strategy to deal with anxiety. Worryingly however, **a majority of households indicated not enacting any strategies to deal with increased levels of stress.**

F. PSYCHOSOCIAL SUPPORT

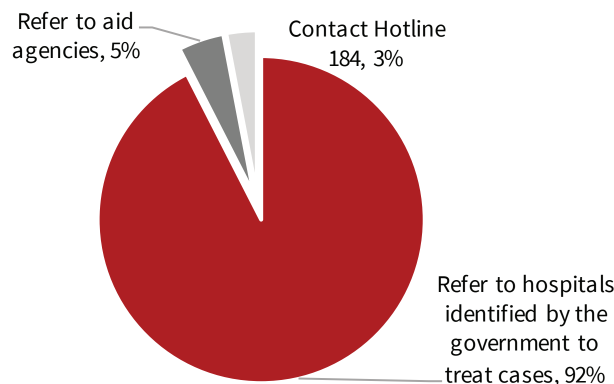
Finding 10: *Stigma and shame associated with COVID-19 was not reported by surveyed households. Refugees are also largely unaware of referral systems for people suffering from psychological distress.*

64% of households stated they did not witness any stigma or shame in the community regarding people who contracted the new coronavirus. However, a quarter (34%) admitted being unsure. Those households (1%) that witnessed the presence of stigma towards those who fell ill with COVID-19, mostly cited social avoidance by other community members. Further, 51% of households were not aware of the existence of referral systems for community or family members suffering from psychological distress (Graph 34). Among those 133 (17%) of households who indicated some knowledge of referral systems, 123 (92%) cited hospitals, cited aid 6 agencies and 5 suggested to contact the hotline 184 (Graph 35).

Graph 34: "Are you aware of any referral systems for people who have the new coronavirus disease or psychosocial issues related to it?" (N=774)



Graph 35: "What referral systems are you aware of for people who have the new coronavirus disease or psychosocial issues related to it?" (N=133)



CONCLUSION

This assessment is based on data collected over the course of 4 weeks and follows the publication of an initial analysis of findings conducted after the first week of data collection. The results from assessment complete and expand on the preliminary observations of the first data round. Overall, the present results are mostly in line with initial observations and represent a confirmation of earlier insights. At the same time however, **a worsening of economic conditions among refugee households** emerged from the present analysis which largely confirmed initial concerns that government-imposed measures to contain the spread of the virus would exacerbate pre-existing, entrenched vulnerabilities among refugees who have limited resources to cope with a situation of prolonged confinement.

The first assessment provided widespread evidence of the existence of entrenched socio-economic vulnerabilities among refugee households in the south east with many households exhibiting protection risks as they are resorting to negative coping mechanisms such as accumulation of debt leading to greater risk of exploitation and abuse. Most households, prior to the outbreak of COVID-19, relied on low paying, occasional daily or seasonal work and are currently unemployed due to government restrictions that forced the closure of all non-essential trades and businesses. The first assessment provided evidence of widespread reliance on negative coping practices prior to the onset of the COVID-19 restrictions, including selling assets and borrowing money from family or friends, or buying food on credit, indicating that households do not have sufficient resources to buffer against a prolonged period of unemployment and are already becoming heavily indebted. In comparing statistics from the two data collection exercises, the current assessment found a worsening **of economic conditions with** a **greater number of households having lost their job because of COVID-19 compared to 4 weeks ago**.

Disproportionally affected will be the more at-risk and marginalized groups including larger families, single and women headed households and persons suffering from pre-existing health conditions such as disabilities or chronic conditions. Data shows that such groups were the least likely to have had any source of income prior to the onset of the COVID-19 crisis and those few who were employed are least likely to have retained their job during COVID-19. These groups risk being pushed deeper into a condition of deprivation as many NGOs have suspended activities or switched to remote modalities of work while many government services have also been suspended. A further vulnerable population group includes those refugees who are unregistered or do not have updated documentation and who risk being barred from accessing key services following the partial suspension of PDMM activities.

The data revealed that **concern over the spread of the virus and its consequences is prevalent among refugee households** in the south-east. Fears of falling ill and being quarantined away from the rest of the family is discouraging many households from approaching and seeking medical help for fear of contracting the virus in hospitals and medical centers. This is compounded by a certain degree of misinformation on services that are available with many holding the belief that hospitals are closed or attend only to coronavirus related cases. Such beliefs may be particularly damaging for those households with members suffering from complex medical conditions, as they may delay seeking help which in turn may cause conditions to deteriorate. In fact, data confirms that **persons suffering from disabilities and/or chronic conditions were also the least informed about available COVID-19 related services.**

On the other hand, **households demonstrated an overall good level of knowledge of the coronavirus symptoms and modes of transmission** and most indicated respecting social distancing and hygiene recommendations, although some gaps in knowledge remain.

