



Health and health care access for Syrian refugees living in İstanbul

Perihan Torun¹ · Meltem Mücaz Karaaslan¹ · Büşra Sandıklı¹ · Ceyda Acar¹ · Ellyn Shurtleff² · Sophia Dhrolia² · Bülent Herek³

Received: 19 December 2017 / Revised: 12 March 2018 / Accepted: 27 March 2018 / Published online: 9 April 2018
© Swiss School of Public Health (SSPH+) 2018

Abstract

Objectives The study was conducted to assess the health needs of urban refugees living in İstanbul.

Methods A mixed methods approach was adopted to interview Syrian women from households, doctors, decision makers and NGO representatives. The data were collected between June and October 2015.

Results The main challenges were the cost of living in İstanbul, increased rent and language barrier. Almost half (49.6%) of the interviewed women did not know about free health care rights for Syrians. In the last 30 days preceding the interview, 58.6% of the participants sought health care primarily through state hospitals, primary health care centres and pharmacies. The participants had difficulty in accessing health care due to the language barrier and a lack of knowledge of the Turkish health care system. Waiting time at hospitals and negative attitudes of health care staff reduced satisfaction in these services.

Conclusions In relation to life in Turkey, the main issues for Syrian refugees were not directly related to health. They have been given the right to access health care, although had many difficulties in understanding and accessing services in a crowded city.

Keywords Health needs assessment · Refugee · Syrian · Turkey

Introduction

Turkey has been hosting refugees for decades, not only from regional countries such as Iraq, Bosnia or Bulgaria, but also from distant countries like China and Afghanistan. In the past, refugee situations have mostly been dealt with on an ad hoc basis. However, facing a sudden influx of migrants from Syria urged the country to develop robust policies and systems to meet the needs of these communities and to accommodate constantly changing conditions. The approach that underpins changes in both legislative and administrative areas demonstrate a shift from national security to a humanitarian one (Seyhan 2014). The

legislation aims to ensure that Syrian refugees have the same basic rights as Turkish citizens and led to the establishment of Directorate General of Migration Management (DGMM) (Ministry of Interior (Turkey) 2013).

It is well established that refugees are likely to have worse health compared to local populations, even with the right to access health care (Refugee Council 2005; Frantz 2003). “Difficulty in accessing healthcare services, lack of awareness of entitlement, problems in registering and accessing primary and community healthcare services and language barrier” are mentioned as the issues leading to ill health following the arrival of a to a host country (Faculty of Public Health (UK) 2008). The high speed and large volume entry of the Syrian population in Turkey has made it almost impossible to modify the systems, for increased navigability and ease of access. Hundreds of thousand Syrian individuals crossed Turkish border within a few days in 2014 (UNHCR 2014a). The initial crisis situation triggered mobilisation of the local community and civil society: in 2016, 42 national and 14 international NGOs worked to support Syrian refugees (Türk 2016).

Almost three million Syrian refugees live in Turkey (UNHCR 2016), mostly settling in urban areas. The initial

Electronic supplementary material The online version of this article (<https://doi.org/10.1007/s00038-018-1096-4>) contains supplementary material, which is available to authorized users.

✉ Perihan Torun
ptorun@hotmail.com

¹ Bezmialem Vakif University, İstanbul, Turkey

² University of Sheffield, Sheffield, UK

³ Istanbul Public Health Directorate, İstanbul, Turkey

response to the entry of Syrian refugees has been to retain the population close to home and to organize support to a population that is contained and easily accessible. The first camp was established in the first month of the crisis and was followed by 20 more in the cities close to border (AFAD 2014a). However, protraction of the crisis in Syria and the resulting exponential increase in the number of refugees led migrants to leave camps and move away from cities already saturated, to those larger and/or closer to the European border. İstanbul, with its cosmopolitan structure, has been one of the main destinations. It is estimated that 450–500 thousand, including the unregistered, live in İstanbul. Although this constitutes a small proportion of the local population compared to cities with a higher proportion of Syrians, the increased burden of living in a 14 million city and of the high demand for services, pose a huge challenge for both populations.

