T.C
REPUBLIC OF TURKEY
HACETTEPE UNIVERSITY
INSTITUTE OF HEALTH SCIENCES

DETERMINATION OF PERCEIVED LANGUAGE BARRIERS IN ACCESSING HEALTHCARE SERVICES ACCORDING TO SYRIAN REFUGEES VISITING TWO TRAINING AND RESEARCH HOSPITALS IN ANKARA

RESHED ABOHALAKA

PROGRAM OF HEALTH MANAGEMENT IN DISASTERS
MASTER THESIS

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APPROVAL PAGE

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This thesis study has been approved and accepted as a Master dissertation in "Health Management in Disasters Program" by the assesment committee, whose members are listed below, on 09/05/2018

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23 Mayıs 2018

Prof. Diclehan ORHAN, MD, PhD
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YAYIMLAMA VE FİKRİ MÜLKİYET HAKLARI BEYANI

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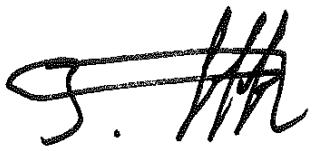
ETHICAL DECLARATION

In this thesis study, I declare that all the information and documents have been obtained in the base of the academic rules and all audio-visual and written information and results have been presented according to the rules of scientific ethics. I did not do any distortion in data set. In case of using other works, related studies have been fully cited in accordance with the scientific standards. I also declare that my thesis study is original except cited references. It was produced by myself in consultation with supervisor (Asst. Professor SIDIKA TEKELİ YEŞİL) and written according to the rules of thesis writing of Hacettepe University Institute of Health Sciences.

RESHED ABOHALAKA



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RESHED ABOHALAKA

ABSTRACT

Abohalaka R., Determination of Perceived Language Barriers in Accessing Healthcare Services According to Syrian Refugees Visiting Two Training and Research Hospitals in Ankara, Hacettepe University, Institute of Health Sciences, Master in Health Management in Disasters, Ankara 2018. The Syrian war which has started in 2011, caused the largest humanitarian and refugee crisis of the present time. Healthcare services are provided at no cost to the Syrian refugees in Turkey, however, the language barrier remains a major problem in accessing healthcare services. We aimed to examine the dimensions of language problem among Syrian refugees, while accessing healthcare services in Ankara. A questionnaire consisting of 38 questions was used as the survey tool. For the study sample characteristics, frequencies and percentages were reported. For cross-tabulations, statistical significance was determined using the Pearson Chi-Square test. Of the 221 participants 46.6% were males, while 53.4% of them were females. Participants were between 18-85 years old (mean: 36 years old). 11.1% can speak Turkish. 77.1% of the participants believed that the language barrier has a negative effect in accessing healthcare services. 51.1% of the participants did not use healthcare services at least once, despite their need. 48.5% of the participants used hospital interpreters while 20.6%, 17.6% and 13.2% of them did not get any help, used ad hoc interpreters such as friends or family members and used a private interpreter respectively during healthcare visits. Perception of language as a barrier was more common, among participants, who were married, jobless, illiterate, had no Turkish speaking relatives or had diseases. Gender, economic status, having Turkish-speaking relatives and having diseases were variables showing association with the method they used to cope with the language barrier. Employment status and having social relationships with the local people seem to be very important in learning the Turkish language, hence having a better access to healthcare services, which highlighted the issue of integration. Nevertheless, with a society like Syrian one, gender preference might be an important factor in this aspect even if such opportunities are available.

Key words: Language barrier, Access healthcare services, Syrian refugees, Turkey

ÖZET

Abohalaka R., Ankara'da iki eğitim ve araştırma hastanesine başvuran Suriyeli sığınmacıların gözüyle sağlık hizmetine erişimde dil sorununun incelenmesi, Hacettepe Üniversitesi, Sağlık Bilimleri Enstitüsü Afetlerde sağlık yönetimi programı Yüksek Lisans Tezi. 2011 yılında başlayan Suriye savaşı, günümüzün en büyük insani krizine yol açmış. Türkiye'de Suriyeli mültecilere sağlık hizmetleri ücretsiz olarak sağlanmasına rağmen, sağlık hizmetlerine erişiminde en büyük problem dil engeli olmaktadır. Bu çalışmanın amacı Ankara'daki Suriyeli mültecilerin sağlık hizmetlerine erişiminde yaşadıkları dil probleminin boyutlarını ve bununla başa çıkmak için kullandıkları yöntemleri incelemektir. Bu çalışma için 38 sorululuk bir anket formu kullanılmıştır. Çalışma örneklemin özelliklerini sunmak için sıklık ve yüzdeler rapor edilmiştir. Çapraz tablolardaki anlamlılık Pearson Ki-Kare testi kullanılarak tespit edilmiştir. 18-85 yaş arasında ve yaş ortalaması 36 olan 221 katılımcının %46,6'sı erkek, %53,4'ü kadındır. %11,1'u Türkçe konuşmaktadır. Katılımcıların %77,1'i sağlık hizmetlerine erişiminde dilin olumsuz etkisi olduğu düşüncesindelerdir. Katılımcıların %51,1'ü ihtiyaçları olmasına rağmen en az bir kez sağlık hizmetlerini kullanmadıklarını beyan etmişlerdir. Sağlık kurumu ziyaretleri esnasında dil açısından katılımcıların, sırasıyla, %48,5'i, %20,6'sı, %17,6'sı ve %13,2'si hastane tercümanını kullanmış, kimseden yardım almamış, arkadaş ve aile üyelerinden yardım almış ve özel tercüman kullanmıştır. Evli, işsiz, Türkçe konuşan akrabası olmayan, eğitim görmemiş ya da hasta olan katılımcılar arasında dilin etkisi daha yoğun gözlenmiştir. Cinsiyet, ekonomik durum, Türkçe konuşan akraba olması ve hasta olması gibi değişkenlerin dil problemiyle başa çıkmada kullanan yöntemlerle de ilişkisi gözlenmiştir. Türkçe öğrenebilmek için çalışıyor olmak veya yerel kişiler ile sosyal ilişkilerin olması önemlidir. Bununla birlikte katılımcıların eğitim seviyesi çok düşük ve işsizlik düzeyi ise çok yüksektir. Sağlık hizmetlerinde Arapça konuşan sağlık personeli istihdamı ya da tercüman kullanımı dil problemiyle başa çıkmada etkilidir. Yine de bu yöndeki Suriye gibi toplumlarda cinsiyet ile ilgili tercihler çok önemlidir.

Anahtar kelimeler: Dil problemi, Sağlık hizmetlerine erişim, Suriyeli mülteciler, Türkiye

CONTENTS

SYMBOLS AND ABBREVIATIONS

AFAD	Prime Ministry of Disaster and Emergency Management Presidency
IOM	International Organization for Migration
IS	Islamic State
ISIL	Islamic State of Iraq and the Levant
NGO	Non-Governmental Organization
SPSS	The statistical software IBM SPSS Statistics
TIS	Translating and Interpreting Service
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
US	United States
WHO	World Health Organization

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1. INTRODUCTION

The Syrian war which started at 2011, became the biggest humanitarian and refugee crisis of our time, where 47,000 people were killed and almost 1.8 million were wounded in an armed fight that started as anti-government protests before rising into a complete civil war (1). Further, more than 13,5 million people are in need of help, 6.3 million have been internally displaced, over 1 million fled to Europe (2) and more than 5 million have left to neighboring countries, seeking refuge in Turkey, Lebanon, Jordan and beyond (3).

Documentation of the health impact of war and conflict is one of the most difficult and yet important public health challenges. Countries that descend into conflict frequently have inadequate vital statistics systems and woefully incomplete death registries prior to that descent (3). With over 60% of hospitals and clinics ruined and about 700 healthcare providers murdered, tortured, or executed, the Syrian war had left extreme pressure and burdens on Syrian's health substructure and human resources particularly, among medical staffs (4).

Turkey now has a Syrian population of over 3.2 million, which makes Turkey the host country with the biggest refugee population in the world. Nearly 90% of Syrian refugees in Turkey stay outside the refugee camps with the majority living in ten provinces in south and southeastern Anatolia (5). Since the onset of Syrian population influx in April 2011, the coordination of the Syrian refugee response in Turkey has been managed by the government of Turkey. Primarily, the government rejected offers of support from UNHCR, so UN agencies and international NGOs mostly organized themselves in parallel to the government. This led to a situation that continues today, involving some inaccuracy in the connections between the communities of coordination (6).

Turkey enabled Syrian refugees to benefit from all of the health care services at all levels provided for its own citizens. Health services for Syrian refugees inside and outside of camps are provided free of charge (7). However, Language was a major barrier for refugees to access healthcare in Turkey, it especially affected the refugees' understanding of available health services and vaccination coverage (8).

Although Turkey has the largest number of Syrian refugees, the studies that are related to the language barrier in healthcare services are limited in Turkey. Hence, the aim of this thesis to determine the perceived language barriers among Syrian refugees while accessing healthcare services and the methods they used to cope with this problem.

2. GENERAL INFORMATION

Migration is: *"The movement of a person or a group of persons, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification"* (9). This definition lets us differentiate between various types of migration: facilitated migration, forced migration, irregular migration and labor migration. The facilitated migration is defined as the following: *"Fostering or encouraging of regular migration by making travel easier and more convenient. This may take the form of a streamlined visa application process, or efficient and well-staffed passenger inspection procedures"*, meanwhile forced migration means: *"A migratory movement in which an element of coercion exists, including threats to life and livelihood, whether arising from natural or man-made causes"*, and the labor migration is: *"Movement of persons from one State to another, or within their own country of residence, for the purpose of employment"*. There is no well-defined or universally established explanation of irregular migration. However, irregular migrations may happen when the previous migrations take place outside the regulatory standards of the sending, transit and receiving countries, these irregular cases are seen when an individual crosses an international border without a valid passport or travel document or without obtaining the necessary administrative permissions for leaving the country (9).

With this understanding, the *"International Organization for Migration (IOM)"* defines a migrant as: *"Any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of the person's legal status; whether the movement is voluntary or involuntary; what the causes for the movement are; or what the length of the stay is"* (9).

The idea of refugee status drew much attention and raised extreme concern at the start of nineteenth century, after the borders of numerous countries, and solid protections for those boundaries were established. *"The UN Declaration of Human Rights"* was the first international document to demand the *"right to seek and to enjoy in other countries asylum from persecution."* in 1948 (10). The descriptions of both

asylum and refugees, are clearly defined in the *"Geneva Convention"* in 1951. This document describes a refugee as: *"Someone who owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country"* (11). According to data collected at the end of 2015, there were 21.3 million of refugees worldwide. The conditions of people who are seeking asylum are generally hazardous and unbearable, especially when they cross national borders to seek security in neighboring countries, and for this reason they become globally recognized as *"refugees"* with the support of states, UNHCR, and civil organizations. Those conditions led us to define *"Asylum seeker"* as the following: *"A person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds"* (9). Asylum seekers are recognized as refugees precisely because it is often too risky for them to come back to their countries, and they need sanctuary elsewhere. These are usually people for whom denial of asylum has possibly lethal consequences.

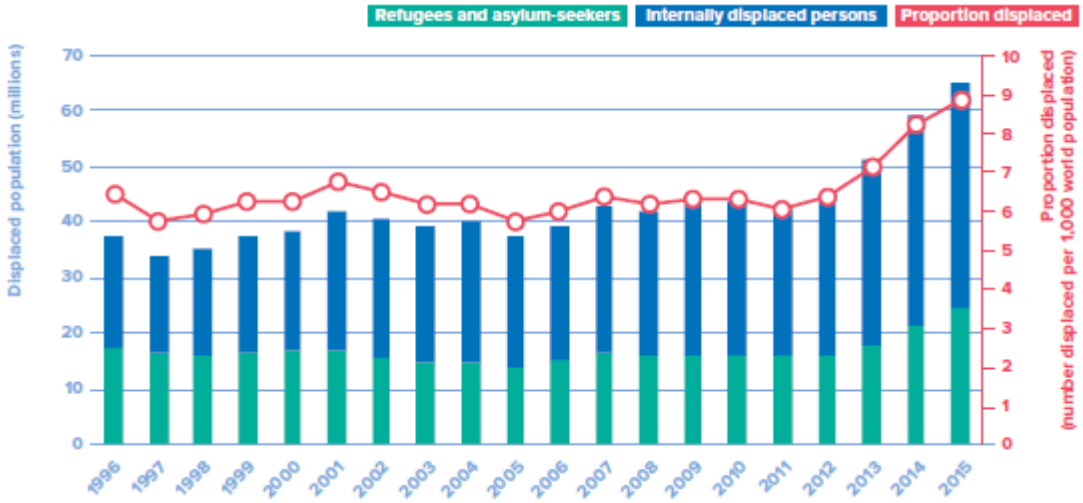

Figure 1.1: *"Trend of global displacement & proportion displaced | 1996 - 2015 (end-year), Source: UNHCR, Global Trends Forced Displacement in 2015"*

Turkish law and international law are different in this aspect. Turkey, because of its location, has a geographic reservation to execute the *"Geneva Convention."* In other words, only asylum seekers who are from European countries by origin can apply to be accepted as refugees. However, according to the Turkish law, the non-European asylum seekers, regardless of the country they have come from, cannot apply to be documented as refugees (12). As a result, Syrian migrants in Turkey are not legally defined as refugees but have been given a temporary protection status. Nevertheless, owing to difficulty in nomenclature they will be referred to as refugees in this study. Anatolian lands have experienced huge refugee movements for a long period of time (13). However, we cannot say that these migration movements have aided Turkey to prepare for the present Syrian refugees emergency crisis. One explanation for that is the migration waves to Turkey have been generally form Turkish consanguine populations of Caucasia, Middle Asia and Middle East. These migrants had cultural practices, religious beliefs, language and traditions similar to those in Turkey so that the integration and the acculturation of these societies were quite facile and smooth. In addition, these migration movements were minor in quantity when compared to the present-day Syrian migration movement. In addition to the Syrian refugees, Turkey has also been receiving migrants form some African countries, such as Eritrea, Somalia, Egypt and Sudan. However, according to the literature, these migrants considered Turkey as a transit country which could help them to complete their journey to European countries (14).

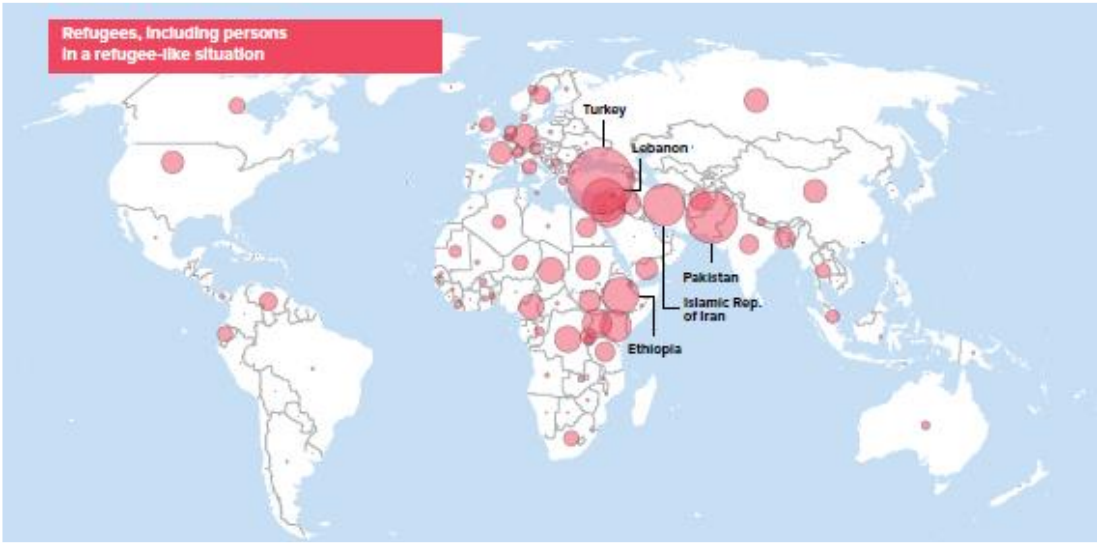

Figure 1.2: *"Populations of refugees | end-2015, Source: UNHCR, Global Trends Forced Displacement in 2015"*

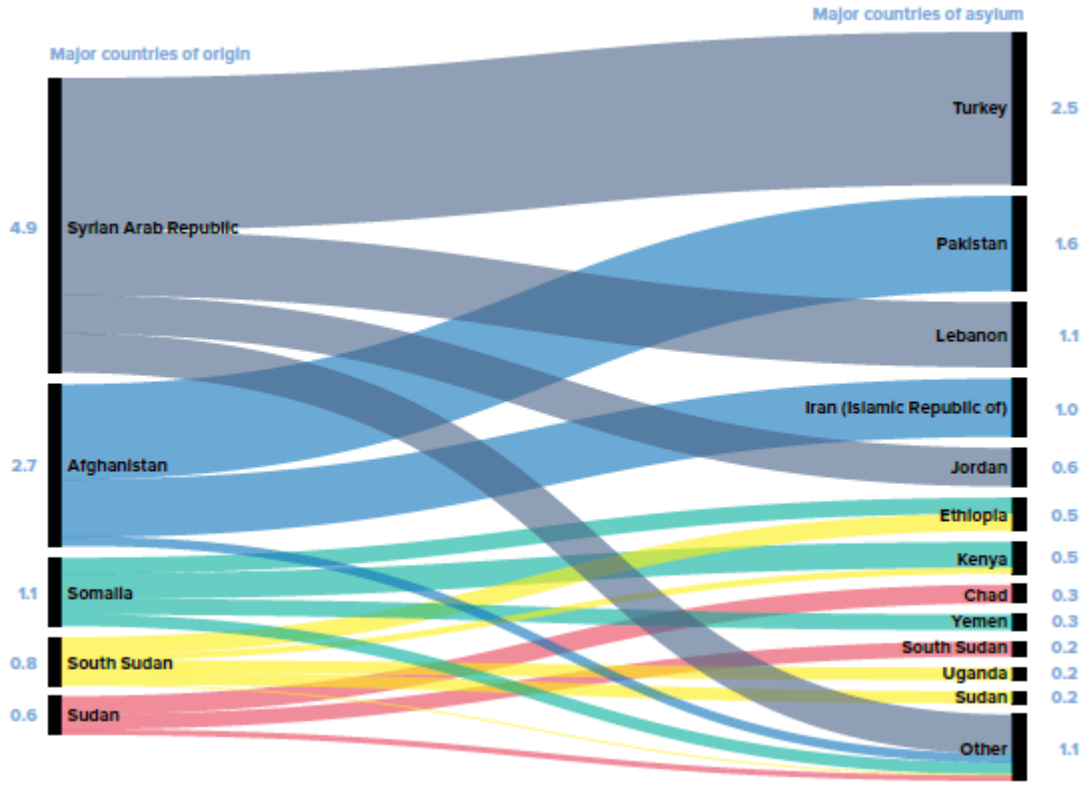

Figure 1.3: *"Where refugees from top 5 countries of origin found asylum | end-2015, Source: UNHCR, Global Trends Forced Displacement in 2015"*

2.1. Who Is a Refugee:

The asylum-seeker term and refugee concept are frequently confused. An asylum-seeker is a person who is applying to be granted refugee status and accompanying privileges but whose application has not yet been fully assessed and accepted by the authorities. An asylum-seeker who is approved through appropriate procedures and is officially accepted becomes a refugee and gets the refugee's rights and freedoms which are guaranteed by international law (12).

According to the United Nations High Commissioner for Refugees, *"a refugee is someone who is living outside of the country of citizenship because of persecution, war, or violence, or the credible threat of these."* In the past and today, this problem has another dimension by overlapping with slavery, human trafficking, and other forms of exploitation across national borders. Those began with the start of recorded history and in every land and section of the world. Nowadays, the countries that host the biggest numbers of refugees are in Africa, Europe, and Asia. For example, Middle Eastern countries, such as Lebanon, or the countries that are near to the Middle East, like Turkey and Pakistan host millions of refugees (1).

The direct threat of hazard or death is not the only motive for migrants to move. Most often, they move to improve their life conditions by searching for better jobs, accessing better education, reuniting with family, or for some, other motives. In contrast to refugees who cannot securely go back to their countries, migrants have no such impairment to return home. They can go back to their countries whenever they wish, and they will continue to receive the protection of their government (11). For specific governments, this difference is significant. Countries treat migrants according to their own immigration legislation and procedures, while also dealing with refugees under standards of refugee protection and asylum that are described in both national and international law. This means countries have specific responsibilities towards anyone seeking asylum on their lands or at their borders.

2.1.1. Syrian Refugees in Turkey:

Since Syrian refugees have been labeled as *"temporary transit visitors"* by Turkey's authorities, some authors have mentioned that Turkey has not been enthusiastic to make plans for the social inclusion of them (12). However, as a result of Turkey's efforts in the refugee crisis, dramatic changes accumulated in the last five years, and recently Turkey has changed from being a transit country to a destination hub for migrants (15).

Due to the *"Geneva Convention"*, Turkey can only consider asylum seekers who are from European countries by origin as refugees. This fact restricts Turkey's responsibilities under the *"Geneva Convention"* only to refugees who are from European countries by origin. The Turkish legislation presented several unique statuses for asylum seekers who are from non-European countries by origin, such as Syrian refugees. For example, the Turkish Law on Foreigners and International Protection presents the *"conditional refugee"* status for refugees from non-European countries, and a *"temporary protection"* status for Syrian refugees. The Turkish Ministry of Health issued the *"Circular on Health Services for the People under Temporary Protection"* to guarantee access of Syrian refugees to healthcare services (12).

2.2. Syria Before the Crisis:

The Syrian Arab Republic is located east of the Mediterranean Sea and to the south of the border of Turkey. Syria has lands of 185.6 thousand square kilometers. It is estimated that Syria's total population was 22.5 million in 2012. The official and native language is the Arabic Language. Damascus is the capital with a population of 1.7 million, and Aleppo, with a population of 4.6 million is the biggest city. Average life expectancy in Syria was 72 for men and 77 for women (16). Before the war in 2011, Syria was previously vulnerable. Unmaintainable authoritarian governance and an economic downfall were creating important internal burdens across the country's tremendously localized society. Syria had various local and sectional alliances with rival regional and international powers, which made it expected that any clash in Syria would quickly become internationalized and prolonged (17). Modern Syria was the outcome of a sequence of political agreements and compromises between the European winners of the First World War and the new authorities of the emerging Republic of Turkey. *"The Anglo-French Agreement"* of 1916 well-defined French and British domains of influence in areas formerly controlled by the Ottoman Empire for almost four centuries (1516-1918). The relatively new political command in the old Ottoman provinces of the Levant became official at the *"San Remo Conference"* in 1920. This arrangement granted France the control over *"Northern Syria"* (currently Lebanon and Syria), and Britain the control over *"Southern Syria"* (presently Israel, Palestinian Territories, Jordan and Iraq) (17).

When the war started in 2011, Syria had an assessed population of 21.5 million people, which was increasing at a rate of 3.4% per year. Of this total population, 10.9 million people were male and 10.6 million were female. In addition, 35.8% of the population was under age 14, and 20.7% of the population (4.5 million people) were aged between 15 and 24, and only 3.5% of the population were aged over 65. The urban population accounted for 55% of the population (about 11.4 million people) and the rural population for 44.3% (9 million people) (17).

The health system was also under growing pressure and enlarged burdens. The small amounts of government investment and prevalence of chronic diseases created an extra load for the health system, especially the diseases that need expensive treatments such as asthma, kidney disease, and cancer. This problem was exacerbated

by the prevalence of chronic diseases, they affected 10% of the population by 2011 (17).

2.3. The Facts Behind the War:

The south of the Syrian city (Deraa) was the start point of the democracy protests that blew up in the middle of March 2011. Those sparked nationwide protests demanding President's resignation. By July, thousands were protesting in the streets all over the country. Under some excuses such as protecting themselves and cleaning their local areas from security forces, opposition supporters ultimately started to be violent and chaotic (18), (19). The violence worsened quickly around the country and the crisis sloped into a civil war as rebel gangs were established to fight government forces in order to gain control over different parts of the country. In 2012 the conflict enlarged and stretched to reach the city of Damascus, which is the capital, and the largest city (Aleppo) (19). Later, as the regional and international powers involved, the fighting became more than just a conflict between the supporters and those against the regime. It has started to take sectarian dimensions, turning the country's Sunni majority against the president's Shia Alawite sect. The growth of the jihadist group *"Islamic State (IS)"* has added more complexity to the conflict (19), (20). Later, other parties that involved a spectrum of antigovernment fractions including Salafi jihadist groups, the *"Islamic State of Iraq and the Levant (ISIL)"*, the mostly Kurdish Syrian Democratic Forces, and a more moderate *"Free Syrian Army"* joined the conflict. Warring parties in Syria have since proliferated to include additional jihadist groups, Russian air forces, US-led coalition air forces, and Iranian, Palestinian, Russian, and coalition special forces (2).

A UN commission of inquiry proved that war crimes such as murder, torture, rape and enforced displacing people have been committed by all sides of the war. It has also an evidence that all parties, as techniques of war, made the civilians suffer by taking out food and water from the cities, blocking access to healthcare services and beleaguering active areas. (21).

The highest level of violence happened in regions under the government control where the biggest population movements occurred, and people have left their homes and moved to areas with less or no violence. After an intense rise of violence

in 2013, the amount of internally displaced populations has continued to increase, with numerous internally displaced populations moving many times because a single move was not enough to protect them as conflict lines continuously changed and fundamental services were taken out one by one across all parts of the country (22).

2.4. The Syrian Humanitarian Crisis:

The Syrian war which started at 2011, became the biggest humanitarian and refugee crisis of our time, where 47,000 people were killed and almost 1.8 million were wounded in an armed fight that started as anti-government protests before rising into a complete civil war (4) (19). Indirect deaths from the conflict have many explanations including increased illnesses and severe shortages of professional medical staff, supplies, and access to facilities. Direct conflict deaths are caused from injuries by violent methods used by fighting parties (2). Further, more than 13,5 million people are in need of help, 6.3 million have been internally displaced, over 1 million fled to Europe (2) and more than 5 million have left to neighboring countries, seeking refuge in Turkey, Lebanon, Jordan and beyond (23). About 10% of Syrian refugees have sought security in Europe, while European countries showed political divisions as countries argued over sharing the burden of refugees (19). The UN declared that it would need $3.2bn to aid the 13.5 million people, including 6 million children, who would need some form of humanitarian help inside Syria in 2016. According to a report from UNHCR in 2017 about 70% of the population was without access to clean drinking water, one third of the population was incapable of meeting their rudimentary food needs, more than 2 million children were without school, and four out of five people lived in poverty (23). Despite these acknowledged impacts, documentation and analysis of its population effects are challenged by inadequate and broken data systems, insecurity for both health staff and researchers, reporting bias, and the so-called fog of war (3).

2.5. The Impact of the Syrian Crisis on Healthcare Services:

2.5.1. The Health System in Syria Before the Crisis:

Health indicators had improved considerably in the Syrian Arab Republic over the past three decades before the civil war, according to data from the Syrian Ministry of Health with life expectancy at birth growing from 56 years in 1970 to 73.1 years in 2009; infant mortality falling from 132 per 1000 live births in 1970 to 17.9 per 1000 in 2009; under-five mortality decreasing meaningfully from 164 to 21.4 per 1000 live births; and maternal mortality dropping from 482 per 100 000 live births in 1970 to 52 in 2009 (24). The Syrian Arab Republic was in epidemiological change from communicable to non- communicable diseases with the newest data presenting that 77% of mortalities before the civil war were caused by non-communicable diseases (25). Total government expenses in health sector was 2.9% of *"Gross Domestic Product"* in 2009 (26).

Despite the improvements in the capacity of the health system before the civil war, some authors mentioned a number of challenges; these include, the using of the capacity was insufficient and full with inequity in the system, the authors also addressed that the data used in health system was invalid, and the organization between healthcare providers was poor and chaotic. In addition, there was a serious problem in distribution of human resources, where highly skilled staff and leadership were dismissed, and the number of trained nurses and associated health professionals was insufficient. Uncontrolled and mainly unregulated growth of private providers, resulting in irregular distribution of medical and healthcare services among geographical areas were also mentioned among the problems of the Syrian health system before the civil war (27).

2.5.2. The Health System in Syria During the Crisis:

Documentation of the health impact of war and conflict is one of the most difficult and yet important public health challenges. Countries that descend into conflict frequently have inadequate vital statistics systems and woefully incomplete death registries prior to that descent (3). With over 60% of hospitals and clinics ruined and about 700 healthcare providers murdered, tortured, or executed, the Syrian war

had left extreme pressure and burdens on Syrian's health substructure and human resources particularly, among medical staffs (4).

Throughout 2012 and 2013, healthcare services decreased intensely, healthcare providers were targeted and murdered, and 72 facilities were decimated. In addition, many medical staff fled in fear of death and supplies were extremely limited. In April, 2013, 57% of state hospitals were impaired and 37% were out of service according to World Health Organization. Moreover, 40% of the country's ambulances have been ruined (28). In March 2014, 60% of Syrian hospitals had been damaged and only 33% of public ambulances and health centers were operative. Vaccination coverage was breaking down (falling from 91% to 52%), and polio began infecting children again in both government and opposition areas (17). Security forces have targeted and threatened doctors who chose not to hold back healthcare services from anti-government groups. At least 160 doctors have been murdered and thousands have been captured (28). In Homs city, at least 50% of the healthcare providers have left and only three general surgeons stayed after 30 months of war (28).

2.5.3. The Influence of Syrian Crisis on Other Countries' Health Systems:

The influx of Syrian refugees has put an immense burden on the national health systems of destination countries (29). As health of migrants is often worse than other citizens (30), it's vital for migrants to receive proper health care services. Also, achieving good health care results will be more cost-effective results and may reduce hospitalization periods and events of infection (e.g. by better treatment adherence) (31).

Since April 2011, the coordination of the Syrian refugee response in Turkey has been managed by the government of Turkey. Primarily, the government rejected offers of support from UNHCR, so UN agencies and international NGOs mostly organized themselves in parallel to the government. This led to a situation that continues today, involving some inaccuracy in the connections between the communities of coordination (6). However, Turkey declared that it will not turn down those escaping the war and that it will welcome them in line with an open-door and free-restrictions policy (7). Turkey now has a Syrian population of over 3.2 million,

which makes Turkey the host country with the biggest refugee population in the world. Nearly 90% of Syrian refugees in Turkey stay outside the refugee camps with the majority living in ten provinces in south and southeastern Anatolia. Since October 2014, a report has been conducted by the *"Prime Ministry of Disaster and Emergency Management Presidency (AFAD)"* and includes the registration, health, education, and access to public services, such as social assistance and labor for refugees, based on the 'The Temporary Protection Directive' (5) (32).

At the end of 2015, Canada began to welcome Syrian refugees, and several family physicians complained about the limited resources in primary healthcare services especially, in mental health care resources. Moreover, when it comes to interpreters, they expressed concerns about how they can do their jobs with the limited number of available interpreters (33). Lebanon, which has a population of 4.5 million, hosted more than 1.1 million Syrian refugees, and treated them with an open-door policy until October, 2014 (34). In January, 2015, Lebanon restricted Syrian refugees from coming to its lands and announced only a 6-month visa for displaced Syrians, which is given only in emergency cases. This action means denying Syrians their refugee status and the rights were given to them before 2015. Jordan as well started to take some restriction steps by cancelling free healthcare services for Syrian refugees, and started to charge them a fee, equivalent to that paid by uninsured Jordanians (35). Turkey, in this aspect, stands up for the Syrian refugees by giving them a free access to healthcare services and free medicines, and more than 25,919,750 patients have visited clinics, 1,143,393 refugees have entered hospitals and 953,466 of them have undergone a surgery (36).

2.6. Barriers for Accessing Healthcare Services:

Accessing health care services is free in Turkey, and many of Syrian patients sought for healthcare services including outpatient health examinations, hospitalizations, wounded patient admission, surgical operations, and childbirths (37). However, many of them did not receive optimal health care due to numerous factors that affect the process of giving and accessing healthcare services. Those factors can include barriers which restrict the ability of giving the best health care services to people in need. In a US study, barriers in achieving optimal care in a multi-ethnic

society were described in two major categories: inherent (e.g., genetic, cultural, and language/communication) or acquired (e.g., those associated with changes in lifestyle and socioeconomic factors) (38).

2.6.1. Religion and Cultural Barriers:

A developing, multicultural society makes sure that healthcare providers will have no easy mission of providing proper healthcare services for persons who have different beliefs, principles, cultural experiences, religions, values, languages, and concepts of healthcare. Many people base their lives around cultural practices and spiritual beliefs, and in order to provide healthcare services of sufficient quality healthcare providers should be both customarily sensitive and culturally experienced (39), (40).

There are barriers formed by firm religious modesty customs and gender preference of medical staff, along with religious understanding of diseases for many Muslims (41). Arab refugees in the United States have faced discrimination and barriers to receiving primary healthcare services. The stereotyping of all Arabs and Arab-Americans as potential terrorists has augmented their marginalization and stress, where discrimination against Arab Muslims in the United States results in unequal access and quality of care (42). Islamic principles deliver a filter for religious Muslims in regards to their social network, diet, health behaviors, and healthcare choices (42). Islam creates an effect on health-related behavior independent of socioeconomic and ethnic identities. That is one reason why recent migrant communities often suffer isolation and discrimination. (43).

On the other hand, the healthcare system should accommodate refugees, which would include honoring the religious or cultural morals of all of their patients. This includes honoring dietary requests for halal foods, gender-concordant medical staff when available and preferred, as well as prayer facilities (44). Medical professionals should not only speak the language of their patients, but should understand their culture in order to help and encourage the patient to do what is necessary to proceed in the treatment process (45). Modesty is a key component in the Islamic belief system. Inappropriate hospital attire can cause a serious anxiety to a Muslim female when her body is exposed to males (44), especially in examinations that include gynecological

or gastrointestinal inspections. This anxiety may cause a Muslim woman or man to reject treatment (41). However, in another study in United States, transportation, lack of knowledge, and language barriers were more important barriers than cultural values and beliefs among Arab refugees who were accessing cancer services (46).

2.6.2. The Language Barrier:

The language barrier is a significant problem in healthcare services. In the US, it is well established that language barriers create health inequalities for patients with limited English proficiency (47). These patients have fewer access to adequate healthcare services, and lower rates of physician visits and preventive services (48-50). Even when they have access to care, limited English proficiency patients often have worse adherence to treatment and follow-up for chronic diseases, decreased comprehension of their diagnoses and treatment after emergency department visits, decreased satisfaction with care, and increased medication complications (51-53). In contrast, in a descriptive study in the US where Spanish-speaking patients with asthma were interviewed, language concordance between patients and physicians augmented patient satisfaction, patient-reported health status, and adherence with medication and follow-up visits (51, 54).

It is becoming more frequent that health providers and patients speak different languages. Language barriers may arise, especially when healthcare providers deal with migrant patients, refugees and asylum seekers (55), resulting in language problems as one of the greatest factors affecting the foreign persons seeking healthcare services (56), socialization and integration (57). To put it in other words, discussions regarding diagnosis, treatment and care of diseases is a very important part of the communication process between the healthcare provider and the receiver. Even people who speak the same language may have problems in terms of perception and communication. It is then very normal that those who are speaking different languages will have additional problems with communicating to each other (58). Interactions with health care professionals, from discussing medical history to describing characteristics and duration of symptoms, can be daunting for those with limited language skills (57).

As a result, language could play an important role in discrimination among patients. In a study in South Africa, the experiences of discrimination, which the participants faced outside of the healthcare system, affected their perception of language as a vehicle of discrimination. For example, among Zimbabweans in the study, participants said that nurses could speak English but tended to communicate in IsiXhosa (the local language), despite the fact that Zimbabweans do not speak this South African language (IsiXhosa). And they added: *"If you speak to them in English, they can ignore you. Or, they can shout at you. It is bad for us. Of course, just because we don't understand their language"* (59). This problem can be significant in a country like Turkey, where in numerous parts of the country, there are solid intergroup tensions in communities hosting Syrian refugees. Public reviews show that anti-Syrian opinions are commonly held 86% of the Turkish people who prefer that the government end the intake of refugees and 30% of whom support the idea that Syrian refugees should be sent back to their country (60).

The Influence of Language Barrier in Healthcare Services:

Migrants often receive less health information than other residents, which makes them vulnerable to communication problems that limit access to health care services (61), because care that is of proper quality mostly depends on effective patient-provider communication (62). Manson (51), has shown in a descriptive study in the US where Spanish-speaking patients with asthma were interviewed, that language concordance (patient and healthcare professional speaking the same language) tended to be linked with better compliance, enhanced appointment keeping and less emergency visits among patients. Also, in a cohort study with English- and Spanish-speaking patients (N =714) presenting with non-emergent medical problems in Emergency Department visits in U.S, language concordance provided an improved chance in obtaining appointments for medical follow-ups (63) and improved health status assessments (64).

Refugees are extremely vulnerable group. In addition to limited access to health services due to the lack of communication, refugees are more likely to experience poorer health statuses due to the long journey they experience. In addition, a huge gap between refugees' expectations of health services and the reality of the

health system may rise. This situation was shown in a study where resettled African refugees were recruited via a purposive snowball sampling method in Australia (65). In another study conducted in South Africa, which is middle-income country, secondary data analysis for patients with a language barrier living in Cape Town (59), showed that not being able to speak the language was by no means the only handicap to accessing health care; however, it was one of the main reasons that participants felt incapable to get proper healthcare services.

The lack of understanding between physicians and patients also has some unexpected complications, *Abate* and *Chandalia* (66) reported that language barriers may create a long-term *"acculturative stress"* associated with an increased risk of type-2 diabetes among US population. This stressful event would not have only an impact on the course of the disease, but it also may affect the psychological state of the patient. The authors of an Australian study, reported that the immigrant patients participating in the study stated that not knowing English made them feel lonely most of the time even if the social life in the community was good, and this added extra struggle to their lives (67). Another finding of this study was that the refugee participants suffered from meaningfully higher levels of psychological distress than the general population, which was also mainly related to poor English language ability. Language problems can also worsen social isolation and has actions as a barrier to engagement and adaptation in the new country and restrict contributions in social events (68).

In a cohort study conducted in Netherlands by *Alderliesten* and *Vrijkotte* (69), being from a different ethnic group was shown as a risk factor for not receiving proper health care services during pregnancy. This study showed that poor language proficiency was one of the main health risk factors among non-Dutch speaking ethnic groups. It was shown that Dutch-speaking ethnic groups were receiving the same healthcare services as the native Dutch-speakers. These findings were reinforced in the study by, *Hemingway* and *Saunders* (70) where bilingual interviews were carried out for non-English-speaking women in London. They found that women whose main spoken language was English reported higher levels of continuity at each phase of health care during pregnancy than women whose main spoken language was not English.

Difficulties encountered in spoken language may not be the only obstacle in terms of language barriers. Understanding written materials, completing paperwork, and problems experienced with the use of interpreters are also important obstacles patients may face (71). Although healthcare systems sometimes provide professional interpreters, there is misunderstanding about who has the responsibility to provide an interpreter. Problems occur when interpreters are not available or when their use is unwanted. Family members and friends are also utilized as interpreters (72). The use of children as interpreters is debated, and some people feel it wrong, especially when discussing personal matters (73). Refugees were anxious that interpreters were not re-telling their stories precisely or explaining medical terms sufficiently (74), resulting in misdiagnosis or incorrect treatment. They also were concerned that personal information was being shared with others in the community (75). The gender concordance of interpreters also facilitated communication (76); however, it is noted some female patients were not concerned by its absence (77). Using the same individual to interpret at each visit was beneficial but it did not completely negate the main concerns (71).

In a US study, in which a five focus group discussions were conducted with 36 participants, Arab-American patients have revealed that the language barrier was one of the most intense and pervasive barriers in accessing healthcare services by both male and female participants. Although several women in that study had lived in the United States for a long time and could speak English, they still desired to see Arabic-speaking medical staff. About 50% of the male focus group participants had Arab primary care physicians. The women participating in the study indicated that they could not entirely explain their symptoms and health concerns in English language. The females, as well as the male participants, also mentioned the lack of translated materials in Arabic and Arabic-speaking interpreters at healthcare services, and questioned why more Arabic resources were not available. Some women had to bring one of the family members such as their husbands or children (both male and female) to assist them as interpreters at the medical visits. However, women escorted by male family members did not feel comfortable discussing certain female-specific health issues, including gynecologic care, and therefore, reported that they did not bring them up during their health care visit. Some women also commented at the importance of

having an Arab healthcare provider so that cultural values and practices would be better understood (72). In a Canadian study, in which 12 female Syrian refugee participated, the participants mentioned that language problems also impacted their privacy, specifically when accessing healthcare services. They said that they would be willing to share their symptoms with professional medical staff, but not necessarily in the presence of an interpreter, especially where there is a tiny society of Arabic-speaking people (78).

The Language Barrier in Psychiatry Clinics:

The language barrier bears more importance in psychiatry clinics, where patients show more anxiety toward having an interpreter. In a Canadian study, Syrian female refugees stated that *"If you speak with a psychiatrist, you would speak normally, but if there is an interpreter as a mediator, and this person might speak about what you said, and now like you have told your story to this and may be this mediator will tell everybody in Canada."* (78). A study carried out in Turkey among 218 Syrian refugee students attending two Temporary Education Centers in Istanbul, identified that among study participants, 40.5% stated that they do not speak or understand Turkish whatsoever. Nevertheless, contrary to the expectations, the language barrier did not show any association with psychological distress or other psychopathologies. This finding was explained with their cohabitation with a relatively large Arabic speaking community in their current neighborhood and attending schools where teachers are from the same country and therefore speak the same language and share a similar culture (79).

The Language Barriers from Physicians' Viewpoint:

A US study reported that, participant physicians consider language the most problematic issue in providing healthcare to African and Hispanic patients. They stated that it can affect understanding the educational instructions given to patients, which affects patient's health behavior. It also makes extremely difficult to achieve the desirable health-related result and higher patient satisfaction (38, 80). This problem can be a real task for physicians in a case where the patient is a child without family. For example, in a case study, in Israel, physicians were further challenged by the fact

that their patients arrived without family, heard a foreign language, and did not know where they were (45).

The Language Barriers from Nurses' Viewpoint:

Nurse-patient relationship is not that much different than physician-patient relationship. It is important for nurses, who play a central role in patient care, to respect cultural values of patients (81), which shows that communication with patients is extremely important. However, nurses face increased difficulties when communicating in cross-cultural care facilities, especially when they do not share the same language as the patient (82). According to a study in Switzerland, when the communication between patient and nurse is quite deficient, the total amount of reported physical and psychological symptoms by patients was about three times lower than when the patient and nurse have decent communication (55).

Patients also express difficulties when they can't understand nurses (31), those issues can increase pain, suffering and anxiety of the patients. Patients are usually anxious to get their test results, and this anxiety may increase if they cannot get their available test results due to the lack of a good communication.

The Language Barriers from Pharmacists' Viewpoint:

Language barriers affect pharmacists as well. In a study where four focus group discussions were held among African refugees in Australia, *Bellamy and colleagues* (65) revealed that refugees were unable to describe their symptoms to a general practitioner or to ask medicine-related questions to a pharmacist, which decreased their self-confidence noticeably and made them afraid to ask further questions to pharmacists. According to *Green* (57) Syrian refugees in Germany expressed concern about understanding directions from pharmacists .

2.7. Coping with the Language Barrier:

Linguistically appropriate health care can be accomplished if healthcare-professionals are expert in several languages, and they are utilized as bilingual personnel when serving patients from dissimilar cultures or who speak different languages (83), or by the use of professional interpreters who are trained and qualified

to work in health related setting (84, 85). For example, in US alone, over 100 languages are generally spoken (86), it is quite problematic to provide language-concordant healthcare services. In a study on use of medical interpretation in primary care practices located in urban areas, physicians stated that they have encountered at least 20 different languages (87). Although some limited language proficiency patients are lucky enough to get the chance to be served by physicians and other medical staff who speak their native language, this language concordance may not be possible once these patients are sent for laboratory testing, apply for emergency care, or are admitted to the hospital. Thus, most of healthcare providers should find other methods to communicate with their limited-language-proficiency patients. Usually, this means a third person who can assist the different sides who speak different languages to communicate orally, or an interpreter, who can vary from an expert professional medical interpreter to anyone who knows the both languages (86). In a study, where the authors review and analyze language assistance programs and health plans (88), they recommend the use of professional interpreters or increasing the use of bilingual clinicians and staff in order to enhance the quality of healthcare services and to decrease health inequalities. A recent literature review concluded that the quality of healthcare services is enhanced by use of professional interpreters or through providing healthcare through bilingual health care providers (89). However, many of the studies that have been mentioned in these previous reviews got their results by examining the effects of different types of interpreters (proficient, trained, ad hoc, untrained) combined, without investigating the effect of every one of them separately based on the quality of healthcare services. Thus, some authors are still unsure about the specific effect of professional interpretation on healthcare services, and how their effect compares with that of ad hoc interpreters (86). Hassan et el (90) mentioned that when language barriers exist among Syrian refugees, teamwork with colleagues who can speak Arabic language or the use of a proficient, professional interpreter who is trained on psychological terms may be essential for correct diagnosis and treatment. Using untrained interpreters such as community or family members (ad hoc interpreters) may raise ethical and practical problems, particularly when it is a matter of safety, confidentiality and quality of communication. Because these ad hoc interpreters are too involved in the patient's social life, traumatic experiences which

may lead to lack of understanding between the patients and the interpreters, and this misunderstanding will reflect directly on the process of clinical inquiry and intervention (91). For that reason, healthcare practitioners need to make sure that qualified and competent interpreters are always available. The wellbeing of the interpreters is also important as they may face some stressful events during the interviews. Therefore, Practitioners should also pay attention to this point, and try to debrief the interpreters after each interview they attend, and add follow-up when it is necessary (90).

In a Canadian study, in which 30 immigrant and refugee women were interviewed, *O'Mahony* (92) has suggested that a decent healthcare that considers the cultural values of immigrant and refugee women means overcoming language barriers through the use of interpreters or via bilingual medical staff. The last one can also provide information to multicultural patients about the health care system and how to access healthcare services smoothly. The study also emphasized the role of ethno cultural agencies that assist new immigrant and refugee families with providing them additional resources.

In another Canadian study, *Ahmed et al* (78) illustrated that opening language training centers and displaying materials in the Arabic language can be a good method for increasing the awareness level, not only among Syrian refugee women, but among their families, and their communities as well, about maternal depression and its symptoms, causes, treatment and consequences.

An Australian study showed that the refugees who have low proficiency in English language experienced major obstacles in making appointments at the reception desk in primary healthcare services (93). Although the government provided a funded *"Translating and Interpreting Service (TIS National)"*, they often required help from ad hoc interpreters such as family, friends or members of the Afghan community in the reception area, or called for a private interpreter through the telephone. However, the healthcare providers had some doubts about the accuracy and adequacy of these informal interpreting approaches.

A German study shows that Syrian refugees struggle with language problems in health care services, because only one percent have any knowledge of German language before arriving to Germany. According to Green (57), Syrian refugees

participating the study expressed concern about calling clinics to make appointments, translating for others during these appointments, and understanding instructions from pharmacists. *Green* also has stated that more efforts should be taken to avoid possible problems in the future with acculturation and healthcare services among Syrian refugees in Germany.

2.7.1. Interpreter:

"The interpreter assists two or more persons, speaking different languages, to communicate orally (or in a signed language) with one another. The interpreter does so by attending to what the speaker is saying, capturing the meaning of each utterance, and then repeating the message of that utterance in the language spoken by the other party or parties". In this study, the terms 'translation' and 'translator' are reserved for the process of re-expressing the content of a written text in written form in another language. An interpreter supposes that the parties speak to each other, not to the interpreter, so that the interpreter can work in "first-person" mode. For example, the interpreter would say *"I"* where the speaker says *"I,"* rather than something like *"The doctor wants me to ask you …"* or *"She says she has a bad headache."* (94)

Health Care Interpreters:

Health care interpreters are *"professionals who interpret bilingual conversations, which usually involve one or more health care providers, a patient or client (speaking another language), and sometimes members of the patient or client's family"* (93). Health care interpreters work in clinics and hospitals, in private medical and dental offices, during home health visits, and in health education. Health care interpreters usually work in *"consecutive mode,"* giving the interpretation of what has been said after a speaker pauses or finishes speaking, rather than in "simultaneous mode," in which the interpreter renders the interpretation as the speaker continues speaking (94).

2.7.2. Coping with the Language Barrier in Turkey:

Turkey enabled Syrian refugees to benefit from all of the health care services at all levels provided for its own citizens. Health services for Syrian refugees inside

and outside of camps are provided free of charge (7). Nevertheless, the majority of health care services for refugees are provided through primary health care centers, 112 medical emergency services, and state hospitals (5). Camp-based refugees can access healthcare through field hospitals and clinics. Non-camp refugees can access medical treatment from public hospitals, family medical centers, and public or NGO-run clinics largely free of charge (8). Additionally, the Ministry of Health has worked with the World Health Organization (WHO) to construct migrant health centers for refugees with Syrian medical personnel (29, 95). In addition, only about 60% of non-camp Syrian refugees accessed health services in Turkey, compared with over 90% of camp-based refugees (96). The lack of refugee registration with UNHCR or AFAD reduces access; 31% of non-camp refugees are unregistered and an identification number is required to apply to hospital (8, 96).

Language was a major barrier for refugees to access healthcare in Turkey, it especially affected the refugees' understanding of available health services and vaccination coverage (8). According to a study conducted in Turkey among nurses, it was indicated that nurses have provided care for different cultures within Turkey (97). However, for the first time, nurses are caring for patients who speak different languages, come from different countries, and have been affected by war. So they are not educated on how to care for refugees in a culturally competent and congruent manner (98). Nurses and patients experienced difficulty in communicating due to language differences. Nurses stated that they experienced difficulties establishing communication and providing nursing care to Syrian patients and their relatives. According to some authors (98), the majority of those difficulties were related to the lack of interpreters. Some nurses found it impossible to communicate efficiently without an interpreter.

While language and translation issues are frequently cited as barriers to quality health care for both physical and mental health problems (57). Turkey has hired Arabic-speaking interpreters in almost all of state hospitals and Syrian physicians in special migrant health centers to overcome the language barrier (8, 29, 99). However, the number of interpreters is insufficient to assist all the needy patients (12), the interpreter might not always be able to translate accurately, might not be medically

competent or has no medical background at all, which is a crucial problem that makes the health service provider unsure about the correctness of his actions (31, 98).

Although Turkey has the largest number of Syrian refugees, the studies that are related to the language barrier in healthcare services are limited in Turkey. The aim of this thesis to examine the language problem dimensions among Syrian refugees and the methods they used to cope with this problem, when they do access healthcare services.

3. METHODS

A field survey was carried out in November and December 2017 to examine the study questions. Permissions to conduct the study were obtained from the "*Ministry of Interior Directorate General of Migration Management, Ankara Provincial Health Directorate"* and both *"Ankara and Numune Training and Research Hospitals"*, as well as an ethical clearance from the *"Hacettepe University's Ethical Committee"* (Appendixes 3-7). We did not obtain any personal information from our participants (i.e. name, address, phone number, etc.). An informed consent form was signed by the participants during the survey (Appendix 1).

The budget of the study was provided by the researcher himself. Mainly, the budget was spent on printing the questionnaire and the thesis. The total budget was about 500 Turkish Lira (about 125 €). Interviewers supported the study voluntarily.

3.1. Research Site:

The survey was carried out in two state hospitals in Ankara, Turkey. These two hospitals were *"Ankara Eğitim ve Araştırma Hastanesi (Ankara Training and Research Hospital)"*, and the *"Numune Eğitim ve Araştırma Hastanesi (Numune Training and Research Hospital)"*.

The age distribution of the Syrian refugees in Turkey is provided in 'Table 2.1'. Ankara is the capital of Turkey with a population 5,346,518 people, and it hosts 67,141 Syrian refugees which makes them about 1,26% of the total population (100).

The Syrian refugees in Ankara are mainly living in the neighborhoods of the ALTINDAĞ district, where both of the hospitals are also located. The Ankara Training and Research Hospital is the nearest state hospital to the neighborhoods where the Syrian refugees live. The hospital consists of seven blocks with 468 beds and 245 external clinics. The Numune Training and Research Hospital is located in a neighborhood which is known as "hospital area" due to the presence of many hospitals, including public, university and private hospitals. However, it is the only state hospital in the area.

In the Ankara Training and Research Hospital, two interpreters have been employed, while only one interpreter has been working in the Numune Training and

Research Hospital. The interpreters in the two hospitals cover both external and internal clinics. However, there was no interpreter serving in emergency rooms during the study.

Table 2.1: The age distribution for the Syrian refugees in Turkey

Age	Number	%
0-4	321,460	11.34%
5-9	411,046	14.50%
10-14	308,862	10.90%
15-18	308,974	10.90%
19-24	349,064	12.32%
25-29	274,353	9.68%
30-34	233,456	8.24%
35-39	170,272	6.01%
40-44	127,139	4.49%
45-49	97,257	3.43%
50-54	80,012	2.82%
55-59	54,927	1.94%
60-64	38,781	1.37%
65+	58,838	2.08%
Total	**2,834,441**	**100%**

Source: *"Health Status Survey of Syrian Refugees in Turkey, 2016 (16)".*

3.2. Study Design and Procedure:

This was a descriptive study carried out in two state hospitals of Ankara among Syrian refugees visiting the hospitals during the study period. All the patients were Syrian, above the age of 18 years old, speak Arabic as their native language and are registered under 'temporary protection' status for Syrian refugees.

A questionnaire was used as the survey instrument. It was prepared by the researcher based on the relevant literature. The questionnaire included socio-demographic characteristics, information on experiences about language barriers while accessing health services and methods used to overcome these problems. The questionnaire was prepared in Turkish, and afterwards was translated to Arabic by the researcher himself, and then was translated to Turkish again by a translator. The two

versions of the Turkish questionnaires were compared, and there was no major difference between two versions.

The questionnaire was administered face-to-face by three interviewers, who are native Arabic speakers. Two of the interviewers were Syrian and the third one was Sudanese. The interviewers were trained by the researcher. The appropriateness of inventory in the questionnaire was checked with a couple of Syrian refugees and changes were made as necessary before it was carried out in the study population.

3.3. Questionnaire and Measures:

The 38 questions were drawn up on the basis of the aim of the study (Appendix 2). We aimed to assess the socio-demographic information through the first ten questions (Gender, age, marital status, age of the children, education level and information on the community they came from, the period they have been in Turkey, and if they have been to refugee camps or not). To assess the level of knowledge on Turkish and other languages we asked four questions (questions 11- 14). In order to evaluate the economic situation of the refugees 13 questions were asked. The 28th and 29th questions were aimed to identify the health condition of the refugees, and then there were nine questions that served to identify the problems they face in accessing healthcare services and how they cope with them, with a focus on the language barrier.

3.4. Analysis:

The statistical software *"IBM SPSS Statistics 23 (IBM Corp; Armonk, New York USA)"* was used to enter, clean, and analyze the data. For the study sample characteristics frequencies and percentages were reported. For cross-tabulations, statistical significance was determined using the Pearson Chi-Square test. A new categorization process was performed because there were insufficient observations in some of the variables. These variables were as follows.

Age was asked as date of birth in order to calculate accurately. After the calculation of the age of each participant, age was recoded into three groups as follows; 18 -25 years old, 26 – 50 years old, and above 50 years old.

Marital Status was recoded into two groups, as married (both civil or religious marriage) and currently single which included single, divorced, widower/widow and other.

Number of the children was recoded into four groups; no children at all, 1 to 3 children, 4 to 6 children and above 6 children.

Education level was recoded as no formal education (can't read and write, able to read and write but never made it to school), primary or secondary school, and high school or college.

Type of living place in Syria was recoded into two categories as urban and rural.

Duration of stay in Turkey was recoded as less than two years, two to four years, and more than four years.

4. RESULTS

4.1. Study Participants' Characteristics:

A total of 221 Syrian refugees were surveyed. Of them, 75 were interviewed in Numune Hospital, while 146 were interviewed in Ankara Hospital. 46.6% (n: 103) of the participants were males, while 53.4% (n: 108) of them were females. The mean age of the sample was 36 years old (SD: 13.6), while the oldest refugee was 85 years old and the youngest was 18 years old. Most of them (81.9%, n: 181) were married and 75.1% (n: 166) of them were married as civil marriage (registered their marriage contract in the city hall). All the single people have no children, while all the participants who have been married, have one or more child, with a mean of 3 children (and a median of 3). The largest age group (57.9%, n: 128) of the sample was between 26 and 50 years old. While 22.2% (n: 49) and 19.9% (n: 44) of them were under 25 years old and above 50 years old respectively. However, we could not apply a statistical test to determine the significance of the differences in marital status and age due to the imbalance in the distributions of the variables (Table 3.2).

Moreover, 16.3 % (n: 36) of the participants have no children, while 44.8% (n: 99) and 30.3% (n: 67) of them have 1 to 3 and 4 to 6 children respectively. The rest of them (8.6%, n: 19) have more than 6 children (Table 3.1).

Table 3.1. Demographic information of the study participants:

		Frequency N	**Percent %**
Study setting: (N=221)	Numune Hospital	75	33.9
	Ankara Hospital	146	66.1
Gender: (N= 221)	Male	103	46.6
	Female	108	53.4
Age groups: (N= 221)	25 >	49	22.2
	26-50	128	57.9
	50 <	44	19.9
Marital status: (N= 221)	Civil Marriage	166	75.1
	Religious Marriage	15	6.8
	Single	36	16.3
	Divorced	1	0.5
	Widow/Widower	3	1.4

Table 3.1. Demographic information of the study participants (Continue):

		Frequency N	Percent %
Number of Children: (N= 221)	0	36	16.3
	1-3	99	44.8
	4-6	67	30.3
	7 <	19	8.6
Education level: (N= 221)	Can't read and write	44	19.9
	Able to read-never made it to school	20	9.0
	Primary school	86	38.9
	Secondary school	31	14.0
	High school	16	7.2
	College/ University	24	10.9

Table 3.2. Marital status according to age

		Participant's marital status				Total
		Married		Single		
		N	**%**	**N**	**%**	**N**
Age	25 >	21	42.9	28	57.1	49
	26-50	116	90.6	12	9.4	128
	50 <	44	100	0	0	44
Total		181	81.9	40	18.1	221

28.9% (n: 64) of the Syrian refugees have never made it to school, and almost 20% (n: 44) of them can't even read or write in any language. More than half of them (60.1%, n: 133) made it to school, while only 10.9% (n: 24) of them have made it to college or university (Table 3.1).

Most of the participants (87.3%, n: 193) lived in urban areas in Syria, whereas 7.2% (n: 16) and 5.4% (n: 12) of them lived in a village and in a district outside the city respectively (Table 3.3).

Table 3.3. Type of settlement in Syria:

		Frequency N	Percent %
Type of settlement in Syria (N= 221)	Village	16	7.2
	District	12	5.4
	Province	193	87.3

None of the participants has arrived to Turkey before 2011, while only 0.9% of them have arrived in 2011. The largest percentage (38.9%, n: 84) of the participants have arrived in 2014. 75% (n: 162) of them have come to Turkey after 2013, while only 8.3% (n: 18) of them have come in 2017.

88.9% (n: 193) of the participants have never stayed in a refugee camp before. The rest of them (11.1%, n: 24) have reported that they have stayed at least once in a refugee camp before. 72.2% (n: 13) of the 24 people who have stated that they have stayed in a refugee camp, have stayed less than one year while the rest of them (27.8%, n: 5) have stayed more than one year (Table 3.4).

Table 3.4. Distribution of variables regarding information on migration history:

		Frequency n	**Percent %**
Duration of time in Turkey: (N=216)*	Less than one year	18	8.3
	One year	14	6.5
	Two years	46	21.3
	Three years	84	38.9
	Four years	25	11.6
	Five years	27	12.5
	Six years	2	0.9
	Total	**216**	**100**
Whether stayed in camps: (N= 217)**	No	193	88.9
	Yes	24	11.1
	Total	**217**	**100**
Duration of time in camps: (n= 18)	0-6 Months	3	16.7
	7-12 Months	10	55.6
	13< Months	5	27.8
	Total	**18**	**100**

* 5 missing values, ** 4 missing values

4.2. Information on ability to speak in different languages:

Only 11.1% (n: 24) of the participants expressed that they can speak Turkish. We did not ask for any certification or diploma for the languages; we recorded the statement of the responders. Almost half of them (50.7%, n: 110) expressed that they cannot speak Turkish language at all, while the rest of them were still learning Turkish from different sources. Of the responders, who could speak or were learning Turkish,

37.4% (n: 40) and 30.8% (n: 33), learned the language at work and from social relationships respectively. Internet was also one of the sources to learn Turkish among study participants (Table 3.5).

Table 3.5. Distribution of the ability of the participants to speak in Turkish, learning source of the Turkish language and ability of speaking other languages:

		Frequency n	**Percent %**
Knowing the Turkish language: (N= 217)*	Knows	24	11.1
	Still learning	83	38.2
	Doesn't know	110	50.7
	Total	**217**	**100**
The place where they learned the Turkish language: (N= 107)	At work	40	37.4
	Free course	19	17.8
	Social relationships	33	30.8
	Internet	12	5.4
	Native	1	0.9
	Total	**107**	**100**
Other languages they know: (N= 221)	None	196	88.7
	French	1	0.5
	English	24	10.9
	Total	**221**	**100**

* 4 missing values

10,9% (n: 24) of the participants spoke English (Table 3.5). We checked for the correlation between Turkish and English speaking participants. However, none of the participants who spoke Turkish, spoke English Language as well. In addition, we could not apply a statistical test to determine the significance of the differences in knowing Turkish Language according to; other languages they know, having Turkish friends and neighbors, current employment status and age due to the imbalance in the distributions of the variables (Table 3.6).

Table 3.6. Knowing Turkish Language according to other languages they know, having Turkish friends and neighbors, current employment status and age.

		Knowing the Turkish language						Total
		Knows		Learning		Doesn't know		
		N	**%**	**N**	**%**	**N**	**%**	**N**
Second language except Turkish	Speaks	0	0	20	80	5	20	25
	Doesn't speak	24	12.4	63	32.6	106	54.9	193
Total		24	11.1	83	38.2	110	50.7	217
Having Turkish friends and neighbors	Has	24	16.8	75	52.4	44	30.8	143
	Doesn't have	0	0	8	10.8	66	89.2	74
Total		24	11.1	83	38.2	110	50.7	217
Age	25 >	11	22.9	20	41.7	17	35.4	48
	26-50	10	8	56	44.8	59	47.2	125
	50 <	3	6.8	7	15.9	34	77.3	44
Total		24	11.1	83	38.2	110	50.7	217
Current employment status	Jobless	8	4.6	60	34.5	106	60.9	174
	Working	16	37.2	23	53.5	4	9.3	43
Total		24	11.1	83	38.2	110	50.7	217

4.3. Information on Employment and Economic Status:

The majority of the participants (80.2%, n: 174) were jobless at the moment the study took place. 12,9% (n: 28) of the participants had permanent job with a regular monthly income. All of the working participants were handcrafter. The percentage of unemployment was lower when the participants were in Syria; nevertheless 63.3% (n: 140) of them were jobless also before they fled from Syria (Table 3.7). However, we could not apply a statistical test to determine the significance of the differences in the employment status distribution according to gender due to the imbalance in the distributions of the variables (Table 3.8).

Table 3.7. Distribution of employment status:

		Frequency N	**Percent %**
Current employment status: (n=217)*	Jobless	174	80.2
	Permanent job	28	12.9
	Temporary job	15	6.9
	Total	**217**	**100**
Type of employment: (n=221)	Jobless or didn't declare his job	187	84.6
	Carpenter	4	1.8
	Painter	3	1.4
	Electrician	2	0.9
	Cabinet Maker	12	5.4
	Vendor	2	0.9
	Tailor	11	5.0
	Total	**221**	**100**
Employment status in Syria: (n=221)	Jobless	140	63.3
	Permanent job	65	29.4
	Temporary job	12	5.4
	Farmer	4	1.8
	Total	**221**	**100**

* 4 missing values

Table 3.8. The employment status distribution according to gender.

		Current employment status				Total
		Jobless		Working		
		N	**%**	**N**	**%**	**N**
Gender	Male	57	57.6	42	42.4	99
	Female	117	99.2	1	0.8	118
Total		174	80.2	43	19.8	217
		Employment status in Syria				Total
		Jobless		Working		
Gender	Male	28	27.2	75	72.8	103
	Female	112	94.9	6	5.1	118
Total		140	63.3	81	36.7	221

Half of the participants (50.7%, n: 112) assessed their economic status as moderate, while 30.3% (n: 67) of them declared that their economic status is bad and 15.4% (n: 34) of them thought that they were in very bad conditions economically.

Only 3.6% (n: 8) of them assessed their economic situation as good. However, most of them (70.1%, n: 155) thought that they were in same economic level with other Syrian refugees in their close environment. When the participants were asked to assess their economic status before they migrated to Turkey (i.e. when they were in Syria) more than 40% of them thought that they were living in good or excellent economic conditions. Only 18.1% (n: 40) of them thought that their economic status was bad or very bad (Table 3.9). We also found a significant association between self- assessed economic status when they were in Syria and employment status in Syria, where working participants had better economic status (Table 3.10).

Table 3.9. Economic information:

		Frequency N	**Percent %**
Self-assessed current economic status: (N=221)	Good	8	3.6
	Moderate	112	50.7
	Bad	67	30.3
	Very bad	34	15.4
Self-assessed current economic status compared to other families in the environment: (N=221)	Good	8	3.6
	Moderate	155	70.1
	Bad	35	15.8
	Very bad	23	10.4
Self- assessed economic status when they were in Syria : (N=221)	Very Good	31	14.0
	Good	59	26.7
	Moderate	91	41.2
	Bad	28	12.7
	Very bad	12	5.4

Table 3.10. Self- assessed economic status when they were in Syria according to Employment status in Syria.

		Self- assessed economic status when they were in Syria						Total	*P* Chi-Square
		Good		Moderate		Bad			
		N	**%**	**N**	**%**	**N**	**%**	N	
Employment status in Syria	Jobless	50	35.7	58	51.4	32	22.9	140	0.028*
	Working	40	49.4	33	40.7	8	9.9	81	
Total		90	40.7	91	41.2	40	18.1	221	

*** p <0.001; ** p <0.01; * p <0.05

4.4. Social and cultural relationships:

The majority of participants (64.7%, n: 143) said that they have at least one Turkish friend or neighbor. Also, half of the participants (50.4%, n: 59) who have Turkish friends or neighbors said that they have 4-6 Turkish friends or neighbors. While the rest (35.3%, n: 78) said that they don't have any Turkish friends or Turkish neighbors. In addition, the majority of the participants who stated that they have Turkish friends or Turkish neighbors (67.1%, n: 96), assessed their relationships with them as negative and said that they have bad or very bad relationships with them (Table 3.11).

Table 3.11. Information on the social relationships of the participants:

		Frequency N	**Percent %**
Have Turkish friends or neighbors: (n=221)	Doesn't have	78	35.3
	Has	143	64.7
	Total	**221**	**100**
Number of Turkish friends or neighbors: (n=117)	1-3	24	20.5
	4-6	59	50.4
	7-10	18	15.4
	11<	16	13.7
	Total	**117**	**100**
Assessment of the relationship with their Turkish friends or neighbors: (n=143)	Very Good	8	5.6
	Good	4	2.8
	Moderate	35	24.5
	Bad	68	47.6
	Very bad	28	19.6
	Total	**143**	**100**
Having relatives, who speak Turkish language: (n=221)	Doesn't have	108	48.9
	Has	113	51.1
	Total	**221**	**100**
Number of first degree relatives, who speak Turkish language: (n=113)	0	35	31.0
	1-3	53	46.9
	4-6	17	15.0
	>7	8	7.1
	Total	**113**	**100**

Table 3.11. Information on the social relationships of the participants (Continue):

		Frequency N	**Percent %**
Number of second degree relatives, who speak Turkish language: (n=113)	0	48	42.5
	1-3	31	27.4
	4-6	19	16.8
	>7	15	13.3
	Total	**113**	**100**
How helpful were the Turkish friends or neighbors in case of need for language problems: (n=143)	Always helpful	75	52.4
	Sometimes helpful	16	11.2
	Unhelpful	52	36.4
	Total	**143**	**100**
How helpful were the relatives in case of need for language problems: (n=140)	Always helpful	78	55.7
	Sometimes helpful	19	13.6
	Unhelpful	43	30.7
	Total	**140**	**100**
Similarity of the Turkish culture comparing to Syrian culture: (n=217)	Very different	50	23.0
	A little different	44	20.3
	Similar	108	49.8
	Exactly the same	8	3.7
	Doesn't know	7	3.2
	Total	**217**	**100**

Although, the majority of the participants who stated to have Turkish friends or Turkish neighbors (67.1%, n: 96), assessed their relationships with them negatively, more than half of them (52.4%, n: 75) stated that their Turkish friends and neighbors help them anytime they need them. 36.4% (n: 52) of them stated that their Turkish friends and neighbors were unhelpful when they were in need of their help.

Almost half of the participants (48.9%, n: 108) have got relatives who can speak Turkish. In order to get more accurate data, we preferred to ask to degree of the relatives speaking Turkish (i.e. first degree relatives and second degree relatives) (Table 3.11).

While 52.4% (n: 75) of the participants, said that their Turkish friends and neighbors help them anytime they need help regarding language problems, similarly 55.7% (n: 78) of them said that their relatives help them whenever they need (Table 3.11).

4.5. Information on the health status of the participants:

Despite 66.5% (n: 147) of the respondents stated that they did not have any mental or physical diseases, only 5.4% of them thought that they were in a very good health condition. 72.3% (n: 157) of the respondents mentioned that they were in a moderate or a bad health condition. Hypertension, diabetes and depression were the largest stated health problems (5.4%, n: 12, 5.9%, n: 13 and 5.9%, n: 13 respectively) among the participants (Table 3.12).

Table 3.12. Information on the self-assessed health status of the participants:

		Frequency N	**Percent %**
Self-assessed health status: (n=217)*	Very Good	12	5.5
	Good	48	22.1
	Moderate	76	35.0
	Bad	81	37.3
	Total	**217**	**100**
Existence of previously diagnosed mental or physical disease : (n=221)	Doesn't have any	147	66.5
	Has	74	33.5
	Total	**221**	**100**
Diseases history: (n=221)	Doesn't have or didn't declare his disease	165	74.7
	Asthma	3	1.4
	Depression	13	5.9
	Diabetes	13	5.9
	Wounded	1	0.5
	War wounded	1	0.5
	Eye disease	2	0.9
	Graves' disease	2	0.9
	Hepatitis	3	1.4
	Hypertension	12	5.4
	Migraine	1	0.5
	Paralyzed	4	1.8
	Stomach Ulcer	1	0.5
	Total	**221**	**100**

* 4 missing values

The majority (78.5%, n: 172) of the participants, were using state hospitals in order to get healthcare services, while 17.8% of them visited family health centers.

3.7% (n: 8) of the respondents mentioned that they did not visit any healthcare services before. (Table 3.13).

Table 3.13. Accessing healthcare services:

		Frequency N	Percent %
Ability to Access healthcare services: (n=221)	Able to access	209	94.6
	Didn't need healthcare services	12	5.4
Type of the healthcare service, they usually use : (n=219)*	Family Health Centre	39	17.8
	State hospital	172	78.5
	Didn't need healthcare services	8	3.7

* 2 missing values

4.5.1. Perceived barriers in accessing healthcare:

In order to find out the eventual factors associated with restricted access to healthcare services among Syrian refugees, we asked about participants' experiences regarding problems in accessing healthcare services. Language barrier was the most mentioned factor (40.3%, n: 89), followed by the expensiveness of the healthcare service or transfer cost. (Table 3.14).

Table 3.14. Participants' experiences regarding reasons of not accessing healthcare services.

	Affected		Did not affect	
	Frequency	Percent	Frequency	Percent
Language problems (n=221)	89	40.3	132	59.7
Distance or transportation difficulties (n=221)	12	5.4	209	94.6
Healthcare services and transfer to services are expensive (n=221)	17	7.7	204	91.9
Anxiety and embarrassment (n=221)	5	2.3	216	97.7
Thinking that healthcare services are not useful (n=221)	5	2.3	216	97.7
Inappropriate behaviour of health personnel. (n=221)	12	5.4	209	94.6
Not knowing from where and how to receive healthcare services (n=221)	7	3.2	214	96.8

4.5.2. Language Barrier:

Of the respondents, 51.4% (n: 110), thought that the language barrier plays an extremely negative role in accessing healthcare services. Only 22.9% (n: 22.9) of them said that the language barrier doesn't have any adverse effect on them.

51.1% (n: 113) of the respondents, stated that they experienced not being able to access healthcare services despite their need due to language barriers, and 14.2% (n: 16) of these people said that they face this problem all the time. Also, 40.7% (n: 46) of them have faced the inaccessibility to healthcare services because of language barriers at least few times, and 34.5% (n: 39) of them have faced this problem more often (Table 3.15).

Table 3.15. Perceived effect of language barrier in accessing healthcare services

		Frequency N	**Percent %**
Perceived effect of language barrier: (n=214)*	Does not have any negative effect	49	22.9
	Partly has a negative effect	55	25.7
	Has an extremely negative effect	110	51.4
	Total	**214**	**100**
Despite of need, experienced not accessing healthcare services: (n=221)	Hasn't experienced such a situation	84	38
	Have experienced	113	51.1
	Didn't remember	24	10.9
	Total	**221**	**100**
Despite of need, how often they experienced not accessing healthcare services: (n=113)	At least once	12	10.6
	A Few times	46	40.7
	Often	39	34.5
	Always	16	14.2
	Total	**113**	**100**

* 7 missing values

4.5.3. Coping with the Language Barrier:

Almost half of the participants (48.5%, n: 99), used hospital interpreters when they access healthcare services. While 20.6% (n: 42), 17.6% (n: 36) and 13.2% (n: 27) of them tried to manage the situation by himself, used ad hoc interpreters such as friends or family member and used a private interpreter respectively. Furthermore, the percentages didn't change too much when we asked about the method they had used

during the previous visit to a healthcare service. While 64.9% (n: 131) of them thought that the method they have used during the previous visit was effective, 11.9% (n: 24) of them thought that it wasn't effective at all and 23.3% (n: 47) of them believed that it was partly effective.

The percentages of the responds did not change significantly when we asked about the method which they perceive as most useful: 47.1% (n: 79) of them thought that using the hospital interpreter is the most effective method (Table 3.16).

Table 3.16. Distribution of the methods the participants use to cope with language problem

		Frequency N	**Percent %**
Coping method: (N=204)*	Hospital interpreter	99	48.5
	Private interpreter	27	13.2
	Ad hoc interpreter (Friends or family member)	36	17.6
	Managed himself	42	20.6
	Total	**204**	**100**
The method perceive as most useful: (N=206)**	Hospital interpreter	97	47.1
	Private interpreter	24	11.7
	Ad hoc interpreter (Friends or family member)	44	21.4
	Managed himself	41	19.9
	Total	**206**	**100**
The method used during the previous visit to a healthcare service: (N=207)***	Hospital interpreter	98	47.3
	Private interpreter	27	13.0
	Ad hoc interpreter (Friends or family member)	32	15.5
	Managed himself	50	24.2
	Total	**207**	**100**
Was the method used during the previous visit to a healthcare service effective? (N=202)****	Effective	131	64.9
	Wasn't effective	24	11.9
	Was partially effective	47	23.3
	Total	**202**	**100**

* 17 missing values, ** 15 missing values, *** 14 missing values, **** 19 missing values

4.6. Assessment of Eventual Associated Factors with Experiencing Language Problems and Coping Methods Used for Them:

There was no statistical difference between the two hospitals considering perceived effect of language barrier in accessing healthcare services. Gender did not show any statistical difference in this context as well. Marital status showed a statistical difference in our study population, (P=0.004), married participants (civil and religious marriage) perceived language problems more seriously than the single ones in accessing healthcare services.

Unemployment worsens the language problem. The participants who are currently jobless or were jobless when they were in Syria, perceived language problems more seriously compared to the participants, who were working or had worked in Syria, and the differences were statistically significant (P<0.001) (Table 3.17).

Table 3.17. The distribution of some variables according to perceived effect of language barrier in accessing healthcare services:

		Perceived effect of language barrier						Total	***P***
		Does not have any negative effect		Partly has a negative effect		Has an extremely negative effect			
		N	**%**	**N**	**%**	**n**	**%**	**n**	
Study setting	Numune	22	29.3	13	17.3	40	53.3	75	0.70
	Ankara	27	19.4	42	30.2	70	50.4	139	
Gender	Male	29	29	28	28	43	43	100	0.49
	Female	20	17.5	27	23.7	67	58.8	114	
Current employment status	Jobless	40	23.5	32	18.8	98	57.6	170	0.001> ***
	Working	9	22.5	19	47.5	12	30	40	
Employment status in Syria	Jobless	18	13.2	43	31.6	75	55.1	136	0.001> ***
	Working	31	39.7	12	15.4	35	44.9	78	

Table 3.17. The distribution of some variables according to perceived effect of language barrier in accessing healthcare services (Continue):

		Perceived effect of language barrier						Total	***P***
		Does not have any negative effect		Partly has a negative effect		Has an extremely negative effect			
		N	**%**	**N**	**%**	**n**	**%**	**n**	
How helpful were the Turkish friends or neighbors in case of need for language problems	Helpful	25	29.8	24	28.6	35	41.7	84	0.554
	Unhelpful	20	38.5	12	23.1	20	38.5	52	
Having relatives who speak Turkish language	Doesn't have	32	29.6	20	18.5	56	51.9	108	0.013*
	Has	17	16	35	33	54	50.9	106	
How much helpful were the relatives in case of need for language problems	Helpful	12	12.9	27	29	54	58.1	93	0.001> ***
	Unhelpful	17	42.5	11	27.5	12	30	40	
Self-assessed health status	Good	17	29.8	16	28.1	24	42.1	57	0.207
	Moderate	16	22.2	20	27.8	36	50	72	
	Bad	16	19.8	15	18.5	50	61.7	81	
Existence of previously diagnosed mental or physical disease	Doesn't have any	36	25.7	41	29.3	63	45	140	0.036*
	Has	13	17.6	14	18.9	47	63.5	74	
Type of the healthcare service, they usually use	Family physician	12	34.3	12	34.3	11	31.4	35	0.039*
	State hospital	37	21.9	39	23.1	93	55	169	
Marital status	Married	33	19	43	24.7	98	56.3	174	0.004**
	Single	16	40	12	30	12	30	40	

Table 3.17. The distribution of some variables according to perceived effect of language barrier in accessing healthcare services (Continue):

		Perceived effect of language barrier						Total	***P***
		Does not have any negative effect		Partly has a negative effect		Has an extremely negative effect			
		N	**%**	**N**	**%**	**n**	**%**	**n**	
Education level	Never made it to school	21	36.8	8	14	28	49.1	57	0.027*
	Primary school or Secondary school	20	17.1	35	29.9	62	53	117	
	High school or College/ University	8	20	12	30	20	50	40	
Duration of time in Turkey	Less than one year	7	21.9	5	15.6	20	62.5	32	0.366
	1-3 years	29	23	29	23	68	54	126	
	4 years and more	12	23.5	17	33.3	22	43.1	51	

*"*** p <0.001; ** p <0.01; * p <0.05"*

Having helpful Turkish friends or neighbors does not attenuate the perceived language barrier in healthcare services statistically, while, having relatives who can speak Turkish attenuates the perceived effect of the language barrier (*P*=0.013). However, this association depends if the relatives are helpful or not; in a case of unhelpful relatives, this effect diminishes (*P*<0.001).

The self-assessed health status of the participants did not show a significant association though, having a previous mental or physical disease worsens the perceived effect of language problems in accessing healthcare services (*P*=0.036). The facility where the participants access healthcare services was found to be significantly associated with perceived effect of the language barrier (P=0.039) (Table 3.17).

Furthermore, participants tend to face more problems with language in state hospitals compared to family physician clinics

The Association Between the Methods Used for Coping the Language Barrier and Other Factors:

The gender of the participants was associated with the method they use to overcome the language barrier. While females tend to use ad hoc interpreters such as friends, family members or manage the situation by themselves, males tended to use the hospital interpreter more ($P<0.001$). In addition, participants who stated that their economic situation was good in Syria, tend to use hospital interpreter more than the ones whose economic situation was moderate or bad ($P<0.001$).

While having Turkish friends or neighbors did not show a significant association in this aspect, having relatives who can speak Turkish showed a statistically significant association. Participants who have Turkish speaking relatives preferred to use friends or family member as interpreters more than the participants, who did not have Turkish speaking relatives ($P<0.001$).

Participants with a previous mental or physical diseases tended to use hospital interpreter more than the participants who did not mention of having diseases ($P=0.01$) (Table 3.18)

Table 3.18. The distribution of some of the explanatory variables according to the methods used for coping with language problem:

		The method they use to cope with language problem								**Total**	***P***
		Hospital interpreter		**Private interpreter**		**Ad hoc interpreter (Friends or family member)**		**Managed himself**			
		N	**%**	**N**	**%**	**n**	**%**	**n**	**%**	**n**	
Gender	Male	67	67	8	8	8	8	17	17	100	0.001> ***
	Female	32	30.8	19	18.3	28	26.9	25	24	104	
Self- assessed economic status when they were in Syria	Good	51	60.7	8	9.5	11	13.1	14	16.7	84	0.001> ***
	Moderate	40	48.2	11	13.3	20	24.1	12	14.5	83	
	Bad	8	21.6	8	21.6	5	13.5	16	43.2	37	

Table 3.18. The distribution of some of the explanatory variables according to the methods used for coping with language problem (Continue):

		The method they use to cope with language problem								**Total**	***P***
		Hospital interpreter		**Private interpreter**		**Ad hoc interpreter (Friends or family member)**		**Managed himself**			
		N	**%**	**N**	**%**	**n**	**%**	**n**	**%**	**n**	
Have Turkish friends or neighbors	Doesn't have	35	46.7	12	16	8	10.7	20	26.7	75	0.103
	Has	64	49.6	15	11.6	28	21.7	22	17.1	129	
Having relatives who speak Turkish language	Doesn't have	56	53.8	12	11.5	8	7.7	28	26.9	104	0.001> ***
	Has	43	43	15	15	28	28	14	14	100	
Existence of previously diagnosed mental or physical disease	Doesn't have any	57	42.9	19	14.3	21	15.8	36	27.1	133	0.01 **
	Has	42	59.2	8	11.3	15	21.1	6	8.5	71	

*"*** p <0.001; ** p <0.01; * p <0.05"*

5. DISCUSSION

Within our study, there were 75 participants from Numune Hospital and 146 participants from Ankara Hospital. We think that the location of Ankara Hospital, which is close to the neighborhood where the majority of Syrian refugees in Ankara live, is the main cause of the difference in the number of participants. Additionally, Ankara Hospital has two interpreters while Numune Hospital has only one interpreter, this might also make Ankara Hospital more attractive among Syrian refugees. Furthermore, all the foreigners (including the refugees) visiting Ankara Hospital has to register at a certain place, before they are referred to the clinics they want to visit, which made it easier for us to recruit them. As there was no such a process at the Numune Hospital, it was more difficult to enroll the Syrian refugees to the study.

There were slight more female participants than male participants (53,4%, 46,6%), probably because we had more women interviewers (one male and two female interviewers) and female patients preferred to be interviewed by a female interviewer.

The number of children below the age of 15 years constituted around 37.5 per cent of the total Syrian population in 2009 (101). In addition, this percentage is near to the percentage of Syrian children below the age of 15 years in Turkey (36.74%) (16). However, in our study the total number was definitely higher than this percentage, which may be a reflection of the socio-economic level of the participants which might indicate the low awareness of family planning among the participants.

The education level of the participants was also very different than the general education level in Syria before the war. As Syria had made a considerable effort to provide free and public education and had issued a compulsory education law in 2002, basic education was extended from primary education to the end of the intermediate level. Therefore, the illiteracy rate for the age group 15 years and above was 16.8 per cent in 2008. In this context, considerable disparities exist between males and females, with an illiteracy rate of 9.9 per cent for males and 24 per cent for females in 2008 (101). In our study, 29 per cent of the participants have never made it to school. However, the illiteracy rate was not very different between males and females (43.8% and 56.3% respectively). Furthermore, there was an imbalance in the distribution of type of the settlement in Syria, which also enable us to perform x^2 test.

None of the participants came to Turkey before the Syrian crisis started on 15th March 2011. Additionally, more than half of them (50.5%) came between 2013-2014 and 75% of came to Turkey after 2013, the same year when the battle in Aleppo city (the largest city in Syria and the nearest to the Turkish border) started.

Only 11.1% of the sample had stayed in camps before, and the largest amount of them (83.4%) had stayed more than 5 months. As 90% of Syrian refugees in Turkey remain outside of camps (5), (32) our sample present parallel results in this respect.

The Turkish government made an effort to provide Syrian refugees with free language courses through many of its foundations. However, only 17.8% of the participants who, reported themselves as Turkish speaking or learning the Turkish language, learned or were learning it from those courses (Table 3.5). In addition, almost half of the participants (50.7%, n: 110) did not know the Turkish language at all. This is a substantially higher percentage of refugees with language abilities in the host-country language than has been found in other similar groups. For example, only 6.1% of Arabic, Somali, Dari or English-spoken migrants who have been enrolled in a study in Sweden did not understand what was being told and 27.8% of them had low quality of communication (61).

The use of the internet as a source to learn the language while free language courses is provided, may point out further barriers in access for those courses. The working environment was a popular option to learn Turkish among the participants.

None of the participants, who stated that they can speak Turkish can speak English as well. Speaking English may affect the need to learn Turkish as the refugees may use their English to communicate with others in Turkey. However, the sample size wasn’t large enough to fully support this hypothesis.

The unemployment rate in Syria was 10.9 per cent in 2008, while the female unemployment rate reached 24.2 per cent in that same year. Unemployment was exacerbated by a weak demand for labor, low growth of major productive sectors and ceilings imposed on public sector employment. This may have increased female unemployment knowing that females tend to prefer the public sector and perceive the private sector to be biased against them (101). However, in our study the unemployed participants have the greatest share of the participants, considering both current employment status and employment status in Syria. The current employment

percentage in our study was 19.8% (n: 43) which is slightly lower than the employment rate of the Turkish and Moroccan migrants in Amsterdam (25.5%) (56). However, the migration in Amsterdam was voluntary unlike the Syrian refugees' situation in Turkey.

Half of the participants (50.7%) assessed their economic status as moderate, while 30% of them declared that their economic status is bad and 15.4% of them thought that they are in very bad conditions economically. Only 3.6% of them assessed their economic situation as good. Yet the economic status was self-evaluated, and this assessment may be biased because some of them may think that they will get some financial help after the study. Also it may be biased in the other direction, in which people with Islamic culture may tend to say that their economic status is good even if it is bad or moderate as a kind of show of gratefulness to God in all situations.

In a study among Syrian refugees in Germany, socialization and integration problems due to the German Language (57) were shown, but most of the participants in our study have Turkish friends or neighbors. However, it may not mean a smooth socialization, because almost half of them (47.6%) stated that their relationships with their neighbors were bad. In addition, knowing the Turkish language also seems to be an important factor for social relations (Table 3.6), considering that everyone in the sample who can speak Turkish tended to have at least one Turkish friend or neighbor. Nevertheless, even if the relationships were expressed as bad, more than half of the participants said that their Turkish friends or neighbors help them when they needed help. This finding might suggest that speaking the local language is effective to improve the relationships between the host and guest communities. In this aspect, we can find similar results in previous studies (67), which support the fact that language difficulties can worsen social isolation and act as a barrier to engagement and adaptation in a new country and limit participation in social events (68).

In the study mentioned above 5.3% of the Turkish and Moroccan migrants in Amsterdam self-reported that they were in a very good health condition (56). In our study, 5.4% of the respondents thought that they were in a very good health condition. Moreover, 55.4% of Turkish and Moroccan migrants mentioned that they were in a moderate or a bad health condition, which was 72.3% in our study. However, the general health profile of the participants was self-assessed, this might have affected the results. Further, our survey was conducted in the external clinics in two hospitals

so the general health profile may not reflect the Syrian refugees' health conditions in Ankara. The largest part of the participants declared that they don't have a physical or mental disease that has been diagnosed by physicians, which may also reflect that most of them visit the clinics for acute diseases such as contagious diseases. *Sevinç et el* (31) stated that achieving good health care improvements will yield cost-effective results such as decreasing hospitalization durations and occurrences of infection, which is supported by the evidence from our study.

Our study supports the previous literatures in accessing healthcare services among the Syrian refugees in Turkey (36), (8) whereas all the participants were able to access healthcare services at least once in Ankara. But, the study was conducted in hospitals, and it is important that we mention the selection bias possible with regards to this finding.

In the studies by *Manson* and *Crane* (51), (52), it was shown that even when patients do have access to care they have poorer healthcare services because of language barriers, which was in accordance with our findings. Our participants, similarly, thought that language problems restrict their access to healthcare services. *Fassaert (56)* also noted that language problems are one of the most important factors affecting the foreign individuals seeking health care. This fact was underlined in our study, by the language problem being the most mentioned factor that restricts access to healthcare services.

Although public surveys in Turkey indicate that anti-Syrian sentiments are common, with around 86% of the Turkish people wanting the government to stop the intake of refugees and 30% supporting the view that refugees should be sent back to their home country, only 5.4% of the participants reported to be mistreated by medical staff. Unlike Zimbabweans in South Africa where they reported to be mistreated by medical staff just because they speak different language (59, 60). This fact may be due to professionalism among Turkish healthcare providers.

Turkey has hired Arabic-Speaking translators in almost all of the state hospitals to overcome the language barrier, also it has been employing Syrian healthcare personnel in migrant health centers (8, 99). Although, there are Syrian healthcare personnel in migrant health centers, 78.5% of the participants in our study still visit state hospitals for health problems. This result is obviously due to the study setting.

When we examined the association between the perceived effect of the language barrier and other factors, we found that the following factors were statistically significant; marital status, education level, current employment status, employment status in Syria, having relatives who speak Turkish language, level of helpfulness of the relatives in interpretation, existence of previously diagnosed mental or physical disease and type of the healthcare service, they usually use. We could not perform X^2 test to analyze the association between perceived effect of language barrier and age, number of children, settlement type in Syria, speaking Turkish, self- assessed economic status when they were in Syria, having Turkish friends or neighbors and similarity of the Turkish culture compared to Syrian culture. However, some of these factors might show associations with a proper sample size. For example the review of *Jacobs* (47) indicates that after learning the native language of the healthcare providers, patients become less likely to ask for an interpreter.

Age seem to be an important factor in perceiving the effect of language barrier. However due to the restricted sample size we were not able to perform Chi-Square test. When we look at the distribution of age considering perceived effect of language barrier, of the participants, who were under 25 years old, 24.4 %, of the ones between 26-50 years old, 56.5 %, and of the ones above 50 years old 73.2 % perceived that the language barrier has an extremely negative effect. Those results may show us that language problem became worse by age. It may be because of communication problems or the ability to learn a new language. It's expected that learning Turkish language is more difficult among the older participants than the younger ones (Table 3.6).

The results showed that married people were inclined to speak less Turkish. However, this finding might be related to the age of the participants, since the age distribution of the single people was younger than married people. Nevertheless, the distribution was not appropriate for Chi-Square test.

Participants with more children reported to suffer more with the language barrier compared to the participants with fewer or no children at all. The reason for this difference may be the frequent need to visit healthcare services, possibly due to unhealthy living conditions since children may be the most vulnerable group to get sick.

The type of the settlement in Syria seems to be one of the factors associated with less negative perceptions of the effect of language barrier. While 26.3% of the participants who lived in urban areas in Syria perceived that the language barrier has no negative effect, none of the participants from rural areas in Syria reported no negative effect. We didn't find a significant difference in education level between these two groups. However, the communication skills and the intellectual background they gained by living in the city might have an important role in this difference.

The current employment status was important in learning Turkish language. Working people were more inclined to learn Turkish than unemployed people. As learning Turkish is vital for overcoming the language barrier, participants who were employed at the time of the study had to struggle less with the language problem in healthcare services.

Although the employment status in Syria doesn't seem to affect the learning of Turkish language, it seems to have an impact on perceiving the language as a barrier. This statement may indicate an eventual association between the economic status and the perception of the language as a barrier which might be related to the positive correlation between better education and better economic status.

Having a previous mental or physical disease seems to increase the perception of the degree of language barrier among the participants. This might be caused by the increased number of visits they make due to their illnesses. Another reason for the increased perception of the degree of the language barrier might be related to the study setting. Various factors, such as the employment of Syrian health personnel in family health centers (94, 99) decreases the degree of awareness of language barriers compared to the state hospitals.

When we examined the association between the method they use to cope with the language barrier and other factors, we found that following factors were statistically significant; gender, economic status in Syria, having relatives who speak Turkish language and existence of previously diagnosed mental or physical disease. In addition, some of the following variables showed some differences, but imbalance in the distribution of these variables did not enable us to apply the Chi-Square test. These factors were age, marital status, number of children, educational level, residing place in Syria, speaking Turkish, speaking a second language, self-assessed current

economic status, employment status in Syria, similarity of the Turkish culture compared to Syrian culture, duration of time in Turkey, how helpful the relatives were in case of the need for overcoming language problems and type of the healthcare service.

The gender of the participants was associated with the method they used to cope with the language barrier. While females tended to use friends, family members or cope with the situation themselves, males preferred to use the hospital interpreters more. As most of the Syrian refugees have an Islamic culture, females may feel uncomfortable to use a stranger to help them in communicating with healthcare providers, especially if the interpreters are males. This finding might demonstrate that some barriers are created by the strict religious modesty norms and associated gender preference of their health care provider and religious understanding of illness (40, 42).

The self- assessed economic status when they were in Syria was associated with the method that participants used to cope with the language barrier. One explanation may be the level of education among the refugees who stated to have good economic status in Syria. These groups might be more knowledgeable about how to ask for a hospital interpreter than the participants who had a worse economic level in Syria. However, our study did not examine this aspect among the Syrian refugees and this hypothesis is far from being verified.

Refugees who have Turkish speaking relatives tend to use a family member as an interpreter more to contact healthcare providers, while refugees who did not have such relatives leaned on managing by themselves.

Syrian refugees with previous mental or physical diseases tend to use the hospital interpreter more often than the refugees without chronic diseases. The higher number of visits to the clinics due their diseases, allowed them to be aware of the hospital interpreter and use this service more effectively.

This study provides a valuable insight into the language barriers in accessing health care services among Syrian refugees in Ankara. It does, however, have some limitations. Like in most cross-sectional designs it is not possible to infer causal relationship. Additionally, due to the conditions, a representative sample size and a probability sampling strategy could not be used. Despite the descriptive characteristic of the study, it supplies fundamental information about the language barriers in

accessing healthcare services among the Syrian refugees in Ankara, Turkey. Additionally, the study setting (hospitals), might have caused some selection bias.

6. CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion:

Despite its' descriptive characteristics, our study provides valuable information on the language barriers that Syrian refugees face while accessing healthcare services. Of the 221 participants, only 11.1% (n: 24) could speak Turkish language, while 50.7% (n: 110) could not speak at all. 34.4% (n: 76) of the respondents stated that they experienced not being able to access healthcare services despite their need because of language barriers. Further, almost half of the participants (48.5%, n: 99) used hospital interpreters to access healthcare services, while 20.6% (n: 42), 17.6% (n: 36) and 13.2% (n: 27) of them tried to manage the situation by himself, used ad hoc interpreters such as friends or family member and used a private interpreter respectively.

Of all explanatory variables, marital status, education level, current employment status, employment status in Syria, having relatives who speak Turkish language, how much helpful these relatives were in need of interpretation, existence of diagnosed mental or physical disease and type of the healthcare service used might be the eventual predictors for experiencing language barriers among Syrian refugees in accessing healthcare services.

In case of language barriers, the most common methods used to overcome language barriers were the use of hospital interpreter, managing the situation by themselves and Ad hoc interpreter respectively.

6.2. Recommendations:

Considering the findings of the study, our suggestions for further steps are summarized below.

- Based on the findings of the study, further analytic studies should be conducted to have a deeper and clearer understanding of the language problems that the Syrian refugees face with in Turkey to access healthcare services.
- It seems that working environment provides suitable conditions to learn the local language among adult population, hence providing appropriate job opportunities to refugees, might help refugees to learn the language and

correspondingly to integrate in the society and get a better access to healthcare services.

- Speaking Turkish seems to be an important factor to have Turkish friends, so learning the language may facilitate the integration to the local society.
- In a conservative society like Syrian society, gender is an essential issue. This matter should be considered while providing solutions to overcome the language problems in accessing healthcare services among Syrian refugees.
- Interpreters seem to be one of the coping methods perceived as effective, however considering the number of Syrian population in Turkey, providing enough interpreters to each hospital might not be economically feasible. Reference hospitals might be a solution in this aspect.
- Considering the refugees with no literacy or low education level, only providing the service may not be enough. Thus, informing about the service and finding the effective way how to provide the refugees with information are important.

7. REFERENCES

1 UNHCR. UNHCR. Facts at a glance [Internet] 2016 [Access date 08.09.2017]. Available from: http://www.unhcr.org/en-us/figures-at-a-glance.html.

2. Guha-Sapir D, Schluter B, Rodriguez-Llanes JM, Lillywhite L, Hicks MH. Patterns of civilian and child deaths due to war-related violence in Syria: a comparative analysis from the Violation Documentation Center dataset, 2011-16. The Lancet Global health. 2018;6(1):e103-e10.

3. Mowafi H, Leaning J. Documenting deaths in the Syrian war. The Lancet Global health. 2017;6(1):e14-e5.

4. Fouad FM, Alameddine M, Coutts A. Human resources in protracted crises: Syrian medical workers. Lancet (London, England). 2016;387(10028):1613.

5. Simsek Z, Yentur Doni N, Gul Hilali N, Yildirimkaya G. A community-based survey on Syrian refugee women's health and its predictors in Sanliurfa, Turkey. Women & health. 2017:1-15.

6. UNHCR The UN refugee agency. Evaluation of UNHCR's Emergency Response to the influx of Syrian Refugees into Turkey - Full report [Internet]: 2015 [Access date 09.09.2017]. Available from: http://www.unhcr.org/research/evalreports/58a6bbca7/evaluation-unhcrs-emergency-response-influx-syrian-refugees-turkey-full.html?query=syrian%20refugees.

7. Altıner AO, Yeşil ST. Emergency Medical Service (EMS) Utilization by Syrian Refugees Residing in Ankara, Turkey. Prehospital and Disaster Medicine. 2018:1-5.

8. DeJong J, Ghattas H, Bashour H, Mourtada R, Akik C, Reese-Masterson A. Reproductive, maternal, neonatal and child health in conflict: a case study on Syria using Countdown indicators. BMJ global health. 2017;2(3):e000302.

9. (iom) Iofm. Glossary on Migration, International Migration Law Series2011.

10. UNHCR. Convention and protocol Relating to the Status of Refugees. Communication and Public Information Service Geneva: UNHCR; 2010 2010.

11. UNHCR. UNHCR viewpoint: ‘Refugee’ or ‘migrant’ – Which is right? [Internet]. 2016 [Access date 11/12/2017]. Available from: http://www.unhcr.org/55df0e556.html.

12. Ekmekci PE. Syrian Refugees, Health and Migration Legislation in Turkey. Journal of immigrant and minority health. 2017;19(6):1434-41.

13. Kirisci K. Post Second World War immigration from Balkan countries to Turkey. New perspectives on Turkey. 1995(12):61-77.

14. Tarımcı A. The role of geographical limitation with respect to asylum and refugee policies within the context of Turkey’s EU harmonization process 2005.

15. Aydogan M. UK envoy praises Turkey's refugee policy. Anadolu Agency 2018.

16. BALCILAR PDM. Health Status Survey of Syrian Refugees in Turkey. 2016.

17. Slim H, Trombetta L. Syria crisis common context analysis. New York: Co-ordinated Accountability and Lessons Learning (CALL) Initiative, IASC Inter-Agency Humanitarian Evaluations Steering Group; 2014.

18. FISHER M. Straightforward Answers to Basic Questions About Syria's War. The New York Times. 2016.

19. Lucy Rodgers DG, James Offer and Patrick Asare. Syria: The story of the conflict [Internet]. 2016 [Access date 11.09.2017]. Available from: http://www.bbc.com/news/world-middle-east-26116868.

20. Watch HR. Syria Events of 2016. [Internet]. 2017 [Access date 12.12.2018] Available from: https://www.hrw.org/world-report/2017/country-chapters/syria.

21. Independent International Commission of Inquiry on the Syrian Arab Republic: United Nations Human Rights Office Of The High Commissioner [Internet]. 2016 [Access date 06.09.2017] Available from: http://www.ohchr.org/en/hrbodies/hrc/iicisyria/pages/independentinternationalcommission.aspx.

22. Doocy S, Lyles E, Delbiso TD, Robinson CW. Internal displacement and the Syrian crisis: an analysis of trends from 2011–2014. Conflict and Health. 2015;9(1):33.

23. UNHCR. Syria Emergency [Internet]: 2017 [Access date 12.11.2017]. Available from: http://www.unhcr.org/syria-emergency.html.

24. Syrian Arab Republic, Ministry of Health Statistics [Internet] 2009 [Access date 19.12.2017]. Available from: http://www.moh.gov.sy/Default.aspx?tabid=337.

25. WHO. Syrian Arab Republic: World Health Organization - Non-Communicable Diseases (NCD) Country Profiles [Internet]; 2014 [Access date 10.10.2017]. Available from: http://www.who.int/nmh/countries/syr_en.pdf.

26. Kherallah M, Alahfez T, Sahloul Z, Eddin KD, Jamil G. Health care in Syria before and during the crisis. Avicenna Journal of Medicine. 2012;2(3):51-3.

27. Alsadat R, Dakak A, Mazlooms M, Ghadhban G, Fattoom S, Betelmal I, et al. Characteristics and outcome of critically ill patients with 2009 H1N1 influenza infection in Syria. Avicenna Journal of Medicine. 2012;2(2):34-7.

28. The L. The war on Syrian civilians. The Lancet.383(9915):383.

29. Tekeli Yesil S. IE, Unal Y., Aljomaa Almossa F.,Unlu H., Aker T. A. A comparative study: Mental disorders among Syrian refugees in Turkey and internally displaced people in Syria, and factors affecting them. American Journal of Public Health. 2018.

30. Solé-Auró A, Crimmins EM. Health of Immigrants in European countries. The International migration review. 2008;42(4):861-76.

31. Sevinc S, Kilic SP, Ajghif M, Ozturk MH, Karadag E. Difficulties encountered by hospitalized Syrian refugees and their expectations from nurses. International nursing review. 2016;63(3):406-14.

32. European Neighborhood Policy and Enlargement Negotiations. The Facility for Refugees in Turkey [Internet] 2016 [Access date 15.09.2017]. Available from: https://ec.europa.eu/neighbourhood-enlargement/news_corner/migration_en.

33. Hall JL. Welcoming Syrian refugees. Canadian Family Physician. 2016;62(3):269-.

34. Syrian refugees seeking help. Lancet (London, England). 2015;385(9964):202.

35. Balsari S, Abisaab J, Hamill K, Leaning J. Syrian refugee crisis: when aid is not enough. Lancet (London, England). 2015;385(9972):942-3.

36. Suriyeli Sığınmacılara Yapılan Yardımlar [Internet] 2017 [Access date 25.12.2017]. Available from: https://www.afad.gov.tr/upload/Node/2373/files/Suriyeli_Siginmacilara_Yapilan_Yardimlar.pdf.

37. Doganay M, Demiraslan H. Refugees of the Syrian Civil War: Impact on Reemerging Infections, Health Services, and Biosecurity in Turkey. Health security. 2016;14(4):220-5.

38. Dagogo-Jack S, Funnell MM, Davidson J. Barriers to achieving optimal glycemic control in a multi-ethnic society: a US focus. Current diabetes reviews. 2006;2(3):285-93.

39. Wiener L, McConnell DG, Latella L, Ludi E. Cultural and religious considerations in pediatric palliative care. Palliative and Supportive Care. 2013;11(1):47-67.

40. Contro N, Davies B, Larson J, Sourkes B. Away from home: experiences of Mexican American families in pediatric palliative care. Journal of social work in end-of-life & palliative care. 2010;6(3-4):185-204.

41. Yosef AR. Health beliefs, practice, and priorities for health care of Arab Muslims in the United States. Journal of transcultural nursing : official journal of the Transcultural Nursing Society. 2008;19(3):284-91.

42. Almontaser E, