Impact of the COVID-19 Outbreak on Syrian Refugees in Turkey

Results from Rapid Needs Assessment conducted in Istanbul, Izmir, Manisa, Gaziantep, Kilis and Reyhanli

RI Turkey

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Introduction

Global outbreak[1]

Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. The outbreak was first identified in Wuhan, Hubei, China, in December 2019, and was recognized as a pandemic by the World Health Organization (WHO) on 11 March 2020. As of 20 April, according to the WHO, across all continents, there are over 2 million confirmed cases with the USA, Spain and Italy most affected. Due to the nature of transmission, the number of suspected cases increases exponentially on a daily basis.

COVID-19 in Turkey

The Government of Turkey (GoT) has reported its first case on 11 March 2020. As of 30 April, the country has recorded almost 120,000 confirmed cases. The spread among Turkish cities is demonstrated in Figure 1.

Figure 1: Distribution of Confirmed COVID-19 Cases across Turkey

Since the outbreak was declared in Turkey, the GoT has progressively taken measures to reduce the widespread of the disease. These include flight bans, closing of the schools, suggesting self-isolation, reducing movements for people over 60 years and under 20 years of age, closing non-essential shops, and reducing hours of supermarkets with staggered entrances. Since 10 April, the GoT has also applied weekend curfews to halt the spread of the virus.

[1] WHO COVID-19 situational update, https://www.who.int/emergencies/diseases/novel-coronavirus-2019

At the same time, Turkey hosts over 3.5 million Syrian refugees, the largest number of registered Syrian refugees in the world, among whom almost half are children.[2] Over 98% of Syrians under Temporary Protection live in urban and rural areas, with less than 2% residing in the seven remaining temporary accommodation centers.[3]

Access to routine and or specialized healthcare services for refugees in Turkey is challenging. Among the main barriers are a lack of information, limited financial means, and language barriers/interpretation.[4] In this context, ensuring prevention and preparedness measures are accessible to and adopted by refugee communities, while also strengthening communication and awareness of good practices, are key to limiting transmission of the new coronavirus among the refugee community in Turkey.

Relief International program in Turkey

Relief International (RI) began humanitarian activities in Turkey in 2014. RI's current portfolio includes support to six comprehensive physical rehabilitation (PR) and five mental health (MH) centers across the southeast of Turkey, Izmir and Istanbul; a community health awareness project in Istanbul; and a livelihood project for disabled Syrian refugees in Istanbul. RI currently operates, through partnerships with local organizations, in the six provinces of Gaziantep, Hatay, Istanbul, Izmir, Kilis, and Manisa.

Survey objective and methodology

Survey objective

RI conducted a rapid needs assessment (RNA) to explore the impact of the COVID-19 outbreak and the measures to restrict its spread on its program participants, given that the provision of services was interrupted, that access to essential services became harder, and that the measures taken by GoT restrict movements of specific age groups.

The RNA aimed to explore the following:

- Awareness about COVID-19 and the impact of the COVID-19 outbreak on program participants.
- Access to the essential services, such as food and hygiene.
- Access to health services, including medicine.

Methodology

The questionnaire designed by RI was translated to Arabic by a native Arabic speaker and tested to ensure clear understanding.

The questionnaire was set up in KOBO, and the link was shared with RI's partner organizations (7) for circulation among program participants through their case managers. The link to the questionnaire was shared along with a message on the confidentiality of data collection in line with Turkey's Data Protection Law. Anonymous answers to the questionnaire were provided directly by the beneficiary or by a caregiver, family member, or a friend, depending on what phone number was provided to the center or who was able to best communicate with the center.

Data collection started on 9 April, 2020 and finished on 17 April, 2020, and took place in five provinces: Istanbul, Izmir, Manisa, Gaziantep, Kilis, and Hatay.

[2] Ministry of Interior, Directorate General of Migration Management, Temporary Protection Statistics, https://en.goc.gov.tr/temporary-protection27
[3] Regional Refugee and Resilience Plan in Response to the Syria Crisis – turkey country, January 2020
[4] 3RP 2018-2019

Limitations

In consideration of the methodology and conditions in which the RNA was conducted, there are several limitations that should be mentioned:

- As a result of the outbreak and the restriction of movements, the data collection was done electronically through an online survey.
- The RNA was designed to be based on self-reporting, and therefore is not validated by objective measures. However, this self-reporting also provides important information about perception and is a valid methodology for this situation.
- As the majority of respondents were actually caregivers, family member, or a friend, there could be limitations in their understanding of the needs.
- Since the survey was done electronically and required respondents to have access to and be familiar with technology, it might be expected that people without phone and/or internet were not able to participate in the survey.