Finally, household members described feeling anxious, stressed and frustrated as a result of the loss of income and uncertainty for the future with commensurate increase in household tension. Global trends have already widely reported a strong association between increasing household tensions among populations under lockdown and increases in GBV. While the needs assessment did not explicitly address GBV issues, it is safe to assume that the two will correlate strongly, highlighting a need for interventions aimed at diffusing tensions and ensuring a certain level of economic support to those households that are struggling the most, and specialized case management for those at the receiving end of violence and abuse.

RECOMMENDATIONS

Multi-purpose cash assistance and Livelihoods:

A. Although the ESSN is supporting up to 1.7 million refugees, needs are anticipated to significantly increase in the next weeks and will include vulnerable refugee households as well as households who were previously self-sufficient. Though findings suggest that practically any household would benefit from material support – both in the form of direct cash[7] or voucher assistance - requiring a sort of "blanket approach", initial prioritization, based on the findings of this assessment, can cover the following particularly vulnerable groups:

- Widowed/single and female headed households
- Households with family members suffering from pre-existing health conditions including persons with disabilities and/or suffering from chronic conditions;
- Families with six or more members, with one or less working family members during the crisis.
- Unregistered refugees that may be cut off from governmental services and support programs.

Given the unprecedented nature of the crisis, it is too early to understand how local markets will be impacted in Turkey as well as which population groups will develop vulnerabilities. As a result**, a flexible approach to cash and voucher assistance programming** including flexibility in targeting and in shifting transfer modalities as the situation evolves, will be of paramount importance. Additionally, to ensure sustainability of program outcomes, it is also recommended that existing cash programs are integrated with protection services such as case management and PSS support, particularly to address longer term consequences of resort to negative coping mechanisms and cumulative distress.

B. **GBV case management** and multi-modality support for GBV survivors, including through **stronger integration with livelihood interventions**, remains crucial. Global trends have widely reported an increase in GBV associated with lockdown measures. While the needs assessment highlighted a rise in household tensions during this period, it did not explicitly address GBV issues. Nevertheless, it is safe to assume that the two will correlate strongly, suggesting the need for a continued robust GBV case management response by governmental and non-governmental agencies, as well as widespread dissemination of GBV hotlines and awareness raising on available recourse options. In parallel, PSS programming, both for children and adults, aimed at promoting constructive conflict resolution mechanisms, and stress management – especially for men and boys – would go a long way in alleviating household tensions and, potentially, reducing incidents of GBV.

COVID-19 awareness raising/outreach

C. There is an acute need for **blanket information dissemination on COVID-19 services available**. This includes presence of hospitals that treat or test for COVID-19, the number of hotlines families can call if a member falls ill as well as reliable sources households can refer to for updates on government directives. Presently, there is no identified need for a blanket approach to Covid-19 awareness raising. However, **community-based, interactive approaches** where misinformation from online sources is addressed and corrected may be a particularly useful approach to ensure only correct information is retained from the plethora of half-truths and otherwise unreliable information available online.

7 Challenges with cash transfers without existing financial transfer systems in place suggest that a voucher modality, covering multiple basic needs, may be preferable.

Health and psychosocial support

D. Access to healthcare remains a major concern. While no systemic blockages were identified, the reluctance of respondents to seek medical attention is disconcerting. **Community-based, medically trained refugees by NGOs** may present a viable link between government-run healthcare services and community members. A database of such community-based medical professionals can be created at district levels, and phone numbers shared with beneficiaries who may feel more comfortable contacting a fellow refugee for first-hand medical counseling. Knowledge of the government-run hotline with Arabic translation option is also important, and can complement COVID-19 information dissemination as well as healthcare referrals and translation/accompaniment services by NGOs. A further **ease of restrictions on Arabic-speaking professionals to practice** by the Government of Turkey would go a long way in alleviating language barriers challenging refugees' access to healthcare services.

E. A majority of surveyed households indicated feeling high levels of stress and anxiety with the main reported reason being loss of income and uncertainty about the future. **There is a need to increase psychosocial support to refugee households (using remote modalities where possible) that are tailored to gender and age.** Such interventions should aim at addressing the psychological distress related to future uncertainty, social isolation and aim at strengthening the psychological resiliency of families. Further it is paramount to scale up psychosocial support to victims of abuse given the proven increase incidence of GBV during times of lockdown and social isolation, while engaging men and boys who, as traditional breadwinners of the family, may feel particularly distressed by the current situation.