A scoping review to assess the health needs of refugees identified a number of studies conducted in Turkey, although no comprehensive study with a robust methodology was available for İstanbul. National studies conducted outside İstanbul found reduced access to health care among urban refugees compared to those living in the refugee camps (AFAD 2013, 2014b). This study aimed to assess the health and health care access of Syrian origin refugees living in İstanbul, to ensure that services are planned based on need and are also effective.

Methods

This study was conducted using a mixed methods approach in Zeytinburnu district of İstanbul between June and October 2015. The district has a sizeable refugee population, including approximately 15,000 Syrian refugees at the time of the survey.

Sample size for the quantitative household survey was calculated as 734, using design effect of 2. Based on the assumption of average household size of 6, the aim was to visit 122 households although interviews were stopped as sample size reached 891 with the 111th household.

The data were collected face-to-face by female English and Arabic speaking Syrian interviewers who interviewed one Syrian woman in each selected household. An algorithm was developed to select the participant giving women with young children preference. The aim was to study a representative sample; however, there is no registration system for refugees that is accessible by researchers. Therefore, a snowball sampling method was employed, and multiple entry points were used to approach a representative sample as much as possible.

The data collection tool was adapted from a questionnaire developed by the UNHCR (2014b, c). Based on local

issues reported, further questions on determinants of health such as registration status, employment, humanitarian assistance, education of children, life in Turkey and use of contraceptive methods were added. A free-text section was included for reflection on other experiences not covered by the questions (Online resource 1). The questionnaire was devised in Turkish and then translated into English. Following structured and semi structured pilot interviews the tool was modified. The data were analysed using Epi-Info 7.1.5 software program.

Semi-structured interviews were conducted with 31 Syrian women and nine key informants (comprising Syrian and Turkish doctors, decision makers and NGO representatives) with a focus on access to health care. Two focus group discussions were held with Turkish and Syrian NGO managers and staff. Qualitative data collection and analysis were carried out by two masters students from the University of Sheffield, United Kingdom. Interviews were audio recorded, transcribed, and analysed thematically.

The study was conducted in collaboration with İstanbul Public Health Directorate.

Results

One hundred and eleven Syrian women representing 891 household members were interviewed using the household questionnaire, 31 of whom were also included in the semi-structured interviews. The majority of participants (72.1%) were from urban Syria, and from Aleppo, Damascus and Kamisli cities. Although not asked, some women mentioned living in Egypt, Lebanon and Iraq prior to settling in Turkey.

More than three quarters of women (78.4%) had been living in İstanbul for at least 12 months and 60.4% of the households had at least one member who can speak Turkish. The majority of women wanted their children to learn Turkish (74.8%); they also expressed their wish to learn the language themselves in semi-structured interviews. When they were asked whether they would like to stay in Turkey, 61.3% expressed an intention to go back to Syria as soon as possible, 14.4% to go to another country and only 20.7% had a desire to remain in Turkey.

The primary school educated participants formed the largest group by 40.5% among the interviewed women and by 34.1% among all 493 adults in the sample (Table 1).

Determinants of health

In 91.9% of the households, at least one individual was in paid employment. Almost 60.0% of the household heads were in full time employment, and only 14.4% ($n = 16$) household heads were looking for a job at the time of the

Table 1 Characteristics of Syrian household members, İstanbul, Turkey, 2015

	Number	%
Level of education—all adults (<i>n</i> = 493)		
Illiterate	105	21.3
Literate	67	13.6
Primary school	168	34.1
Secondary school	76	15.4
High school	40	8.1
University	29	5.9
University student	8	1.6
Employment status—household head (<i>n</i> = 111)		
Working F/T	62	55.9
Working irregularly	2	1.8
Unemployed—seeking job	16	14.4
Unemployed—not seeking job	21	18.9
Retired	6	5.4
Other	4	3.6
No of employed persons—all adults (<i>n</i> = 111)		
≥ 5	3	2.7
3–4	34	30.6
1–2	65	58.6
0	6	5.4
No response	3	2.7
Interviewee registered with authorities (<i>n</i> = 111)		
Yes	89	80.2
No	22	19.8
Any children left education (<i>n</i> = 111)		
Yes	61	55.0
No	48	43.2
No response	2	1.8
Schooling—7–18 aged children (<i>n</i> = 291)		
Attending Turkish school	15	5.2
Attending Syrian school	34	11.7
Not attending school	153	52.6
No response	89	30.6

