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Factors Affecting Access to Health Care Services for Syrians in Turkey

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ABSTRACT

Objectives: This study was conducted to find out about the access of Syrians residing in a neighborhood densely populated by Syrians in Izmir to therapeutic health care services and to identify the factors affecting their access.

Methods: The dependent variable of this cross-sectional study is the status of Syrians' access to therapeutic health care services. The independent variables of this study include age, gender, educational background, marital status, working status, perceived economic status, registration status, whether speaking Turkish, presence of language barrier, time of residence in Turkey and Izmir, type of housing, presence of heating, number of individuals, family, rooms and individuals per room in the housing. The population of this study was composed of all Syrians residing in the neighborhood between September and October 2015.

Results: In this study, 556 Syrian individuals were interviewed in 97 households. It was found that 132 (56.9%) of the 232 individuals who needed access to health care services could not access them. The increase in the number of people sharing housing and presence of language barriers had a negative impact on access to health care (p=0.029 and p=0.001, respectively).

Conclusion: Immigrant polyclinics that provide primary health care should be generalized to prevent the language barrier from being an obstacle in access to health care.

Keywords: Communication barriers, delivery of health care, transients and migrants

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INTRODUCTION

One of the most devastating outcomes of the Syrian Civil War, which was the last stop of the Arab Spring, has been the obligatory migration movements. In Turkey, which is one of the primary locations of Syrians who want to escape from the environment of civil war, the number of Syrians has reached four million in eight years.[1] Almost all of the Syrians living in Turkey maintain their lives through their own means outside the camps.[2] The number of Syrians in Izmir, which is one of the most remote provinces to the Syrian-Turkish border and is often used as a passage in transitions to Europe due to its proximity to Greek islands, was reported to be 146.891 as of October 2019 by the Directorate General of Migration Management.[2]

Syrians, who have come to provinces where there are no shelters, such as Izmir, generally settle in city's regions with lower socioeconomic levels through their own financial and social means.[3] Poor sheltering and negative environmental conditions, failure to access healthy water and food, presence of language barriers, lack of legal registration and low-income levels affect this group's health and access to health care services.[4]

Access to health care services is defined as the "timely use of health care services to obtain the

best health outputs" and health care services are affected by structural, financial and personal factors.[5] Access of Syrian living in our country to health care services is regulated by the amendment to the regulation "Principles Relating to Health Care Services to be Provided to Temporary Protection Beneficiaries".[6] According to the legislation, registered Syrians can apply to polyclinics called immigrant health center or directly to secondary and tertiary care centers under the ministry. Immigrant health centers have been established in the locations where immigrants have a dense population to offer health care services more effectively and efficiently and to overcome the problems due to language and cultural barriers. Formed by a physician and allied health personnel who would serve every 4000 people on average, these centers operate similarly to the family medicine.[7] Health care expenses of all registered Syrians are free of charge.[6] Emergency treatment services, immunization programs for infectious diseases that are highly likely to pose a problem for public health, and tuberculosis treatment are free of charge for all registered or non-registered Syrians who can access health care services. [8] Other than these health conditions, access to protective, therapeutic and rehabilitative health care services is only possible through their own financial means or via the support of benevolent associations.

This study was conducted to find out about the access of Syrians residing in a neighborhood densely populated by Syrians in Izmir to therapeutic health care services and to identify the factors affecting their access.

METHOD

This cross-sectional study was conducted in a neighborhood densely populated by Syrians in the city center of Izmir. The population of this study was composed of all Syrians residing in this said neighborhood between September and October 2015, who fled from the civil war in Syria to Turkey. With the smallest sample size calculated to be 294, it was aimed in this study to reach the whole population without selecting a sample. To reach the whole population, the plan of the neighborhood was used to identify the streets, and the streets were visited in order so that all Syrian individuals could be reached. A total of 621 Syrian individuals living in the neighborhood within the study dates were found, and 556 (89.5%) individuals were reached. Only 9 (1.4%) of the individuals living in the neighborhood refused to participate in this study, and 56 (9.0%) of them could not be reached as they were working although they were visited for the second time.

