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COVID-19 Pandemic in Turkey: An assessment of readiness and impact on Refugees living in-camps

WFP Turkey Country Office

WRITERS

Edgar Wabyona (Head of VAM and M&E)

Berçin Başak Doğan (VAM Officer)

Ayşenur Özcan (Information Management and GIS Officer)

CONTRIBUTORS

Isabelle Devaux (WHO)

Monica Zikusooka (WHO)

Ömür Çınar Elçi (WHO)

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Norwegian Ministry
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Table of Contents

Executive Summary.....	1
Highlights	2
Chapter 1: Introduction	4
Chapter 2: Objectives and Methodology	6
Chapter 3: Findings	8
3.1. Demographics and High-Risk Groups	8
3.2. Awareness, Knowledge and Practices	10
i. Awareness and Perception of COVID-19.....	11
ii. Awareness of Symptoms and Prevention Measures	12
iii. Practices.....	14
3.3. Access to Food and Hygiene Items	17
i. Markets in camps and Customer Behavior	18
ii. Product Availability	19
iii. Affordability	20
iv. Impact of Intervention	21
3.4. Income Sources and Coping Strategies.....	23
i. Income Sources	24
ii. Coping Strategies.....	26
Conclusions	29

List of Figures

Figure 1: Age Breakdown	8
Figure 2: Gender Distribution.....	8
Figure 3: Family Size.....	9
Figure 4: Main Information Channels	11
Figure 5: Reasons of COVID-19 related anxiety and stress	12
Figure 6: Knowledge level on Symptoms.....	13
Figure 7: Awareness level of Prevention Measures	14
Figure 8: Practice in Prevention Measures	15
Figure 9: Stress Coping Behaviors.....	16
Figure 10: Customer Shopping Behavior	19
Figure 11: Product Availability by Camps	20
Figure 12: The Percentage of Beneficiary Perception of Increased Food Prices by Family Size and Employment Status.....	21
Figure 13: Satisfaction with the hygiene kits.....	23
Figure 14: Perception of how long the kits would last.....	22
Figure 15: Satisfaction with the quantity of the assistance by family size.....	22
Figure 16: Households who lost jobs or experienced a reduction in salaries by gender and family size.....	25
Figure 17: Reduced Coping Strategy Index by Gender, Family Size, Main Income Category.....	27
Figure 18: Most Used Livelihood Coping Strategies (LCS) by Gender and Employment Status	28
Figure 18.1: LCS by Gender.....	28
Figure 18.2: LCS by Employment Status.....	28



Executive Summary

The Covid-19 pandemic resulted in both a health and a socioeconomic crisis. It will likely increase poverty and inequality and jeopardizes progress towards the Sustainable Development Goals (SDGs) on a global scale. Since the beginning of the pandemic, countries have enforced various measures to prevent further spread of the virus, along with assistance programmes for their citizens such as one-off transfers, unemployment benefits, etc. Assessments made to measure the scale of the crisis and its impact on affected populations have played just as important a role as the interventions designed to respond to the crisis in a comprehensive and effective way.

This assessment aims to assess the knowledge and practices related to COVID-19 amongst in-camp refugees; assess the impact of COVID-19 on refugees' livelihoods and access to basic food and hygiene item needs and; evaluate WFP's intervention in response to COVID-19.

Data collection was conducted through a panel survey in two rounds: the first round was completed between 25 - 29 April 2020 and the second round was conducted between 12 May - 10 June 2020.

Throughout the report, comparisons between the two rounds have been made when relevant. In addition, findings have been further disaggregated by gender, family size, education level of the household head, location, employment status and main income categories to better understand root causes behind the results.

Highlights

Demographics and High-Risk Groups

The refugee population in camps is generally young with persons under the age of 18 constituting 54 percent of the population. The average household size in the camps was 5.5 people and they are headed mostly by males (91%). Although a majority of them would not be considered among high-risk groups based on their age or health status, about 10 percent of households have at least one member above 60 years of age and almost one quarter (24%) have at least one member with a chronic disease such as cardiovascular disease, respiratory disease or diabetes etc.

Awareness and Perception of COVID-19

Almost all (99%) participants stated that they had heard of COVID-19 and its spread around the world mainly through television (62%) and social media (29%).

About half (49%) of the respondents reported feeling fear, anxiety or stress in the first round of the survey but this proportion dropped to 30 percent in the second survey. Between rounds 1 and 2, the fear of job loss and stress due to limited freedom of movement increased, while the fear of infection reduced, indicating that respondents have become more aware of how the virus spreads and, having received protective equipment, are now less worried about getting infected. However, it seems that this fear was replaced with anxiety about livelihoods.

Knowledge of Symptoms and Prevention Measures

Respondents were more likely to know about prevention measures than symptoms. In the second round, knowledge level of both prevention measures and symptoms increased: the percentage of people having high-level knowledge of prevention measures and symptoms increased from 8 percent to 15 percent and from 0.4 percent to 2.7 percent respectively.

Most known symptoms were fever (96%), dry cough (88%), and sore throat (44%) while least known ones were widespread aches and pains (14%), diarrhea (12%), and loss of smell and

taste (9%). Best-known prevention measures were avoiding public spaces (82%), wearing a mask outside (81%), and staying at home (76%) whereas least known ones were covering the mouth/nose while sneezing, coughing (14%), and avoid touching the face (10%).

Practices

Respondents did not practice prevention measures in alignment with the knowledge that they demonstrated. The reasons given for not practicing prevention measures were not having enough money to buy hygiene items, having to go to work, other people not taking precautions, markets being crowded, water scarcity in the camps etc. Notably, the percentage of respondents intensely practicing prevention measures increased from 4 percent to 28 percent in the second round. Among these; staying home (75%), wearing a mask outside (81%), and avoiding public spaces (81%) were applied more frequently.

Furthermore, respondents mostly isolated themselves at home (22%), which is a negative strategy for coping with stress, but more positive coping strategies such as keeping virtual contact with friends and relatives, playing with children at home were also adopted. In the second round, the most frequently adopted strategy was keeping virtual contact with friends and family (18%), but isolation was still just as frequently adopted (17%).

Markets in Camps and Customer Behavior

Half of the camp residents stated that they perceived markets/shops to be more crowded than usual after the outbreak, representing a decrease from 72 percent in the first round of data collection. Nonetheless, more people started stockpiling commodities, with an increase from 34 percent to 51 percent in the second round. An additional 16 percent said they would have stocked items had they been able to afford larger quantities.

Product Availability

Food products and hygiene items remained available in the markets. 72 percent reported full availability of food products and 83 percent expressed the same about hygiene items with some variations in different camps. Markets in Hatay camp were reported to have the highest percentage of product availability, while respondents living in Osmaniye camp stated the lowest percentage.

Affordability

Around three out of four households indicated that the prices of food products (80%) had increased since March 2020 in the second round. This percentage is particularly high compared to 66 percent recorded in the first data collection round. The perceptions expressed by the respondents align with the estimations made through WFP market monitoring activities, demonstrating that the average Food Basket cost in the camps increased by 10 percent in April compared to January. Respondents who experienced loss of income or reduced salaries and who live in large families perceived the increase in food prices to be more substantial than their peers did. The perception about the prices of hygiene items remained stable at 54 percent between the two rounds.

Impact of Intervention

While a majority of the beneficiaries (89%) expressed satisfaction with the quality of the kits, satisfaction level on the quantity remained a bit lower (81%). Further analysis indicated negative correlation between the satisfaction with the

quantity of the hygiene kits and the family size: Among the households with up to 4 members, 89 percent were satisfied with the quantity compared to 75 percent of large households with 9 and more family members.