Collection of data in a crowded environment resulted in missing data and exclusion of some questions from the analysis

interview (Table 1). The heads of the 69.4% households worked as artisans, workers or shop keepers back in Syria. Employment related problems were mentioned in qualitative interviews—this included not receiving the promised wages, not being able to work in the area of experience and reluctance on recruitment of people aged above 40 years. For the women who were housewives in Syria, the necessity for their employment was seen as a huge burden.

The study found that at least one child under 18 years was in paid employment in 35.1% of the households (*n* = 39) and in 55.0%, children had left education as a

result of their migration to Turkey from Syria. Those children who were in education attended either Turkish schools or Syrian schools, which were set up by the Syrian community (Table 1). The women emphasised their demands in relation to educating their children, especially the girls, in response to an open question for general comments.

More than half of the households received aid mostly in the form of food (79.4%), although rent and education were the top two most expressed needs (41.5%) among those who responded to the question on the type of aid received (61.3%) or needed (47.7%). Unmatching aid was also discussed in qualitative interviews, but in response, NGO representatives argued difficulties in serving a mobile community. The municipality was keen on providing aid especially through other migrant communities settled in Zeytinburnu, considering the negative consequences for the society and the country as a whole, of leaving refugees in need.

The women were asked to describe the most important problems they faced in Turkey. High prices (28.8%) followed by high rent/housing problems (26.1%) and language barrier (19.8%) were mentioned, which were also asserted in qualitative interviews. Health was mentioned as the most important problem by just 3.6% of the participants.

Women's health

All interviewees except one were in the 15–49 year age group (*n* = 100) and 35.0% of these women (*n* = 35) have been pregnant in Turkey. More than half of the pregnant women (60.0%) received antenatal care, but had difficulties because of language barrier, waiting time and personnel attitudes, although associated numbers were small. Iron and/or vitamin D supplements were used by 57.1% and folic acid by 48.6% of the women. Pregnancies ended in miscarriage in six women (23.1%). A majority of 26 deliveries (85.0%) took place in state hospitals and 30.0% were caesarean section. Only one person had to pay for the delivery.

Interviewers asked about awareness of contraceptive methods to assess the need for education and services. Most women (83.0%) responded positively; however, level of knowledge was not measured and a smaller group (36.0%) used a method during their new life in Turkey. Half of the women (51.0%) experienced at least one sexually transmitted infection symptom.

In qualitative interviews, the increased burden of health consequences on women were brought into discussion. High number of pregnancies, psychosocial problems and need for dental and antenatal care were amongst the issues mentioned.

Child health

In the sample, the number of children aged under 5 years was 107. These children were from 82 households, 54.9% of which had at least one child vaccinated in Turkey. The vaccines were mostly administered in Family Health Centres (FHC) (57.8%). Collection of data on vaccination status of children back in Syria and in Turkey was not successful with many non-responders. Childhood vaccinations were demanded by women as demonstrated by the statements in response to open question of “are there any other issues you would like to mention?”.

All of the seven infants under 6 months were being breastfed.

Chronic diseases and disabilities

In the 73.9% of surveyed households at least one member had a chronic disease and 79.3% were receiving treatment. The three most commonly mentioned conditions were hypertension, musculoskeletal and pulmonary conditions. In the 13.5% of the households there was at least one member under 60 years old who required care at home, in 21.6% a member 60 years old or older who has a chronic disease and in 15.3% a member who is disabled (Table 2). Some participants asked for wheelchair or walking stick for the disabled spouse or parents.

Access to health care

The majority of the Syrian women (80.2%) were registered with the authorities, which allowed them to access services (Table 1). Interviewers did not inquire about registration status of the other household members as a reliable answer was not expected. Almost half of the women (49.6%) did not know about the right to free access to health care. The source of information for those who knew was mostly from a friend, neighbour or a relative (57.8%). Out of 85 women who were asked the question, 24 (28.2%) used social media to learn about their rights for services.

The first point of contact for the 65 households that accessed health care within the last month has been a government hospital (40.0%), a FHC (33.8%), a community pharmacy (16.9%), even though pharmacies were not listed in the close-ended question, or a private clinic for a small group of participants; 73.8% received care at these facilities. As the response rate for the question on access has been as low as 63.1%, numbers were too small to be reported by reason for non-access.

Language barrier and unawareness of how to access services have been the most frequently mentioned barriers for not vaccinating children and second and third following

payment in antenatal care and chronic disease care. When receiving care, language was identified as a problem, specifically in understanding the results of health assessments and dealing with paperwork, as mentioned in the free text responses. Waiting times have been a problem; however, the associated numbers were small. Queries were made by the participants on how to seek care for specific health issues, such as psychological support for children or check-ups for breast cancer. NGOs specialised in health care were scarce and mostly not providing long-term support.

In qualitative interviews the women expressed dissatisfaction with health services due to not being able to choose female doctors, the complexity of making appointments and long waiting times. Syrian doctors were dismayed by the wasted opportunity of not working at least at this initial urgent stage to look after Syrian patients. Distrust of Turkish doctors resulting from language barrier has driven some patients towards illegal Syrian clinics. Challenges as a result of increased workload for doctors and other health professionals, especially in obstetrics services, exacerbated with language barrier caused friction between Turkish doctors and Syrian patients, which seems to have led to perceptions of mistreatment. Difficulties with obtaining medicines were mentioned in qualitative interviews, as well as in the free text section of the questionnaire.

Discussion

The results from the study indicate that the Syrian refugee community living in Zeytinburnu has many challenges with regards to health and access to health care. However, the main issues in relation to life in Turkey were not directly related to health, confirmed by a later study conducted in other districts of İstanbul (Support to Life 2016). The refugees suffered from the predictable difficulties of living in a city with a population over 14 million and from the consequences of unemployment or insufficient income. The majority of Syrian refugees living in İstanbul are known to be from Aleppo (AFAD 2013, Support to Life 2016), confirmed by the current study, a city with a population below 2.5 million. Most women were not interested in settling in Turkey, which was also found in other studies (Dorman 2014; AFAD 2013).

Chronic diseases were common as evidenced by a member with a chronic disease in almost three out of four households. Another similar study of 124 households in six other districts of İstanbul and studies from Lebanon and Jordan yielded lower prevalences for chronic diseases among Syrians, 8.0, 14.6 and 39.8%, respectively (Dorman 2014; UNHCR 2014b, c). The discrepancy may have originated from the reporting of some musculoskeletal

Table 2 Chronic diseases and home care need in Syrian households, İstanbul, Turkey, 2015

	Number (<i>n</i> = 111)	%
Member with chronic disease		
Yes	82	73.9
No	23	20.7
No response	6	5.4
Chronic diseases		
Hypertension	28	25.2
Musculoskeletal disorders	28	25.2
Lung disease	22	19.8
Heart disease	14	12.6
Gastrointestinal disease	14	12.6
Neurological disease	10	9.0
Diabetes	9	8.1
Kidney disease	8	7.2
Cancer	3	2.7
Other (gynaecological disorders, skin disorders, psychiatric disorders, anemia and hernia)	15	13.5
Member with home care need (aged < 60 years)		
Yes	15	13.5
No	91	82.0
No response	5	4.5
Member with home care need (aged ≥ 60 years)		
Yes	6	5.4
No	18	16.2
No member aged ≥ 60 years	87	78.4
Member handicapped (all ages)		
Yes	17	15.3
No	89	80.2
No response	5	4.5

complaints under chronic diseases in the current study. Hypertension affected most households and is known to be a common condition in Syria (WHO 2015). Untreated hypertension was also reported to be common amongst Syrian refugees (Balcılar 2016). In recent decades, the countries in Eastern Mediterranean Region have been facing many challenges in health and health care with increases in the burden of risk factors and chronic diseases (Alwan 2017; GBD 2015 Eastern Mediterranean Region Cardiovascular Disease Collaborators and Mokdad 2017; GBD 2015 Eastern Mediterranean Region Diabetes and CKD Collaborators and Mokdad 2017; GBD 2015 Eastern Mediterranean Region Obesity Collaborators and Mokdad 2017); hypertension has become the top leading risk factor for disability adjusted life years (DALYs) in the region (GBD 2015 Eastern Mediterranean Region Collaborators and Mokdad 2017).

The refugees faced certain barriers when seeking health care in relation to antenatal care, childhood vaccinations and care for chronic diseases. Language was one of the

most frequently mentioned obstacles, as it was in studies from high-income countries (Norredam et al. 2006; Morris et al. 2009; Mangrio and Forss 2017), and complicated access to health care at every level. Willingness to learn Turkish was common as was also shown in other studies conducted in İstanbul and in the border region (Support to Life 2016; AFAD 2013). Language support fell short of meeting the need although UNHCR and NGO supports were available (Türk 2016), and local solutions such as use of volunteers were sought. A national phone line for interpretation was made available in 2013 (Ministry of Health (Turkey) 2013); however, it is not used very effectively in crowded hospital environments with long queues. Language barrier seems to be diminishing considering that there was at least one person able to speak Turkish in 60.4% of the households and fast progress is expected with the increasing number of Turkish language classes for Syrians. Women suffered from health consequences of increased burden. In another study social

isolation was reported to be a major concern among Syrian refugee women (Dorman 2014).

The expectation from the health services was high in İstanbul as well as in Lebanon and Jordan, which was demonstrated by the disappointment with prolonged waiting times. In Lebanon, long wait times has been identified as the largest challenge for access to vaccination services, and in both Lebanon and Jordan it also contributed to the second most important reason for inability to access services for chronic diseases (UNHCR 2014b, c). Staff attitudes, again, appeared amongst the difficulties, also in the Lebanon and Jordan studies. It is not uncommon to have queues and related tense environments in the Turkish health care system, especially in İstanbul (TUIK 2013). In cities closer to the Syrian border, just above one in ten refugees was found to be dissatisfied with health services (AFAD 2013). In agreement with the literature (Morris et al. 2009; Mangrio and Forss 2017), another important obstacle was the lack of an understanding of how to access health care, although the current study did not measure the level of knowledge of the participants. Only 2.0% of the women living around the border had the same problem (AFAD 2014b), which may be associated with the existence of Arabic speaking local communities and allocation of greater resources to the border region. Therefore, a guidance on how to access local health services and how to cope with challenges could be beneficial especially for those refugees settled in İstanbul. In similar studies conducted in Lebanon and Jordan, cost, long waiting times and not knowing where to go are the top three reasons for inability to access services (UNHCR 2014a, b), which aligns with our findings, except that the language complicates the communication in Turkey. In the Turkish health care system every individual is registered with a family doctor, although gatekeeping is not implemented, and consultations require appointments. Furthermore, private hospital care is integrated into the system as government hospitals do not have the capacity to cover their catchment population. All these features make the system complex for refugees, and studies identified many issues associated with the access of refugee population (Sanduvac 2013, Support to Life 2016). Free health care was provided in the bordering cities under the temporary protection act until 2013, when refugees were granted free access rights in hospitals by law, but the regulation concerning the implementation by government and civil society institutions was issued in late 2015 (Ministry of Health (Turkey) 2015). Free access rights followed the de-facto access to health care by refugees: between 2011 and 2014, over three million outpatient, 250,000 inpatient and 200,000 surgical cases received care, and 40,000 babies were delivered outside the camps (DGMM 2016). The point of contact and the referral chain have changed over time, which added to the difficulties

with understanding the structure and processes especially by a mobile population. Almost half of the women did not know about their right of free access, but knowledge level of men would also influence the access of the family members to services. Non-registration—or registration in another city—is one of the barriers to access to services. Changes to registration processes, waiting times and willingness to settle in European countries were reported as the reasons behind non-registration (Support to Life 2016; Mutlu et al. 2016). One third of Syrian women use social media to learn about their rights and key-person interview revealed common use of Facebook among Syrians. A single Arabic website or a phone application would be very useful to keep Syrians informed for the processes and any changes to regulations and practices.

The first point of contact has been the government hospitals for almost half of the participants accessed care in the last month. FHCs were also used by one in three participants as the first health care organization. These centres provide care to the population registered with them, which excludes unregistered Syrians. However, family doctors are known for volunteering especially during the initial stages of the migration. Childhood vaccinations were organised by the Public Health Directorate through mop-up campaigns (Nacar 2015), as vaccine provision to the FHCs is based on the need of the registered population. In Lebanon and Jordan refugees accessed health care mainly through primary care facilities (UNHCR 2014b, c). Migrant clinics were opened by the Turkish government to provide primary care services to refugees—although in limited number and at a later stage—but they have not been very functional in İstanbul due to many barriers such as distance to certain districts and difficulties with the recruitment of staff. Another issue is of course the creation of parallel health care systems, which could have long term negative consequences (Ammar et al. 2016).

At least one person in 91.9% of the households was in paid employment although the work permit had yet to be granted to Syrian refugees at the time of study. In 35.1% of the households at least one child under 18 years was in paid employment, which means interrupted education with accompanying adverse consequences. Another study from Southeastern Turkey found that 50.0% of children were not in school (Dorman 2014).

The most commonly provided aid was in the form of food and clothing and lack of aid for education and rent support were mentioned, which is consistent with the finding regarding the most important problems perceived by the refugees themselves. Unmatching aid calls for the assessment of downward accountability especially in NGO work.

The challenges of refugees, especially in accessing health services, were similar to those reported from Europe

and elsewhere, as well as from Jordan and Lebanon. One important shared feature between Turkey, Jordan and Lebanon is the number of Syrian refugees involved and the rate of entry into these countries, which have already been hosting large numbers of refugees when the Syrian crisis erupted. Moreover, all three countries were classified by the World Bank as upper middle-income countries, and their health care systems could not make to the top 50 in the World Health Organization ranking (Tandon et al. 2000).

The systems in the host country have been going through fast changes, but it is equally important to assess the impact of these changes on the access of refugee communities, using perhaps a guidance developed internationally (UNHCR 2011). Ensuring involvement of local authorities and taking into account the health of the local population is crucial in success.

The findings are compatible with that of a more recent study conducted in İstanbul, and the study provides valuable baseline information for further research. The problems were described from the viewpoint of women who were more likely to be disadvantaged. Except the analysis of survey data, collection and analysis of data in both quantitative and qualitative parts of the study were done by female Syrian interviewers/interpreters and female students from the UK. It can be reasoned that the women would be more likely to express their concerns and problems freely to a non-Turkish female, and hence the data are valid and reliable.

Limitations

In the quantitative survey, collection of data for all household members in a crowded environment, especially on some sensitive or complicated topics, resulted in missing data and small numbers in some cells. Therefore, cross comparisons were not performed, and some questions were excluded from the analyses.

In conclusion, refugees face challenges in the host countries even with access to free health care. Language barrier exacerbates the problem and needs addressing. Campaigns to inform refugees of available resources have to be used.

Acknowledgements The authors would like to thank Snyya Taha for her contribution to organisation and implementation of the data collection and for reviewing this manuscript.

Funding This work was supported by the Bezmialem Vakif University Scientific Research Projects Funding Scheme (6.2015/24).

Compliance with ethical standards

Ethical approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964

Helsinki declaration and its later amendments or comparable ethical standards. Ethical clearance for the study was obtained from the Ethics Committee of Bezmialem Vakif University, İstanbul.

Informed consent Informed consent was obtained from all individual participants included in the study.

Conflict of interest The authors declare that they have no competing interests.

References

- Alwan A (2017) Moving to action in the Eastern Mediterranean Region. *Int J Public Health. Suppl. The state of health in the Eastern Mediterranean Region, 1990–2015.* <https://doi.org/10.1007/s00038-017-1013-2>
- Ammar W, Kdouh O, Hammoud R, Hamadeh R, Harb H, Ammar Z, Atun R, Christiani D, Zalloua PA (2016) Health system resilience: Lebanon and the Syrian refugee crisis. *J Glob Health* 6(2):020704. <https://doi.org/10.7189/jogh.06.020704>
- Balcılar M (2016) Health status survey of Syrian refugees in Turkey. AFAD/MoH (Turkey)/WHO, Ankara, Turkey
- Directorate General of Migration Management (DGMM) (2016) Türkiye göç raporu, 2014 (Migration report Turkey, 2014). Directorate General of Migration Management, Ankara
- Disaster and Emergency Management Authority (AFAD) (2013) Syrian refugees in Turkey, 2013—field survey results. Disaster and Emergency Management Authority, Ankara
- Disaster and Emergency Management Authority (AFAD) (2014a) Syrian guests in Turkey, 2014. Disaster and Emergency Management Authority, Ankara
- Disaster and Emergency Management Authority (AFAD) (2014b) Syrian women in Turkey. Disaster and Emergency Management Authority, Ankara
- Dorman S (2014) Educational needs assessment for urban Syrian refugees in Turkey. YUVA Association, İstanbul. <https://data2.unhcr.org/en/documents/download/42946>. Accessed 19 Feb 2018
- Faculty of Public Health (UK) (2008) The health needs of asylum seekers. Briefing statement. Faculty of Public Health (UK), London
- Frantz E (2003) Report on the situation of refugees in Turkey: findings of a five-week exploratory study December 2002–January 2003. Forced Migration and Refugee Studies, American University of Cairo, Cairo. http://madde14.org/images/9/9e/Eli_zabethFrantz.pdf. Accessed 19 Feb 2018
- GBD 2015 Eastern Mediterranean Region Collaborators, Mokdad AH (2017) Danger ahead: the burden of diseases, injuries, and risk factors in the Eastern Mediterranean Region, 1990–2015. *Int J Public Health. Suppl. The state of health in the Eastern Mediterranean Region, 1990–2015.* <https://doi.org/10.1007/s00038-017-1017-y>
- GBD 2015 Eastern Mediterranean Region Cardiovascular Disease Collaborators, Mokdad AH (2017) Burden of cardiovascular diseases in the Eastern Mediterranean Region, 1990–2015: findings from the Global Burden of Disease 2015 study. *Int J Public Health. Suppl. The state of health in the Eastern Mediterranean Region, 1990–2015.* <https://doi.org/10.1007/s00038-017-1012-3>
- GBD 2015 Eastern Mediterranean Region Diabetes and CKD Collaborators, Mokdad AH (2017) Diabetes mellitus and chronic kidney disease in the Eastern Mediterranean Region: findings from the Global Burden of Disease 2015 study. *Int J Public Health. Suppl. The state of health in the Eastern Mediterranean Region, 1990–2015.* <https://doi.org/10.1007/s00038-017-1011-2>

- Health. Suppl. The state of health in the Eastern Mediterranean Region, 1990–2015. <https://doi.org/10.1007/s00038-017-1014-1>
- GBD 2015 Eastern Mediterranean Region Obesity Collaborators, Mokdad AH (2017) Burden of obesity in the Eastern Mediterranean Region: findings from the Global Burden of Disease 2015 study. *Int J Public Health. Suppl. The state of health in the Eastern Mediterranean Region, 1990–2015.* <https://doi.org/10.1007/s00038-017-1002-5>
- Mangrio E, Forss KS (2017) Refugees' experiences of healthcare in the host country: a scoping review. *BMC Health Serv Res* 17:814. <https://doi.org/10.1186/s12913-017-2731-0>
- Ministry of Health (Turkey) (2013) Yabancı dilde gelen çağrılara tercümanlık hizmeti veren telefon hattı (Telephone interpreting line for calls in foreign languages). Ministry of Health (Turkey), Ankara, Turkey
- Ministry of Health (Turkey) (2015) Geçici koruma altına alınanlara verilecek sağlık hizmetlerine dair esaslar (Regulation concerning health services for persons under temporary protection act). Ministry of Health (Turkey), Ankara, Turkey
- Ministry of Interior (Turkey) (2013) Yabancılar ve uluslararası koruma kanunu (Law on foreigners and international protection). Ministry of Interior (Turkey), Ankara, Turkey
- Morris MD, Popper ST, Rodwell TC, Brodine SK, Brouwer KC (2009) Healthcare barriers of refugees post-resettlement. *J Commun Health* 34(6):529–538. <https://doi.org/10.1007/s10900-009-9175-3>
- Mutlu Y, Kırmısoy E, Antakyalıoğlu Ş (2016) Suriyeli mülteci çocuklar ve vatansızlık riski-araştırma raporu (Syrian refugee children and risk of statelessness-research report). *Gündem Çocuk Derneği*, Ankara, Turkey
- Nacar OA (2015) Suriyeli sığınmacılara sunulan sağlık hizmetleri (Utilisation of health services by Syrian refugees). *SD Platf* 34:78–81
- Norredam M, Mygind A, Krasnik A (2006) Access to health care for asylum seekers in the European Union—a comparative study of country policies. *Eur J Public Health* 16(3):286–290. <https://doi.org/10.1093/eurpub/cki191>
- Refugee Council (2005) A study of asylum seekers with special needs. London, UK. <https://www.refugeecouncil.org.uk/assets/0002/8820/AsylumseekersspecialneedsApril2005.pdf>. Accessed 19 Feb 2018
- Sanduvac ZT (2013) Needs assessment report of Syrian non-camp refugees in Şanlıurfa Turkey. Concern Worldwide and Mavi Kalem, Turkey. <https://data2.unhcr.org/en/documents/download/41275>. Accessed 19 Feb 2018
- Seyhan O (2014) Changing the status quo of migration and asylum policies in Turkey: a narrative inquiry. *J Organ Transform Soc Chang* 11:185–206. <https://doi.org/10.1179/1477963314Z.00000000029>
- Support to Life (2016) Vulnerability assessment of Syrian refugees in İstanbul—April 2016. <https://data2.unhcr.org/en/documents/download/54518>. Accessed 19 Feb 2018
- Tandon A, Murray CJL, Lauer J, Evans D (2000) Measuring overall health system performance for 191 countries. World Health Organization (GPE Discussion Paper No. 30), Geneva, Switzerland
- Türk GD (2016) Türkiye’de Suriyeli mültecilere yönelik sivil toplum kuruluşlarının faaliyetlerine ilişkin bir değerlendirme (A review of the role of NGOs working for Syrian refugees in Turkey). *Marmara J Commun* 25:145–157. <https://doi.org/10.17829/midr.20162520723>
- Turkish Statistical Institute (TUIK) (2013) Satisfaction from public services. National life satisfaction survey. Turkish Statistical Institute, Ankara
- United Nations High Commissioner for Refugees (UNHCR) (2011) Ensuring access to health care operational guidance on refugee protection and solutions in urban areas. United Nations High Commissioner for Refugees, Geneva
- United Nations High Commissioner for Refugees (UNHCR) (2014a) Number of Syrian Kurds fleeing to Turkey nears 140,000; humanitarian needs mount. <http://www.unhcr.org/afr/news/latest/2014/9/54214ed19/number-syrian-kurds-fleeing-turkey-nears-140000-humanitarian-needs-mount.html>. Accessed 19 Feb 2018
- United Nations High Commissioner for Refugees (UNHCR) (2014b) Health access and utilisation survey among non-camp refugees. United Nations High Commissioner for Refugees, Amman. <https://data2.unhcr.org/en/documents/download/41025>. Accessed 19 Feb 2018
- United Nations High Commissioner for Refugees (UNHCR) (2014c) Health access and utilisation survey among non-camp Syrian refugees. United Nations High Commissioner for Refugees, Beirut. <https://data2.unhcr.org/en/documents/download/61329>. Accessed 19 Feb 2018
- United Nations High Commissioner for Refugees (UNHCR) (2016) Syria regional refugee response. United Nations High Commissioner for Refugees. <https://data.unhcr.org/syrianrefugees/country.php?id=224>. Accessed 30 Nov 2017
- World Health Organization (WHO) (2015) Global health observatory data—Syrian Arab Republic: country profiles. World Health Organization. http://www.who.int/gho/countries/syr/country_profiles/en/. Accessed 19 Feb 2018