The dependent variable of this study is the status of Syrians' access to therapeutic health care services. The status of access to therapeutic health care services was evaluated with two parameters in individuals who had any health problem in Turkey. These parameters are whether one applied to a health care center when having a health problem and if one applied to a health care center and medication was prescribed, whether they used the medication. To reach the dependent variable, the participants were asked whether they had applied to any health care center when they had a health problem since coming to Turkey. In the cases where the participants had multiple health problems, they were asked to answer for the last health problem they had. In the cases where the individuals with problems applied to a health care center, and if treatment was prescribed, they purchased the drug and used it regularly, such participants were considered to "have access to the health care service".

The independent variables of this study include age, gender, educational background, marital status, working status, perceived economic status, registration status, whether speaking Turkish, presence of language barrier, time of residence in Turkey and Izmir, type of housing, presence of heating, number of individuals, family, rooms and individuals per room in the housing. To determine the registration status, the participants were asked whether they were registered with Turkish bodies and received a temporary identity card. The participants who were unable to speak Turkish enough to make themselves understand and who constantly lived with such individuals were considered to "have language barriers". Educational background was analyzed without the participants at the age of six years or younger who were not at the school age yet and marital status and working status were analyzed without the participants under 15 years old.

The study data were obtained using face-to-face interviews in the company of a translator at participants' homes. Everyone but the participants under 15 years old and individuals who were not capable of answering the questionnaire and had speaking, hearing and mental disability answered for themselves. Information about such individuals was written down by individuals who took care of them. The purpose of this study and that the participants did not have to participate and that their personal information would be kept secret were explained by the translator to the participants. The translator who served in this study was a neighborhood mukhtar's spouse, whose native language was Arabic.

The data were evaluated using SPSS 21.0 software package. For descriptive results, variables indicated by count were expressed in frequency, percentages and variables specified by measure were expressed in median (minimum-maximum). Mann-Whitney U test and chi-square test were uti-

lized to evaluate the relationship between the independent variables and the dependent variable. Logistic regression analysis was used for creating a model based on the factors determining the access to therapeutic health care. The variables found to be significant in the univariate analyses and the gender variable were included in the logistic model, and one of the variables with high correlation among them was excluded. Age, time of residence in Turkey and the number of people sharing the housing were included as continuous variables while gender, registration status and presence of language barrier were included categorical variables in the model. Hosmer-Lemeshow test was used for model fit. The significance level was accepted as $p<0.05$.

RESULTS

Within the research dates, 556 Syrian individuals were interviewed in 97 households. Two hundred and ninety-nine (53.8%) of these individuals are male. The median age of the group was 19.0 (0.0-95.0) years. Four hundred and fifty-eight (82.4%) participants were registered. While 432 (77.7%) participants did not speak Turkish enough to make themselves understood, 239 (43.0%) of them neither spoke Turkish nor were constantly living with an individual who spoke Turkish (Table 1).

Two hundred and fifty-five (45.9%) of the Syrians in the study group stated that their incomes were less than their expenses. A hundred and thirteen (34.0%) people were working

Table 1. Sociodemographic characteristics of the study group

	Whole group (n=556)	Female (n=257)	Male (n=299)
Age groups			
0-1 years	14 (2.5)	5 (1.9)	9 (3.0)
1-4 years	60 (10.8)	25 (9.7)	35 (11.7)
5-9 years	75 (13.5)	39 (15.2)	36 (12.0)
10-19 years	142 (25.5)	60 (23.3)	82 (27.4)
20-64 years	256 (46.0)	127 (49.4)	129 (43.1)
≥65 years	9 (1.7)	1 (0.5)	8 (2.8)
Education status*			
Illiterate	19 (4.2)	15 (7.0)	4 (1.7)
Literate	83 (18.2)	45 (20.9)	38 (15.8)
Primary school graduate	123 (27.0)	69 (32.1)	54 (22.4)
Secondary school graduate	163 (35.7)	62 (28.8)	101(41.9)
High school graduate	57 (12.5)	20 (9.3)	37 (15.3)
University graduate	11 (2.4)	4 (1.9)	7 (2.9)
Marital status*			
Single, never married	86 (25.9)	21 (13.6)	65 (36.5)
Married	202 (60.8)	105 (68.2)	97 (54.5)
Married,separated	21 (6.3)	16 (10.4)	5 (2.8)
Widowed	17 (5.1)	10 (6.5)	7 (3.9)
Divorced	6 (1.9)	2 (1.3)	4 (2.3)
Legal registration			
Exist	458 (82.4)	218 (84.8)	240 (80.3)
Not exist	98 (17.6)	39 (15.2)	59 (19.7)
Speaking Turkish			
Yes	124 (22.3)	46 (17.9)	78 (26.1)
No	432 (77.7)	211 (82.1)	221 (73.9)
Presence of language barrier			
Not exist	317 (57.0)	143 (55.6)	174 (58.2)
Exist	239 (43.0)	114 (44.4)	125 (41.8)

All data are presented as n (%).
*Some variables were missing.

and 75 (22.6%) were looking for a job. Thirty-six (31.9%) of the participants who were working stated that they were ironing or sewing buttons at the tailors in the area.