Income Sources

Some refugees had jobs outside of the camps with the results showing that for some 34 percent of households, this was their main source of income. However, following the implementation of COVID-19 restrictions, more than two-thirds (68%) of households formerly employed off-camp have lost their jobs or suffered a reduction in earnings.

Coping Strategies

The average rCSI decreased in the second round from 12.7 to 7.5, indicating less frequency of resorting to such strategies. Despite the downward trend, 65 percent of the residents still stated in the second survey that they had relied on less preferred, less expensive food on average on 4.2 days per week to cope with a lack of food or money to buy it one week prior to the survey.

Although the frequency of resorting to livelihood coping strategies decreased in the second round compared to the first, on average three out of four households had used some form of negative livelihood coping strategy¹ in the 30 days preceding the survey: 45 percent borrowed money, 29 percent spent savings, 20 percent sold household assets, and 18 percent bought food on credit to meet their basic needs.

¹ Livelihoods-based coping strategies reflect longer term coping capacity of households and the various strategies applied can be categorized as 'stress', 'crisis' or 'emergency', depending on the severity weights. Stress coping strategies indicate reduced ability to deal with future shocks due to a current reduction in resources or increase in debts, which progresses into crisis coping with emergency coping being at the peak. Stress coping strategies include:

sale of household assets/goods; spending savings; borrowing or purchase of food on credit; and borrowing money. Crisis coping strategies include: sale of productive assets; withdrawing children from school; and reduction of essential non-food expenditure such as on health and education. Emergency Coping strategies include: begging; accepting high risk jobs; etc.

Chapter 1: Introduction



Photo: WFP / Murat Karakuş

COVID-19 spread rapidly across the globe after the first cases were reported at the end of 2019. On top of the severe impacts on individual health and national health systems, the COVID-19 pandemic has also had broader macro-economic effects that have resulted in supply chain disruption, increased unemployment or reduced income, and shifts in supply and demand have resulted in corresponding price surges. Since the beginning of the pandemic, countries have enforced various measures to prevent a further spread of the virus. These efforts were further supported by social assistance programmes for citizens such as one-off transfers and unemployment insurance to act as a safety net during such trying times.

Actions taken

to respond to the crisis in Turkey included cash transfers for those not covered by social insurance, introduction of distance education services, expansion of short-term work allowance for over 3 million employees, banning lay-offs and supporting workers on unpaid-leave through monthly cash transfers, deferral of tax and social security payments, provision of additional loan guarantees, providing cash-transfer to low-income households and expanding employment-related benefits.

According to the latest figures of the Directorate General of Migration Management (DGMM), almost 63 thousand Syrians live in camps located in the southeast region of

Turkey by June 2020, corresponding to around two percent of all Syrian refugee population in Turkey². As camps are concentrated areas with dense population, DGMM restricted entrance and exit to the camps to avoid contamination. However, this created another obstacle for camp residents to earn income from jobs outside of the camp area.

WFP has taken quick action to respond to additional needs due to the pandemic, such as one-off unconditional cash assistance and distribution of hygiene kits in the camps. In line with Government policies, WFP provided a one-off 1000TRY top-up in April 2020 to 11,648 households residing in six camps, in addition to its regular 100TRY e-voucher assistance per person. WFP also provided

two rounds of Hygiene Kits distribution in April and June 2020 to all camp residents. The kits had personal hygiene materials such as soaps, shampoo, surface cleaners for the households, as well as reusable masks and sanitizers. The kits were designed to meet the needs of a household of 6 members for 2 months period. Households with more than 6 members received the kits in multiples: households with 7 to 12 members received 2 kits, and households that have more than 12 members received 3 kits. The hygiene kits were delivered one by one to each container and WFP staff took strict safety measures during the delivery. Despite of the newly introduced interventions, concerns remain about the vulnerabilities faced by refugees and immigrants in the face of the pandemic.

² <https://www.goc.gov.tr/gecici-koruma5638>

Chapter 2: Objectives and Methodology

This assessment aims to:

- i. assess the knowledge and practices related to COVID-19 among in-camp refugees;
- ii. assess the impact of COVID-19 on refugees' livelihoods and access to basic food and hygiene item needs and;
- iii. evaluate WFP's intervention in response to COVID-19.

The study adopted an existing methodology and tool by incorporating COVID-19 related questions. The questionnaire used in this exercise was designed by WFP in coordination and consultation with WHO including: information on refugee demographics, their awareness, knowledge, and practice regarding COVID-19, access to food and hygiene items, and changes to income sources and coping strategies.



Photo: WFP / Murat Karakuş

The sample size was determined with a confidence level of 90 percent and 5 percent margin of error. Overall the sample size was proportionally distributed across camps based on the refugee population in each one and participating households were selected through a simple random sampling method.

The survey was conducted as a panel survey in two rounds, the first round serving as a baseline. The baseline survey was conducted with a representative sample of 267 refugee households living in six different

camps (Adana, Kahramanmaras, Osmaniye, Boynuyogun, Yayladagi, Elbeyli) in five different provinces of Turkey whereas in the second round the interviewers reached 255 refugee households among those who had participated in the first round. The majority of the respondents (83%) were heads of households, while 9 percent were spouses and 7 percent were children of the household.



Photo: WFP / Mehmet Özdemir

The data was collected by trained WFP field monitoring assistants through phone calls and uploaded via KoboToolbox. The baseline data collection took place between 25 and 29 April 2020 and the second round was repeated between 12 May and 10 June 2020.

Throughout the report, the results from the two rounds are compared where relevant.

In addition, findings have been further disaggregated by gender, family size, education level of the household head, location, employment status, and main income categories to better understand root causes behind the results.

Chapter 3: Findings

3.1. Demographics and High-Risk Groups

Gender distribution in the surveyed population was balanced: 51 percent men and 49 percent women. However, the majority (91%) of the households were headed by men, indicating the patriarchal

culture of the population. As shown in Figure 1, more than half (54%) of the population in the households were below 18 years of age and 43 percent are of working age between 18 and 59 years old, while 3 percent was above 60 years of age.

Figure 1: Age Breakdown

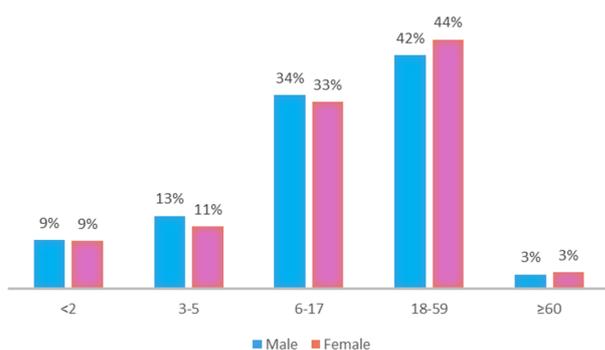
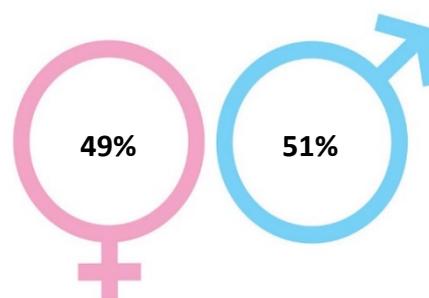


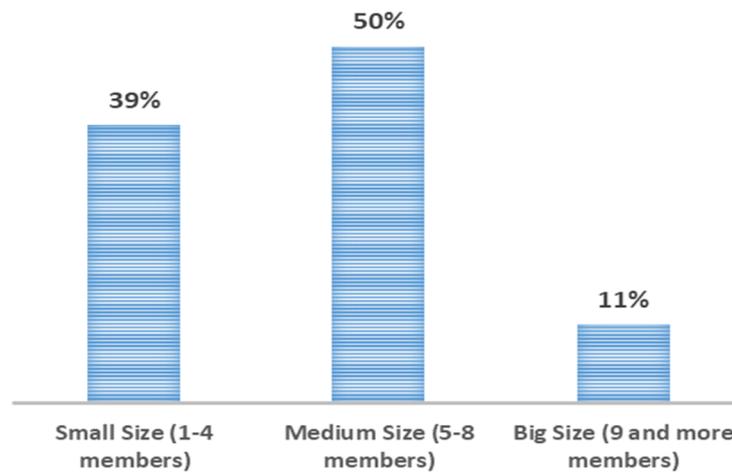
Figure 2: Gender Distribution



Analysis also showed that the average household size in the camps is 5.5 people. Half of the households were medium sized, having five to eight family members, while 39 percent had one to four members, and 11

percent had at least nine people living under the same roof. Given that the refugees are allocated single-room containers that are close to one another, it is apparent that in-camp refugees live in crowded conditions and are unable to maintain social distancing.

Figure 3: Family Size



Scientists agree that people having chronic diseases and/or above 60 years of age are more likely to be seriously affected by COVID-19 in case of infection³. Although the majority of the camp residents would not be considered at high risk due to their age or health status, about 10 percent of households have at least one member over 60 years old and almost one quarter (24%) have at least one member with a chronic disease

such as cardiovascular disease, respiratory disease, diabetes, etc.

Findings also indicate that 8 people developed COVID-19 - like symptoms during the two weeks prior to the survey whereas 7 went to a hospital to seek care and only 4 of them were tested for COVID-19. The one person that did not seek health care said that he did not go to a health facility because he was afraid of being hospitalized.

³https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_10

Awareness, Knowledge and Practices

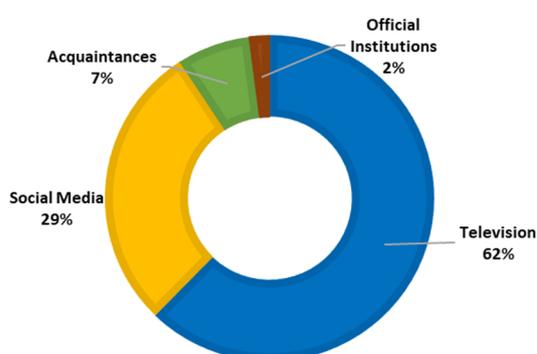
3.2. Awareness, Knowledge and Practices

i. Awareness and Perception of COVID-19

The behavior of the general public has an important bearing on the course of COVID-19 pandemic. This behavior is influenced by people's knowledge and perceptions. Therefore, knowing whether refugees are aware of the pandemic and how they perceive it is critical for government institutions and the humanitarian community to identify the most effective ways to respond.

Almost all (99%) participants stated that they heard of COVID-19 and its spread around the world. Two thirds of those respondents reported that television was their main source of information while 29 percent of the participants stated that they received information through social media. It must be noted that, even though social media appears to be an important way to reach some refugee households, it can also be a source of misinformation.

Figure 4: Main Information Channels



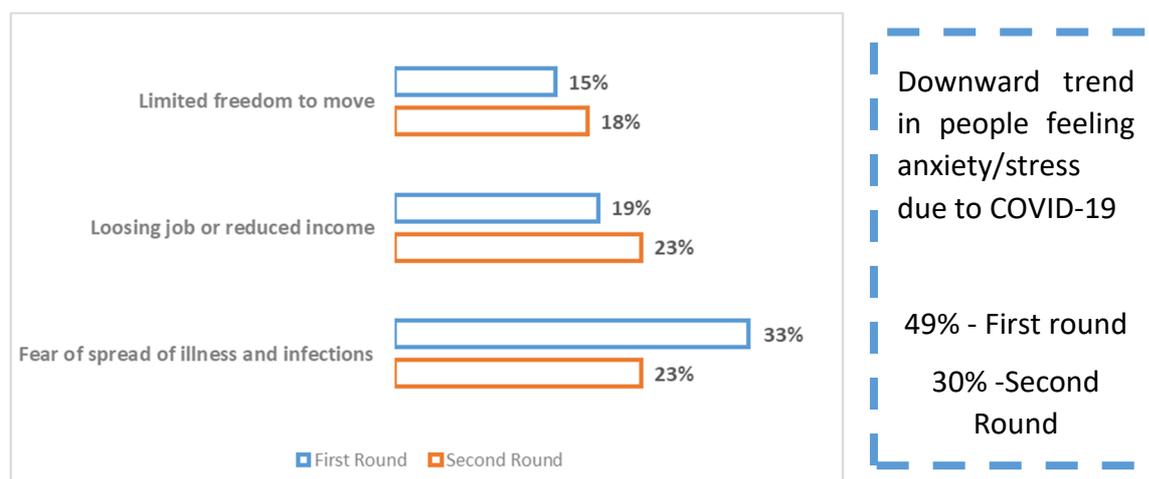
About half (49%) of the respondents reported feeling fear, anxiety or stress in the

first round of the survey but this proportion dropped to 30 percent in the second survey. While this was a positive development, it is still indicative of negative feelings in one-third of the in-camp refugee population. Of those reporting fear, anxiety or stress the majority were men with 49 percent while women were at 55 percent in the first round, and 1 in 3 men and 1 in 5 women in the second round. The fear of illness and infection, losing jobs or reduced income, and limited freedom to move due to the restrictions and to avoid getting infected are the most frequent reasons for stress. Further analysis also shows that, between rounds 1 and 2, fear of losing their job or income and stress due to limited freedom increased, while the fear of infection decreased as shown in Figure 5. This can indicate that respondents have become more aware of how the virus is spread and, having received protective equipment, are now less worried about getting infected, but instead they started to feel anxious about their livelihoods.

Moreover, analysis revealed that women were more worried about the spread of illness and infection (67%), while the main source of the anxiety among men was found to be fear of losing jobs (59%). This finding aligns with the fact that men in the majority of the households are the breadwinners and need to go out to find jobs. Both men and women were stressed over the restrictions imposed due to COVID19. Furthermore, as expected people who stated that they had lost their income or experienced reduced

salaries after the outbreak felt more anxiety than those who had maintained their positions and salaries (32% versus 26%).

Figure 5: Reasons of COVID-19 related anxiety and stress



ii. Awareness of Symptoms and Prevention Measures

Awareness of the pandemic itself does not guarantee that individuals will protect themselves against COVID-19. Governments, scientists and humanitarian agencies are using a range of methods and channels to raise awareness among people about the symptoms of COVID-19 and about how to prevent infection. WHO has published the known symptoms of COVID-19 and necessary prevention measures to avoid infection⁴. In Turkey, the Director General of Migration and Management (DGMM) in collaboration with

MoH prepared and released communication materials about COVID-19 in different languages targeting various refugee and migrant populations.

In this assessment, the analysis results of awareness of symptoms and prevention measures were classified as low, medium, and high⁵. Analysis showed that respondents were more likely to know about prevention measures than symptoms. In the first

⁴ Symptoms: fever, tiredness, dry cough, loss of sense of smell and taste, widespread aches and pains, nasal congestion (stuffy nose), runny nose, sore throat, diarrhoea.

Prevention measures: staying at home to prevent getting infected, avoiding public spaces and gatherings, avoiding physical contact with others (maintaining social distance), covering the nose and mouth when coughing or

sneezing, refraining from touching the face, wearing gloves outside, wearing masks outside, washing hands regularly with soap, using hand sanitizer, keeping the house clean.

⁵ Symptoms = 0-3 low, 4-6 medium, 7-9 high; prevention measures = 0-3 low, 4-7 medium, 8-10 high.

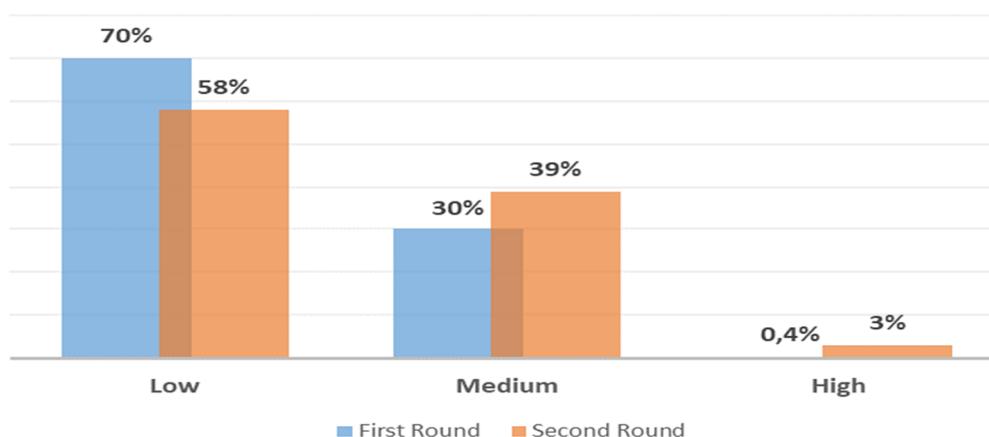
survey, 83 percent of participants demonstrated medium or high level knowledge of prevention measures (4 or more measures) compared to only 30 percent that demonstrated medium or high level knowledge of symptoms officially announced by WHO. In the second round, knowledge level of both prevention measures and symptoms increased: the percentage of people having high-level knowledge of prevention measures and symptoms increased from 8 percent to 15 percent and 0.4 percent to 2.7 percent respectively as shown in Figure 6 and 7. However, 58 percent of the residents still have low-level awareness of symptoms and 16 percent low-level awareness of prevention measures.

of households with a university degree compared to other groups had more knowledge on both the symptoms and prevention measures:

- Women with a low-level of awareness of symptoms (72%) versus men (54%)
- University graduates with a low-level of awareness of symptoms (25%) versus illiterate families (71%)
- Women with a low-level of awareness of prevention measures (22%) versus men (15%)
- University graduates with a high-level of awareness of prevention measures (62%) versus illiterate families (9%)

Further analysis of sub-groups indicated that men compared to women, as well as heads

Figure 6: Knowledge level on Symptoms



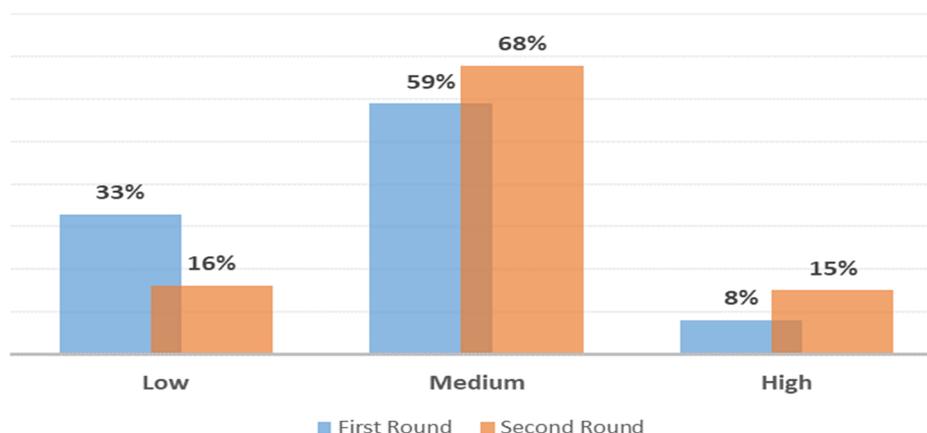
Most known symptoms

- Fever (96%)
- Dry cough (88%)
- Sore throat (44%)

Least known symptoms

- Widespread aches and pains (14%)
- Diarrhoea (12%)
- Loss of sense of smell and taste (9%)

Figure 7: Awareness level of Prevention Measures



Most known prevention measures

- Avoiding public space (82%)
- Wearing mask outside (81%)
- Staying at home (76%)

Least known prevention measures

- Covering mouth/nose while sneezing, coughing (14%)
- Not touching face (10%)

iii. Practices

What is more important than awareness or knowledge in protecting individuals against COVID-19 is to what extent they practice measures to prevent infection. Despite the information available and restrictions implemented by countries, spread of the virus has not been fully controlled in the world; without an approved vaccine developed to date, individual efforts to prevent infection become even more crucial to fight against COVID-19.

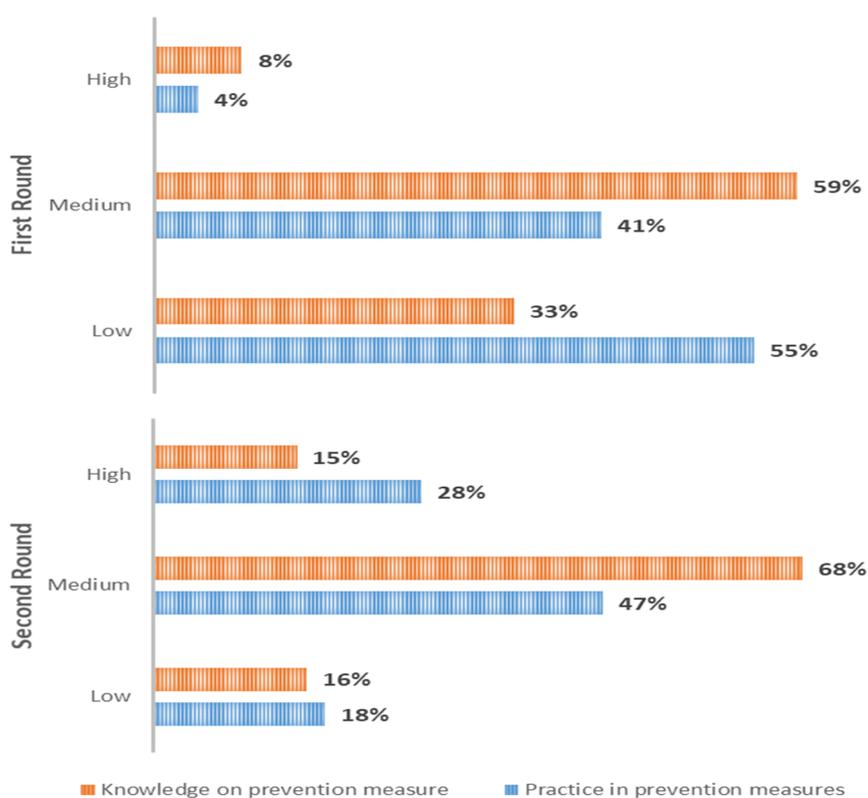
Results show that respondents did not practice prevention measures⁶ in alignment with the knowledge that they demonstrated. While more than half (68 percent) had medium-level knowledge of prevention measures, only 47 percent practiced them at the same level. The reasons for not practicing known prevention measures were not having enough money to buy hygiene items, having to go to work, other people not taking precautions, markets being crowded,

⁶The level of practicing prevention measures was classified into three groups (low, medium, high) depending on the total number of measures being practiced by refugees

water scarcity in the camps etc. Notably, the percentage of respondents carefully practicing prevention measures increased from 4 percent to 28 percent in the second round as shown in Figure 8. Among these; staying home, wearing a mask outside, and avoiding public spaces were applied more frequently. Moreover, especially those who adopted practices at high level also developed addi-

tional precautionary behaviors such as cooking for fewer people for fear of contamination, reducing the frequency of borrowing commodities, and reducing smoking. Complementary actions taken by respondents combined with the fact that some people practiced prevention measures without knowing resulted in higher-level practice compared to their knowledge in some cases.

Figure 8: Practice in Prevention Measures



Most practiced measures

- Avoiding public spaces (81%)
- Wearing a mask outside (81%)
- Staying at home (75%)

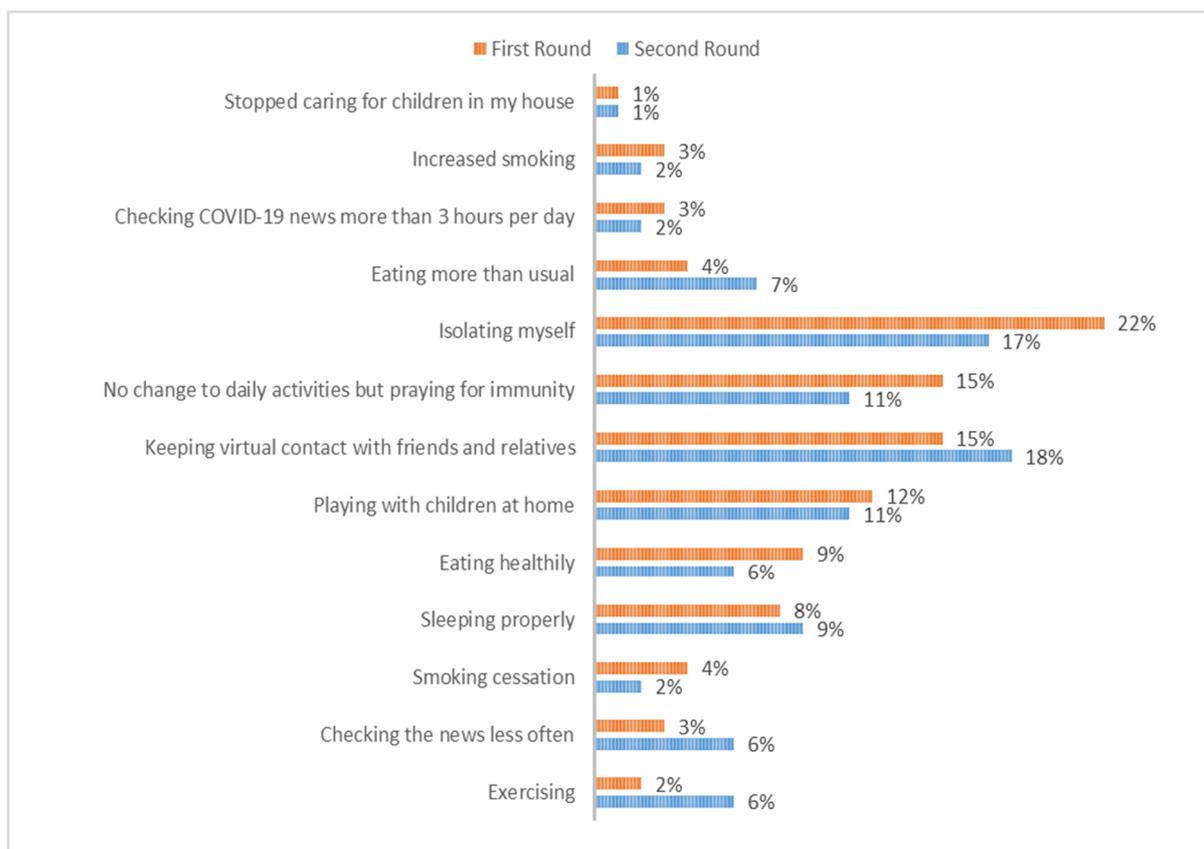
Least practiced measures

- Covering mouth/nose while sneezing, coughing (11%)
- Not touching face (10%)

Further analysis also indicated that women practice prevention measures more than men (33 percent versus 27 percent of high-level practice) in spite of their lower level knowledge. Similarly people who have at least one member over 60 years old in the family are being more careful about practicing these measures (36 percent versus 27 percent of high-level practicing) compared to households without any members above 60. Findings show that households whose heads are university graduates had the highest percentage of high-level practicing (37%), whereas this ratio was found to be 24 percent among households headed by an illiterate person.

Results from the first survey showed that respondents mostly isolated themselves (22%) which is a negative strategy for coping with stress, but more positive coping mechanisms like keeping virtual contact with friends and relatives, playing with children at home were also adopted. In the second survey, the most common coping mechanism was keeping virtual contact with friends and family, but isolation was still just as frequently adopted. Overall, the practice of several positive behaviors increased in the second round. Notably, eating more than usual increased, while eating healthy and smoking less decreased in the second round. Both unhealthy eating and smoking increase the risk of non-communicable diseases (NCD).

Figure 9: Stress Coping Behaviors



Access to Food and Hygiene Items

3.3. Access to Food and Hygiene Items



Photo: WFP / Deniz Akkuş

Access to food and hygiene items has become even more crucial in the face of the pandemic. Ensuring that people have access to food and necessary hygiene items, as well

as sufficient nutrition intake to maintain good health and hygienic conditions for protection against the virus is critical for all stakeholders in the fight against the pandemic.

i. Markets in camps and Customer Behavior

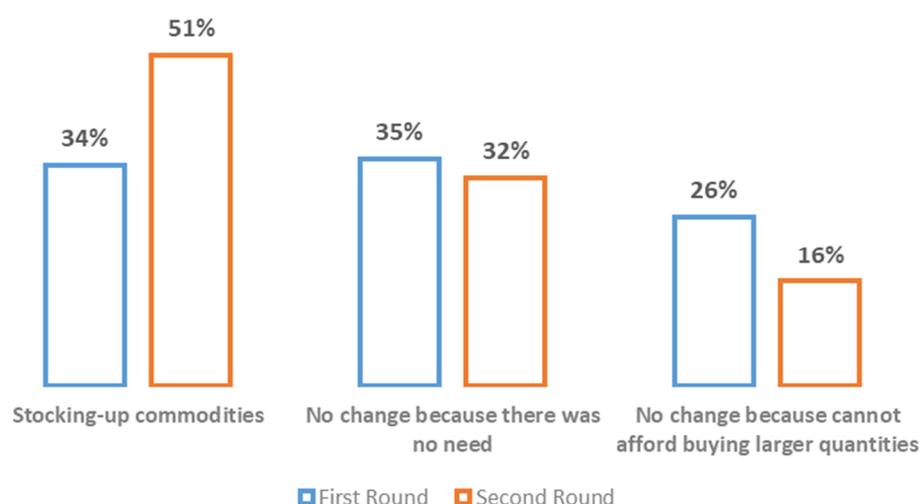
Half of the camp residents stated that they observed markets/shops to be more crowded than usual after the outbreak, representing a decrease from 72 percent in the first round of data collection. While the perception partially explains the fear and stress they feel about the risk of infection, the downward trend can indicate the beginning of a normalization process or less panic among the refugees.

Nonetheless, more people started stockpiling commodities, representing an increase from 34 percent to 51 percent in the second round. One third stated that they did not change their shopping behavior, while 16 percent said they would have stocked more items had they been able to afford larger quantities.

Further analysis showed that among the participants who stated having stocked commodities, half also observed that markets were more crowded than before the outbreak, while only 17 percent reported observing the opposite. This partially explains

that the tendency for stockpiling was due to the perception that markets were more crowded than usual with maintaining social distance often becoming impossible.

Figure 10: Customer Shopping Behavior



ii. Product Availability

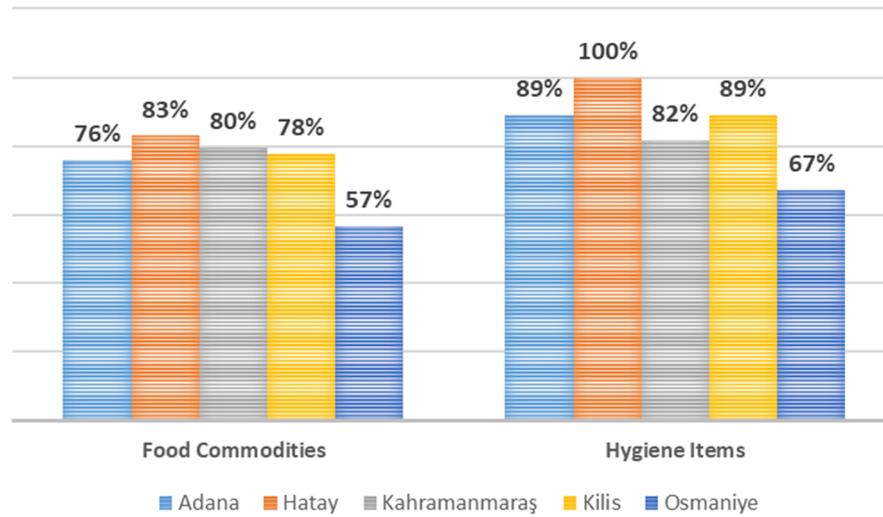
Food products remained available in the markets: 72 percent reported full availability of food products. One quarter of participants reported that food products were sometimes available, but fruits and vegetables quickly running out of stock⁷. Nonetheless, food availability in the markets slightly increased compared to the first round (from 69% to 72%). Further analysis also showed that respondents living in Osmaniye camp reported the lowest percentage of food availability.

Similarly, hygiene items remained available in the markets as reported by respondents: 83 percent of respondents expressed that hygiene items were always available. As for the camp disaggregation, availability of hygiene items was lower in Osmaniye camp compared to others as shown in figure 11.

The comparison between camps may call for a need for further investigation in the camps where products were not always available.

⁷The availability of fresh produce has subsequently been improved in collaboration with the camp store management.

Figure 11: Product Availability by Camps⁸



iii. Affordability

Around three out of four households indicated that the prices of food products (80%) had increased since March 2020. The perception of price increase for food items was particularly high compared to 66 percent recorded during the first round of data collection. WFP market monitoring activities demonstrated that the average Food Basket cost in the camps, including both the contracted and non-contracted shops, was 151 TRY (25.3\$) in January, 152 TRY (25.4\$) in February, and reached 157 TRY in March (25.4\$) 2020⁹. Later, the food basket cost increased by 10 percent in April compared to January and reached 167 TRY (25.4\$). This 10 percent increase in a short time explains the perceptions expressed by the respondents given the limited income of refugees living in camps.

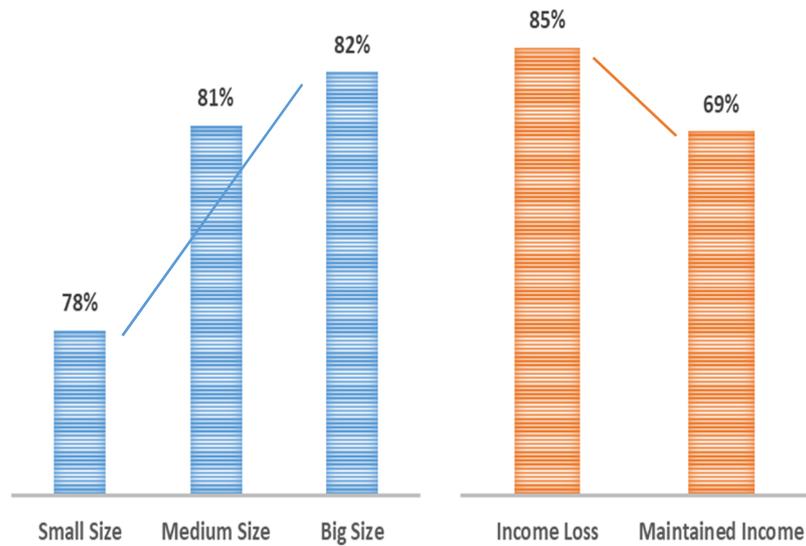
Further analysis confirmed that 85 percent of respondents who had experienced loss of income or reduced salaries perceived food prices to be increasing while this rate was 69 percent for households who maintained their income sources. Looking at family size, results also revealed that perception of an increase in food prices was slightly higher among large families compared to medium-sized and small families, partially because they had to buy larger quantities to meet the nourishment needs of all family members.

About half of the participants (54%) expressed that prices of hygiene items had increased since March. The perception of hygiene item prices remained stable between the two rounds.

⁸Product availability results represent participants' perception on the availability not identified through market monitoring

⁹Exchange rates used: 5.956 for January, 5.983 for February, 6.178 for March, 6.575 for April, 6.967 for May.

Figure 12: The Percentage of Beneficiary Perception of Increased Food Prices by Family Size and Employment Status



iv. Impact of Intervention

Average monthly household expenditure on hygiene items decreased from 185TRY (28.1\$) to 175TRY (25.1\$) in the second round. This can be attributed to the hygiene kits distribution to the camp residents between the two rounds. While the majority

of the beneficiaries (89%) expressed satisfaction with the quality of the kits, satisfaction level on the quantity remained relatively lower (81%). Moreover, one third of the residents stated that the kits would last four weeks whereas 20 percent said three weeks and an additional 29 percent said two weeks.

Figure 13: Satisfaction with the hygiene kits

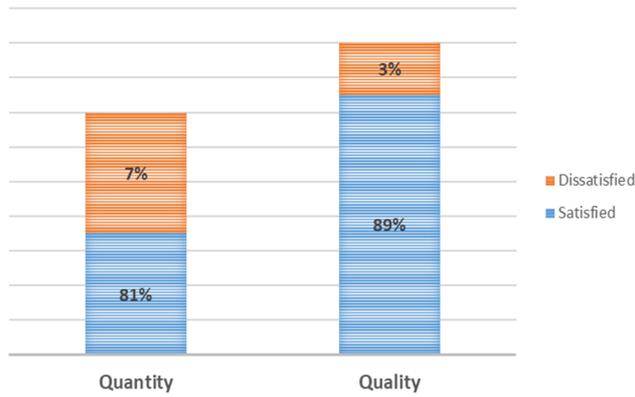
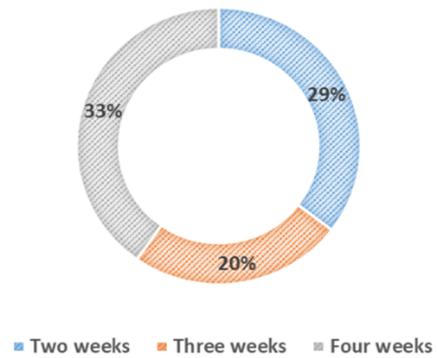


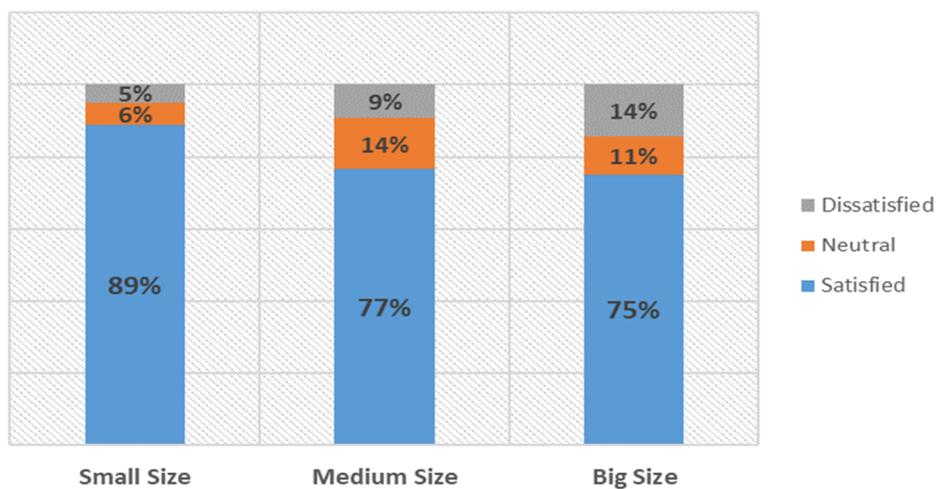
Figure 14: Perception of how long the kits would last



Further analysis indicated negative correlation between the satisfaction with the quantity of the hygiene kits and the family size: large families were less likely to be satisfied with the quantity of the items in the hygiene kits. Among households with up to 4 members, 89 percent were satisfied with the quantity compared to 75 percent of large households with 9 or more family members (p-value: 0.018). A similar correlation was also identified between family size and the perception of how long the hygiene kits

would last (p-value: 0.001): large families expected the assistance to last an average of 2.5 weeks, compared to be 3 weeks and 4 weeks for medium-sized families (5-8 members) and small families (1-4 members) respectively. Even though households received the hygiene kits depending on their household size, results show that larger families were still less satisfied with the quantity, therefore indicating that taking this measure did not allow to fully overcome this tendency.

Figure 15: Satisfaction with the quantity of the assistance by family size



Income Sources and Coping Strategies

3.4. Income Sources and Coping Strategies



i. Income Sources

Assessment shows that the main driving factor of increasing economic vulnerability due to the pandemic is the loss of employment across the globe, particularly for those earning daily wages in the informal sector who are more likely to be affected by COVID-19¹⁰.

All refugees in camps receive a monthly WFP e-voucher assistance of 100 TL (14.3\$ by May 2020), and about half of them (46%)

reported this as being their main source of income.

Some refugees had jobs outside the camps with results showing that for some 34 percent of households, this was their main source of income. However, following the restrictions due to COVID-19, more than two-thirds (68%) of households formerly employed off-camp have lost their jobs or suffered a reduction in earnings.

Photo: WFP / Mehmet Cemtaş

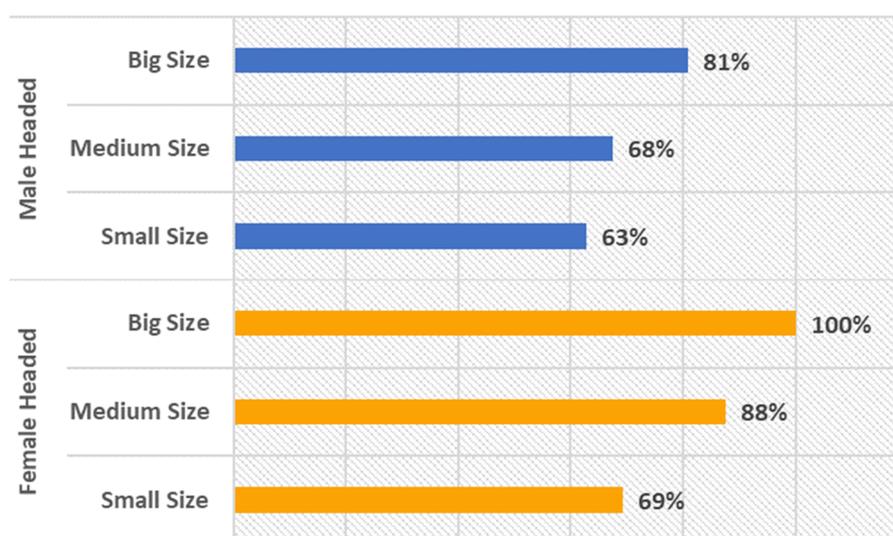
¹⁰COVID-19 Pandemic in Turkey: Analysis of Vulnerabilities and Potential Impact Among Refugees, published by WFP TRCO in April 2020.

Further analysis also revealed that income loss was more prevalent in large families: 82 percent of them reported loss of jobs or reduced salaries, while this ratio was 64 percent and 69 percent for small and medium-sized families respectively. This indicates that employment stability appear to be

more challenging for those who were already more vulnerable due to their large family size. In addition, households headed by women seemed worse off due to income loss or reduced salary compared to male-headed families (shown in Figure 16).

68% lost jobs or experienced a reduction in salaries

Figure 16: Households who lost jobs or experienced a reduction in salaries by gender and family size



While the Food Basket price in Turkey and the Southeast region remained stable through Q1 2020, the cost of a nutritionally balanced diet was already higher than the e-voucher transfer value. Moreover, Food Basket cost increased by 10 percent in April

2020 compared to January. This gap, combined with the loss of additional income and the increasing need for hygiene items, has led to increasing vulnerability among refugees living in-camps.

ii. Coping Strategies

As defined in Maslow's hierarchy of needs, food, clothing and shelter are the most basic human needs¹¹. However, vulnerable people are not always able to meet these needs for different reasons. Even though governments and humanitarian agencies aim not to leave anyone behind, there often exists a gap between need and assistance. In such

cases, individuals resort to a variety of coping strategies in order to meet their basic needs. WFP classifies the coping strategies mainly in two categories: Consumption Coping Strategies that are short-term in nature and intended to meet basic food needs; and Livelihood Coping Strategies which are longer-term solutions to meet not only food, but also all kinds of basic needs.

Consumption Coping Strategies

A household's tendency to resort to consumption coping strategies¹² is captured through the reduced Coping Strategy Index (rCSI) with an established range from 0 to 56. A lower rCSI score indicates that a household is able to meet food needs without changing patterns in daily food consumption. Findings showed that the average rCSI decreased in the second round from 12.7 to 7.5, indicating less frequency of resorting to such strategies. Despite the downward trend, it is noteworthy that 65 percent of the residents stated that they had relied on less preferred, less expensive food to cope with lack

of food or money to buy it one week prior to the survey. The most frequently used food consumption coping strategy was relying on less preferred, less expensive food at an average of 4.2 days per week, followed by reducing the portion of meals practiced almost once in a week.

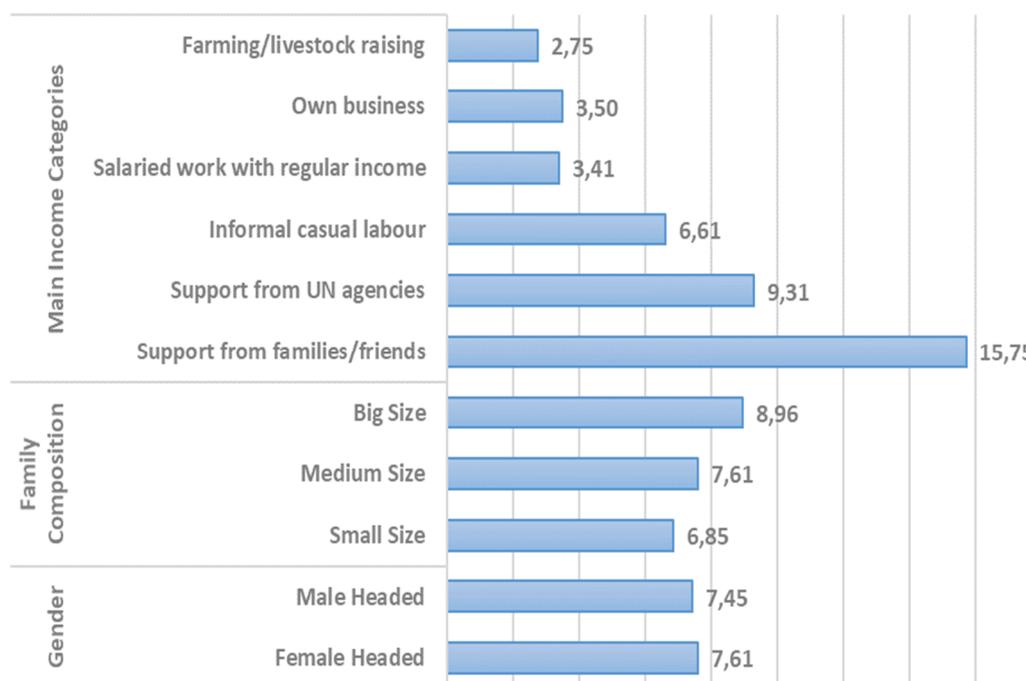
Further analysis also indicated that households depend on support from their families/friends, UN assistance or informal casual labor. Large families and female-headed households were more likely resort to coping behaviors to secure their food intake.

¹¹<https://www.simplypsychology.org/maslow.html>

¹²The reduced Coping Strategy Index (rCSI) measures the weekly frequency and severity of five consumption coping strategies i.e.

reliance on cheaper or less preferred food, borrowing food, reducing the number or size of meals, or reducing food for adults for small children to eat more.

Figure 17: Reduced Coping Strategy Index by Gender, Family Size, Main Income Category



Livelihood Coping Strategies

The livelihoods coping strategies measure the extent of longer-term household coping mechanisms, acting as an indication of their future productive capacities and ability to meet their basic needs. Unless the consumption coping strategies, they are often less reversible. Although the frequency of resorting to livelihood coping strategies decreased in the second round compared to the first, on average three out of four households had used some form of negative livelihood coping strategy¹³ in the 30 days preceding the survey.

Classified by level of severity (stress, crisis and emergency coping strategies), the analysis showed that stress coping strategies were generally the most commonly used: findings revealed that 45 percent borrowed money, 29 percent spent savings, 20 percent sold household assets, and 18 percent bought food on credit to cover their basic needs.

Further analysis also revealed that overall male-headed households were more likely to resort to most commonly used longer-term livelihood coping strategies whereas female-headed household preferred more short-term solutions to meet immediate

¹³Livelihoods-based coping strategies reflect longer term coping capacity of households and the various strategies applied can be categorized as 'stress', 'crisis' or 'emergency', depending on the severity weights. Stress coping strategies indicate reduced ability to deal with future shocks due to a current reduction in resources or increase in debts, which progresses to crisis coping and emergency

coping is at the peak. Stress coping strategies include: Sale of household assets/goods; spending savings; Borrow or purchase of food on credit; and Borrow money. Crisis coping strategies include: Sale of productive assets; withdrawal of children from school; and Reduction of essential non-food expenditure such as on health and education. Emergency Coping strategies include: Begging; accepting high risk jobs; etc.

needs of their family. In addition, one important finding was that women tended to sell household assets while men bought food on credit and borrowed money. This can indicate that men have more ability/possibilities to access credit.

Considering employment status of the refugees, the analysis revealed that households who had lost income or experienced a reduction in salaries frequently resorted to stress coping strategies, in particular borrowing money, practiced by 48 percent of all who experienced a change in their employment status.

Figure 18: Most Used Livelihood Coping Strategies (LCS) by Gender and Employment Status

Figure 18.1: LCS by Gender

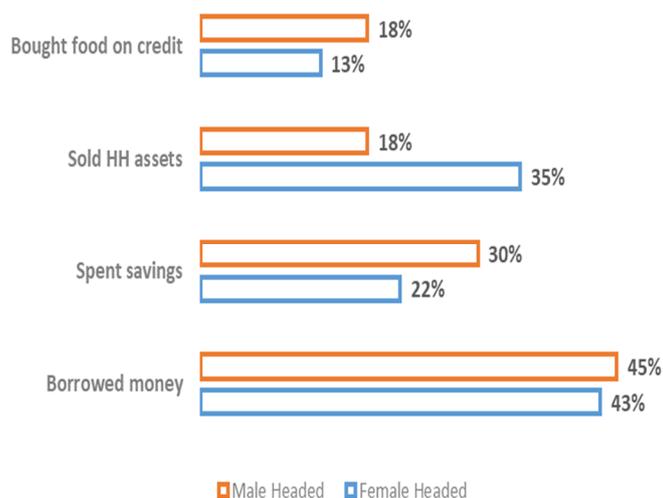
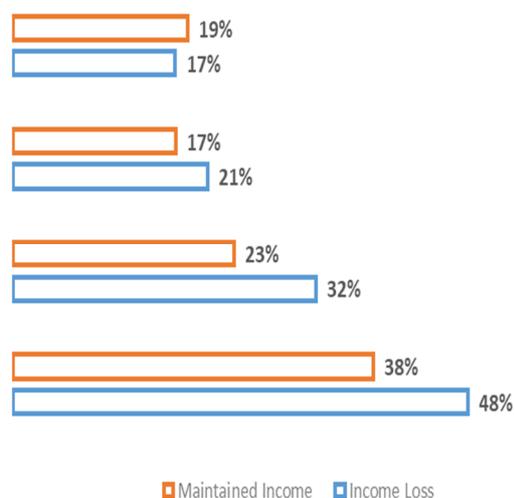


Figure 18.2: LCS by Employment Status



Conclusions

As lockdown measures are being lifted there is hope for the social economic impact of the pandemic to be less pronounced, but recovery will be slow and uncertain especially in sectors that commonly provide employment for refugees as they have been affected the most. At the same time, the risk of spikes in new infection rates remains as the process of reopening gets underway. This calls for a reinforced risk communication to continue to increase awareness on the prevention measures, symptoms and actions to seek medical care. According to this survey men were anxious to return to work, calling for a need for risk communication with targeted messages on how to remain safe in the workplace. Additionally, employers in different sectors should adopt the measures recommended by the Coronavirus Scientific Advisory Board to prepare work environments for a safe return to work.

The pandemic has had a far-reaching socio-economic impact especially on already disadvantaged populations like refugees. This survey shows that participants were adopting some positive strategies for coping with stress, but also some negative ones such as isolation, eating unhealthily. At the same time, some positive mechanisms to cope with stress such as giving up smoking were abandoned by some. Offering mental health support to refugees will be critical in helping them to positively cope with stress. In addition, promotion of a healthy lifestyle and a change in habits related to NCD risk factors should be increased to encourage refugees to adopt more positive lifestyles during this period. Communication with refugees should be language-sensitive and channels preferred and trusted by this population should be used.

WORLD FOOD PROGRAMME
Turkey Country Office

Rafet Canitez Caddesi No 107
Oran / Cankaya / Ankara
T +90 312 491 1138 wfp.org