Survey findings

Demographic Information

RI reached 879 respondents (F: 400; M: 479). Of these, 12% (n. 102) were less than 5 years old (through their caregivers), 23% (n.198) were 5-17 years old, 50% (n.440) were 18-49 years old, and 16% (n.139) were over 50 years old. The average number of household members was six.

Out of 879 respondents, 39% (n.344) were program participants themselves, while the remaining 61% (n.535) were caregivers, family members, or friends. As mentioned in the methodology section, this was mainly dependent on the phone number registered in the center.

Regarding the location of the respondents, 32% (n.283) reported to have received services in Istanbul, 25% (n.219) in Kilis, 19% (n.169) in Gaziantep, 13% (n.117) in Reyhanli and 10% (n.91) in Izmir.

Regarding to the services received by respondents, 29% (n255) reported that they received PR services, 26% (n.229) MH services, 19% (n.167) special needs rehabilitation services, and 26% (n.228) other services.

Out of all respondents (n.879), 2% (11) reported confirmed COVID-19 cases within the household.

Awareness about COVID-19

Awareness raising about COVID-19 is key to prevent the further spreading of the disease. The GoT and its partners have put considerable efforts in ensuring access to information regarding COVID-19 prevention as well as what to do and where to go in case of suspected infection.

Eighty four percent (n.739) of respondents reported they have received information about COVID-19 (see Figure 2). Thirty-seven percent (n.466) reported receiving COVID-19 information through social media (Facebook, WhatsApp, etc.), 18% (n.224) through media (TV, radio), 17% (n.206) through centers and nongovernmental organizations (NGOs), 15% (n.109) through government channels, 9% (n.115) through social networks (family, friends), and 4% (n.46) said other channels. Respondents could provide multiple answers for this question.

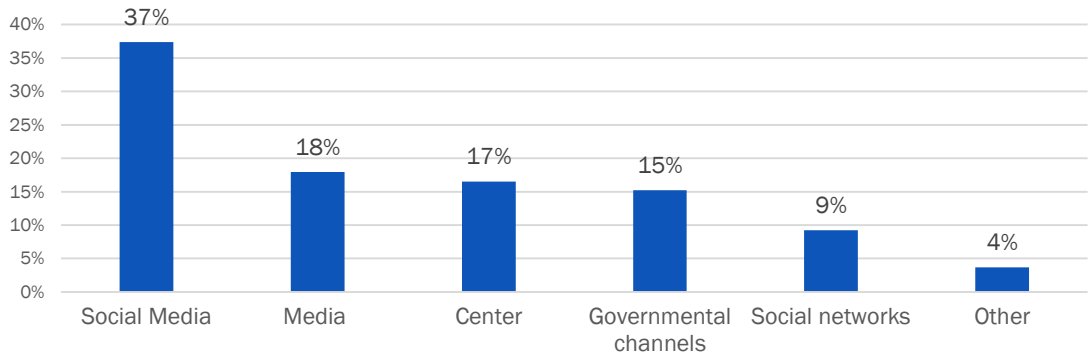

Figure 2: Sources of COVID-19 information

Impact of COVID-19 on program participants

RI asked if the interruption of services due to the outbreak has impacted respondents' health. Forty-four percent (n.384) reported no changes, 26% (n.230) reported a deterioration, 25% (n.222) answered they didn't know and 5% (n.43) reported an improvement.

For those who reported a deterioration in their status (n.230), the majority of whom were in Kilis, RI asked two follow up questions. With regards to the extent of the deterioration, 33% (n.75) reported that their status deteriorated a lot, 51% (n.118) some, and 16% (n.37) a little. Of the reasons for the deterioration, 49% (n.115) reported that their status deteriorated because their situation was complex and they need to complete their treatment plan (i.e amputees, acute MH disorders, etc.), 26% (n.62) that they had fears before COVID-19 outbreak and now these have increased, 13% (n.31) that they needed mobility aids and the center stopped providing the service before they could receive it, and 11% (n.26) that they take medicines that require regular check up with the specialist. (See also Figure 3 below.)