The median months of residence in Turkey for Syrians in the study group were 14.0 (1.0-48.0) months, and the median months of residence in Izmir were 12.0 (1.0-42.0) months. Sixty-eight (70.1%) housing in the study group were slums, and 35 (36.1%) of the participants had no heating. The median number of people living in housing was 6.0 (1.0-25.0) person, and the number of families was 1.0 (1.0-4.0). The median number of rooms in the housing was 2.0 (1.0-7.0) and the number of rooms per person in the housing was 2.5 (0.3-6.0).

Two hundred and thirty-two (41.7%) participants reported that they had had a health problem requiring an application to the hospital since coming to Turkey. A hundred and twenty-five (53.9%) individuals applied to a health care center, and 80 (64.0%) of the 125 people who applied to a health care center were prescribed medication. Fifty-five (68.8%) of the 80 people who were prescribed medication used the whole prescribed medication.

According to Figure 1, 132 (56.9%) of the 232 individuals could not access health care services, and 100 (43.1%) did. The following analyses were represented by classifying all individuals who needed health care services into the groups of "accessed" and "not accessed".

Table 2. Impact of socioeconomic characteristics on access to health services

	Accessed to healthcare	Not accessed to healthcare	Total	p†
Gender				
Female	49 (41.2)	70 (58.8)	119 (100.0)	0.543
Male	51 (45.1)	62 (54.9)	113 (100.0)	
Age groups				
0-14 years	38 (42.7)	51 (57.3)	89 (100.0)	
15-49 years	51 (43.6)	66 (56.4)	117 (100.0)	0.988
≥50 years	11 (42.3)	15 (57.7)	26 (100.0)	
Education status*				
Primary school or lower	38 (42.7)	51 (57.3)	89 (100.0)	0.604
Secondary school or higher	46 (46.5)	53 (53.5)	99 (100.0)	
Marital status*				
Married	43 (45.3)	52 (54.7)	95 (100.0)	0.517
Not married	19 (39.6)	29 (60.4)	48 (100.0)	
Employment status*				
Employed or looking for work	32 (41.6)	45 (58.4)	77 (100.0)	0.639
Unemployed	30 (45.5)	36 (54.5)	66 (100.0)	
Legal registration				
Yes	93 (46.0)	109 (54.0)	202 (100.0)	0.019
No	7 (23.3)	23 (76.7)	30 (100.0)	
Economic status				
Borrowing money	42 (40.4)	62 (59.6)	104 (100.0)	0.451
In balance/could save money	58 (45.3)	70 (54.7)	128 (100.0)	
Speaking Turkish				
Yes	35 (59.3)	24 (40.7)	59 (100.0)	0.004
No	65 (37.6)	108 (62.4)	173 (100.0)	
Presence of language barrier				
Not exist	72 (51.8)	67 (48.2)	139 (100.0)	0.001
Exist	28 (30.1)	65 (69.9)	93 (100.0)	

All data are presented as n (%).

*Some variables were missing.

†Chi squared test.

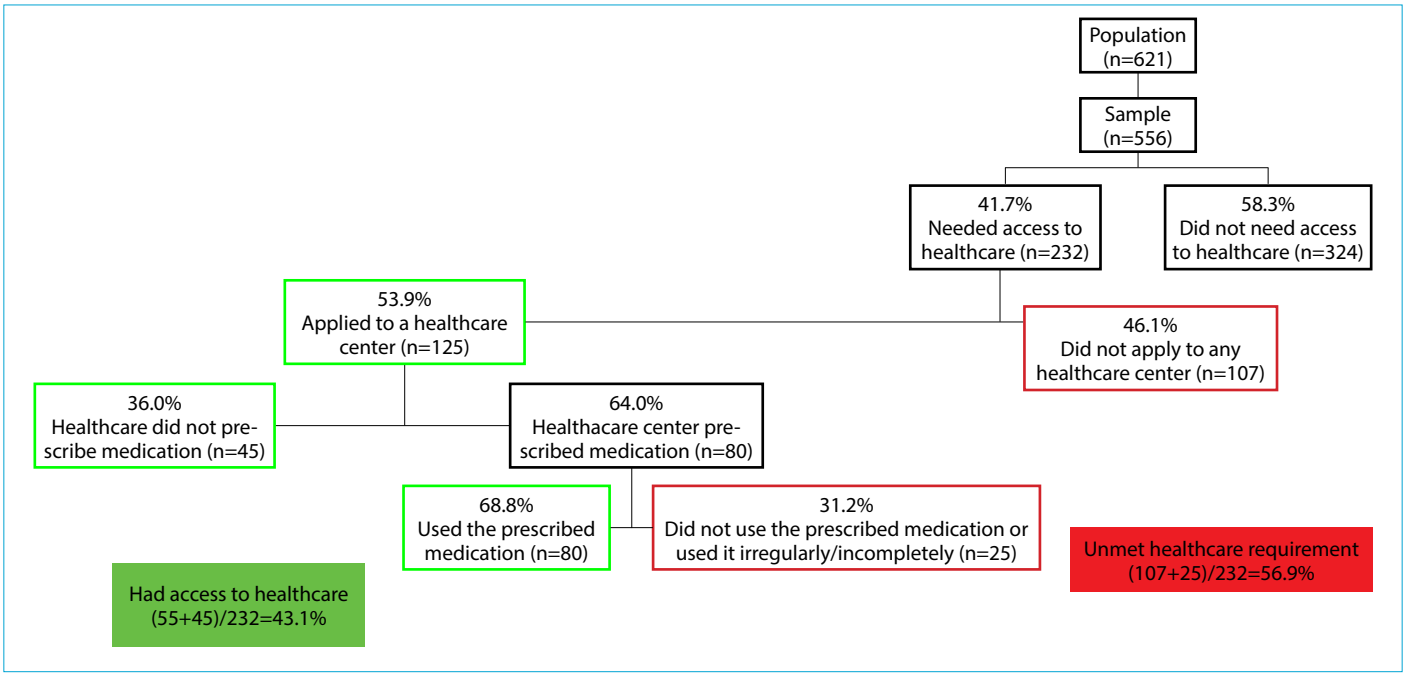

Figure 1. Access of the study group to healthcare services.

As seen in Table 2, registered participants who needed health care services had significantly higher access to healthcare (p=0.019). The participants who could speak Turkish enough to make themselves understood, participants who were constantly living with at least one person that could speak Turkish and the participants who did not have language barriers had significantly more access to health care services (p=0.001).

There was no significant difference between the median age of the participants who had access to health care services and the participants who did not (21.0 (0.0-73.0) vs. 19.0 (0.0-80.0) years, p=0.657). While the median months of residence in Turkey for the participants who had access to health care services were 20.0 (1.0-43.0) months, the median months of residence in Turkey for the participants who did not have access to health care services were 18.0 (1.0-40.0) months, and there was a significant difference between the two groups (p=0.006). Likewise, the participants who had access to health care services had been living in Izmir for a significantly longer period (18.0 (1.0-42.0) vs. 12.0 (1.0-40.0) months, p<0.001). While the median number of people residing the housing of Syrians who had access to health care services were 5.0 (2.0-21.0) people, the median number of people in the housing for the participants who did not have access to health care services were 7.0 (1.0-25.0) people and there was a significant difference between the two groups (p=0.005).

To explain the access to health care in Table 3, a logistic regression analysis, including age, gender, number of people sharing the housing, time of residence in Turkey, and presence of registration and language barrier, was conducted with the backward elimination method. The number of

Table 3. Logistic regression analysis predicting access to healthcare

	Beta	SE	p	OR	%95 CI
The number of people sharing the housing (continuous)	-0.060	0.028	0.029	0.941	0.892-0.994
Presence of language barrier					
Not exist (Reference: Exist)	0.965	0.287	0.001	2.626	1.495-4.612
Constant	-0.403	0.296	0.174	0.668	
-2Loglikelihood: 301.120					

Variables included in the model: Age, gender, time of residence in Turkey, number of people sharing the housing, presence of language barrier, registration status.

people sharing the housing was negatively correlated with access to health care; each increase in such number meant a 5.9% decrease in access to health care (p=0.029). Access to health care was 2.6 times more (p=0.001) among the participants, not having language barriers than the participants having language barriers.

DISCUSSION

Aimed at identifying the access of Syrians residing in an Izmir neighborhood densely populated by Syrians to therapeutic health care services and the factors affecting their access, this study observed that over 40% of the 556 participants had a health problem requiring access to health care services in Turkey. The findings showed that 56.9% of the Syrians who needed access to health care services could not access them. The increase in the number of people sharing the housing and presence of language barriers had a negative impact on access to health care.

In this study, 53.8% of the 556 Syrians in the study group were male. A study conducted in provinces near the border found this rate to be 51.4%, while a field study performed in Bursa, which is a province distant to the border, concluded a rate of 53.3%.[9,10] Despite small discrepancies, given that females are more vulnerable and reluctant in case of challenging travel conditions compared to males might have been the reason why the rate of males in western provinces was higher. Higher rates of males towards western provinces are even more prominent, especially in the European studies, and it is reported that 83.1% of the Syrians that have managed to flee to Greek islands via western provinces are males.[11] Like gender, educational background differs by regions, and educational level increases from the Syrian Arab Republic towards European countries.[12,13]

In this present study, 17.6% of the individuals were not registered. According to the current legislation, being registered is of importance for Syrian individuals as it is the prerequisite of enjoying social benefits such as education and health care.[7] While being registered is in favor of both Syrians concerning exercising their rights and government authorities concerning control, some Syrians do not have themselves registered. Primary reasons for unwillingness to be registered include desiring not to stay in Turkey but to transit to a third country as soon as possible, fear of deportation, and fear that records will be seized by the Syrian government.[14]

It was found that 77.7% of the individuals who participated in this study did not speak Turkish. Language is one of the most important instruments in adapting to social life and accessing services. Although a part of the participants who did not speak Turkish could overcome this barrier thanks to family members constantly living together with them who could speak Turkish, over 40% of them could not speak Turkish or they had nobody constantly living with them who could speak Turkish. A study carried out in Australia stated that the most important barrier to Karen refugee women's access to education was the language barrier, and according to the study, the language barrier was more restrictive than gender and cultural factors.[15] The language barrier also seems to be an important factor in access to health care services.

In this present study, 41.7% of the Syrians in the study group had had a health problem requiring an application to a hospital since coming to Turkey. A rate of 68.5% was reported among the Syrians under the age of 18 living outside the camps in Jordan.[16] The difference between the two studies is that the Jordanian study was on individuals under the age of 18 and the reasons for applying to the hospital were rather upper respiratory tract infections, digestive tract infections, fever, and accident among this age group.

In this study, 53.9% of the Syrians who had a health problem that required them to go to a hospital since coming to Turkey applied to a health care center. As stated by the participants who did not apply to a health care center, the primary reason was that they did not know about the system. In the field study conducted in Bursa, the most common reasons expressed by the participants who did not apply to a health care center were reported to be economic reasons and language barriers.[10] A study performed by a state agency found the most frequent reasons for not applying to a health care center to be not being registered and economic reasons.[8] The reason why causes, such as language barriers and not knowing about the system, were not big problems in the study performed by the state might have been that the study was carried out in southwestern provinces and locals there can commonly speak Arabic and Kurdish.

A component of access to therapeutic health care services to consider is the individual's status of accessing medication. In the study group, 31.2% of the Syrians who had a problem requiring an application to a health care center in Turkey and were prescribed and purchased medication when they applied to the health care center did not use their medication regularly. Another study reported that 54.2% of the participants living outside the camps could not access medication when necessary.[8] This higher rate than the rate found in our study might have been because all individuals living outside the camp had to pay for their medication out of pocket.

Only 43.1% of the participants in need of access to health care services in the study group managed to access these services they needed. In the literature, the most commonly discussed variables as a risk factor in access to health care study include age, economic and educational status.[17,18] Case-specific variables, such as language barriers, legal status, presence of insurance and time spent in the country, are of importance among minorities, immigrants and displaced groups.

Although no significant difference was found in our study, it was observed that the participants who had balanced income-expenses or could save money had more access to health care services. The median number of rooms and people in the housing, which can be considered the indicators of economic status even if indirectly, was significantly different between the participants who could and could not access health care services. According to the results, the participants who had access to health care services were living in housing with fewer rooms and with fewer individuals. Although large and multi-roomed housing is associated with a good income, the slums in the neighborhood with low socioeconomic levels where this study was conducted had many rooms as well. Low-income status is shown as a variable affecting access to health care in several studies. For instance, it was shown in the United States that individuals with low economic status postponed their health care at higher rates.[19] Similarly, in Armenia, 75% of the individuals who did not apply to a health care center reported that it was due to economic reasons.[20] Given that the Syrians had to make their medication expenditures out of pocket during the period of this study, it can be considered that individuals who benefit from health care services should have better income.

The language barrier is an important factor that affects access to health care services at all stages, and the multivariate analysis on the study group found that access to health care was 2.6 times more among the participants who did not have language barriers. There are several studies showing that the most important barrier to access health care services is the language barrier.[21-24] Studies also show that the biggest barrier to that refugees cannot understand and use the prescribed medication is not speaking the language.[25]

One of the most important elements for Syrians in our country to be able to benefit from health care services is to be registered. As addressed before, non-registered individuals in Turkey can use only the emergency health care services and accepted to immunization programs in the cases which threaten the public health. Given that 46.0% of the registered and 23.3% of the non-registered persons in need of health care, as found by our study, had access health care services indicates the importance of access to health care services. In health care, registration can be deemed equivalent to health insurance while there are differences. In the United States, the rate of applying to the emergency room for children under the age of 18 who had any kind of insurance was 37.2% in the last year, whereas the rate was 15.1% for the participants who did not have any insurance.[19] Likewise, a study by Centers for Disease Control and Prevention stated that 7.8% of the insured people and 44.2% of the uninsured people postponed the use of health care services.[19]

The language barrier, which has been discussed as a limitation in most of the immigration studies, posed a barrier between the researcher and the participants in this study as well. However, this barrier was overcome as much as possible in the company of a translator who can fluently speak Arabic. This study aimed to reach all of the Syrians residing only in a neighborhood of Izmir, the smallest calculated sample size was achieved, and the whole population could not be reached due to rejections and individuals that could not be contacted. Given that the individuals who could not be contacted were males at the working age, it is anticipated that such individuals have stronger social integrations, have fewer language barriers as they are working and can, therefore, have access to health care more frequently. The frequency of accessing health care services in our study might have been found lower due to such individuals who could not be included in the study. Another limitation of the study was that participants' diseases and access to health care were based on their self-report. With a good registration system, Syrians' frequency of health problems and access to health care can be measured. Moreover, it should be considered that there might be misleading answers although the individuals were relieved in an attempt in the face of abstaining answers to the questions, especially in unregistered households. Calculating odds ratio in this cross-sectional study is one of the other limitations of this study.

The strengths of this study include that this study was conducted within the society and that explored the problems experienced by Syrians living in our country in the health care system. To our knowledge, this is the first study with a large sample size which aimed to investigate the access to health care and conducted in one of the cities which Syrians frequently use as a step in their transition to Europe. Another significant strength of this study is that not a professional translator but an individual living among them and known to them assisted the communication with the Syrian participants. Participants' trust in the researcher was

ensured thanks to the communication established via a familiar translator. As one can infer, it was a low probability that the participants provided false statements due to this strength.

CONCLUSION

Consequently, in this study, which was carried out in a neighborhood densely populated by Syrians in the city center of Izmir, 43.1% of the participants were found to have access health care services. The multivariate analysis determined that two variables significantly predicting access to health care were the number of people sharing the housing and the presence of language barriers. Considering that the number of people sharing the housing can be an indicator of economic status, the language barrier should have a particular emphasis on access health care services.

Immigrant polyclinics that provide primary health care should be generalized to prevent the language barrier from being an obstacle in access to health care. Translators should be available for 24 hours at all secondary and tertiary health care centers to assist in case of immigrants' referrals. Syrian health care personnel living in Turkey can be employed in Syrian primary care polyclinics in the first place, and then in all health care institutions. With this initiative, the patient-health care personnel relationship can be ensured without a translator. The second important step to overcome the language barrier is to introduce the system to individuals in their own language. Leaflets in Arabic and Kurdish that explain the Turkish health care system and their rights to Syrians should be prepared, and these leaflets should be delivered to them via local administrations.

Disclosures

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Conflict of Interest: None declared.

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