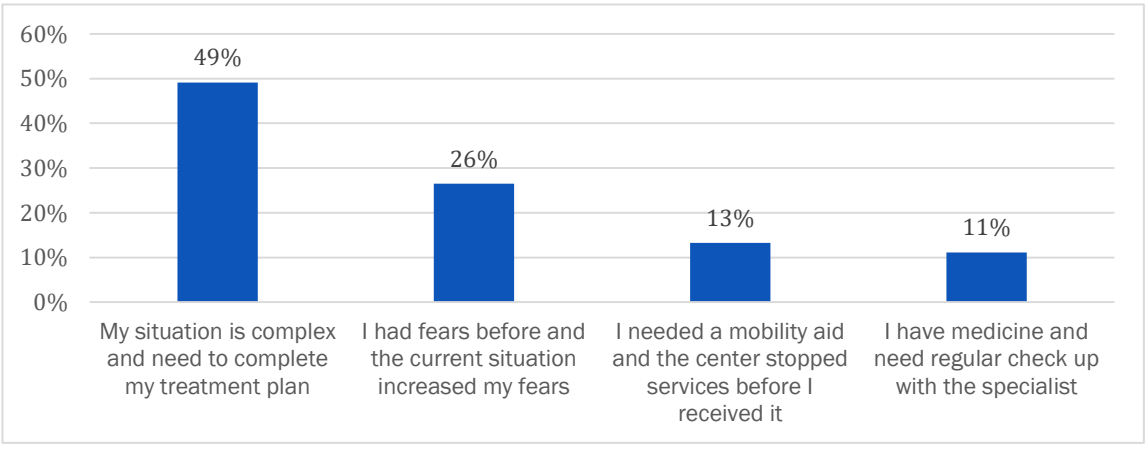

Figure 3: Reasons for deterioration of health status

In order to understand the extent of the effects of the COVID-19 outbreak on program participants, RI asked whether they had urgent needs that cannot be accessed during this outbreak. Eighty-one percent (n.716) reported that they lost access to essential needs (beyond health) since the onset of the outbreak. Of these, 59% (n.611) reported having lost access to food, 37% (n.384) to hygiene materials, and 5% (n.49) to water. The highest percentage across all was recorded in Istanbul (35% food, 32% hygiene materials, and 43% water), and the full

distribution of urgent needs among cities is demonstrated in Figure 4. Worthwhile to note that respondents could provide more than one answer to this question.

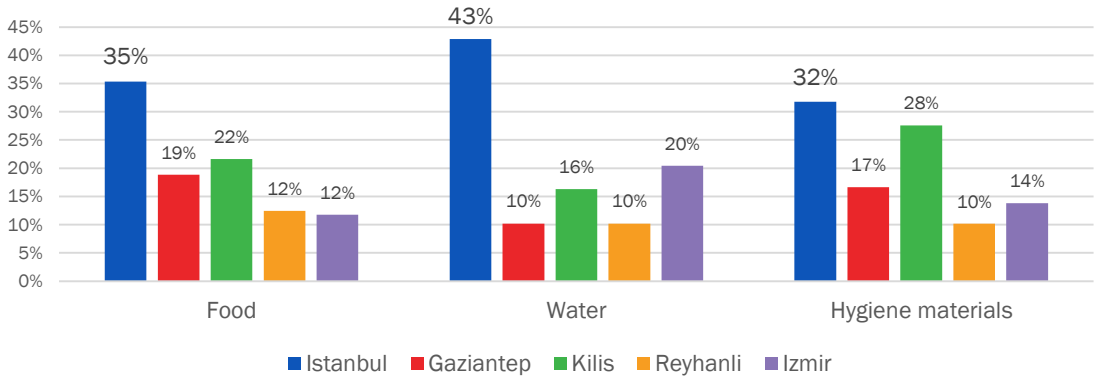

Figure 4: Distribution of urgent needs among cities

When asked about the reasons why they lost the access to these needs, 71% (n.562) attributed the loss to the fact that they are following the recommendation to stay home, 17% (n.134) because there is no access to the service due to the outbreak, and 12% (n.98) because the service provider stop providing the service (see Figure 5).

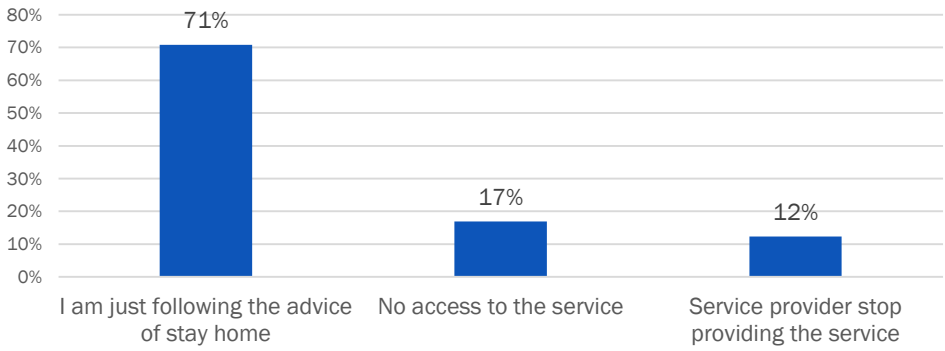

Figure 5: Barriers for urgent needs

Considering livelihoods can have a major impact on the capacity for people to access basic needs, RI asked respondents whether the beneficiary or one of his/her family members had lost their job as a result of the outbreak itself, and 87% (n.761) reported that this was the case.

In terms of coping mechanisms adopted by the interviewees to face the COVID-19 outbreak (multiple responses accepted), 43% (n.402) reported seeking support from families and relatives, 18% (n.167) from centers and NGOs, 12% (n.109) from friends or neighbors, and 28% (n.266) from other resources. Among those who responded "other", 33% (n.80) reported seeking financial assistance as they lost their work, followed by faith (9%, n.23) and relying on themselves (8%, n.21).

Access to health services

With regards to the access to health services, RI's asked whether people had access to health services both prior to and during the outbreak, to compare the situations. Eighty-seven percent (n.764) reported they had access to

health services prior to the COVID-19 outbreak, but only 25% (n.219) have access since the outbreak started. The disaggregation of those who lost access to the services are 35% in Gaziantep, 34% in Istanbul, 25% in Izmir, 23% in Kilis and 19% in Reyhanli.

The major barriers to access services were fear of getting infected (27%, n.236), following the recommendation to stay home (26%, n.226), and financial barriers (25%, n.222). See Figure 6 below for the full breakdown and note that multiple answers could be given to this question.

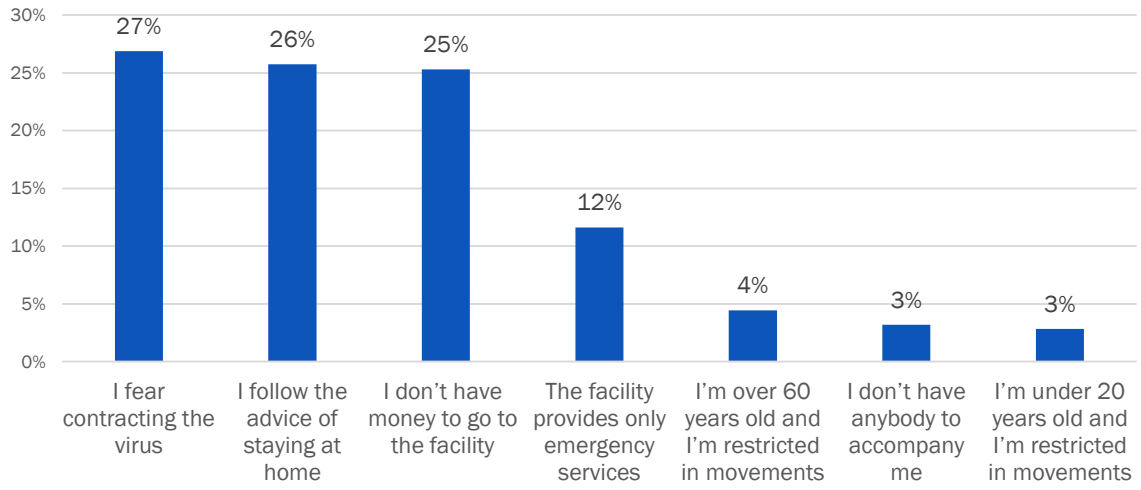

Figure 6: Barriers to access health services after COVID-19

Among the 326 respondents who reported to make regular use of medicines, only 53% (n.172) replied that they still had access to them. Among the main barriers to accessing medicine reported were financial issues (33%, n.93), fear of contracting the virus when leaving the house (18%, n.50), and following the recommendation to stay at home (15%, n.43). It is interesting to note that 12% (n.34) reported that the pharmacies did not accept giving the medication and asked for updated report; and that 9% (n.24) reported the health facility where they usually receive the medication did not renew their prescription (most likely as not considered as an emergency service). See complete disaggregation in Figure 7.

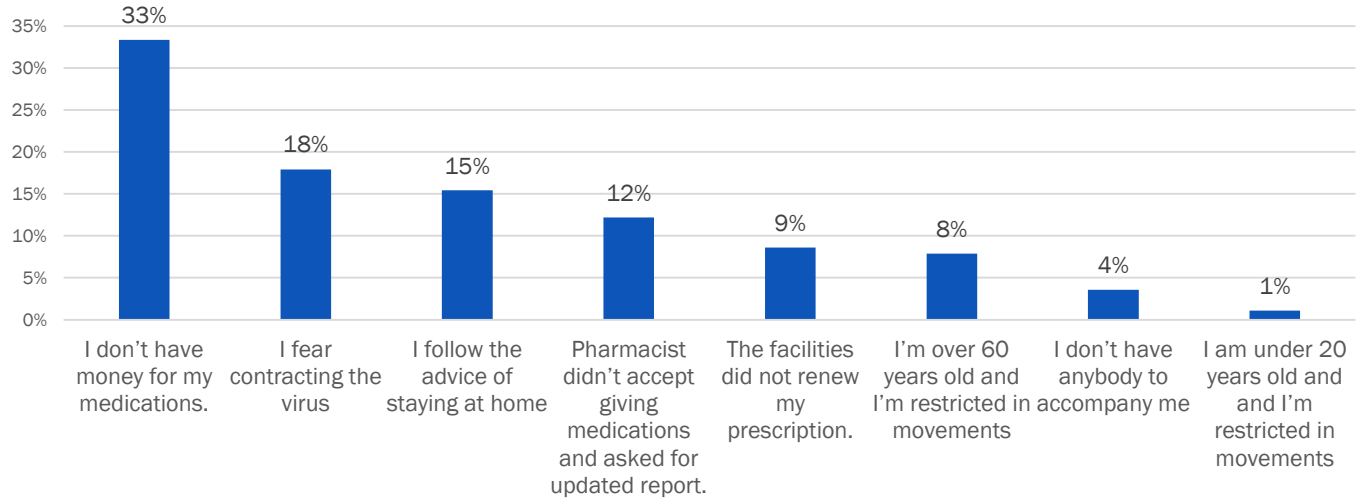

Figure 7: Barriers access to medicine after COVID-19

Respondents were also asked whether they believed that remote sessions (through phone calls, WhatsApp, or video calls), if available, would help. Fifty-eight percent (n.508) reported that they would find it useful, confirming that RI is applying the right approach since it has already started providing tele-health.

Conclusion and recommendations

Conclusion

The COVID-19 outbreak in Turkey appears to have considerably affected Syrian refugees across different aspects of their lives: 87% reported someone in their household lost their job because of the outbreak, 71% reported that they cannot access health services, and 81% reported urgent unmet needs (most likely as result of having lost their job).

Access to health services (including medicines), food and hygiene materials were at the top of the needs reported by respondents; this appears to be more challenging in cities like Istanbul and Izmir. This is most likely due to the size of the cities, knowledge around the availability of the services, and cost of the services. However this deserves to be investigated further since in cities such as Istanbul and Izmir it would also be expected that there is a higher provision of services that should increase accessibility.

It is also interesting to note that while considerable efforts have been made by the GoT to disseminate information about COVID-19, only 84% of the respondents answered to have received information. This means that more should be done to ensure that information reaches Syrian refugees, and this is a definitive role that can be played by NGOs.

Overall recommendations

Based on the findings of the RNA, RI recommends the following:

1. Provide urgent assistance for Syrian refugees to support them in meeting basic needs including food and hygiene materials.
2. Considering the high number of members per household and the need for early self-isolation to halt the spread of the disease, it would be important to invest in strengthening availability of isolation spaces at the community level to ensure that symptomatic people can isolate from the family reducing risks of transmission.
3. Advocate to the Ministry of Health to ensure Syrian refugees can access health services and needed medicines.
4. Continue providing tele-health sessions for MH and PR.
5. Strengthen focus on providing psychosocial support to affected population as fears are reported in different areas and impacted capacities of people to properly access basic needs.
6. Strengthen RI partners' centers', and NGOs in general, role in disseminating information to raise awareness about the COVID-19 outbreak.
7. Continue monitoring the situation to evaluate the impact of the crisis on Syrian refugees in Turkey.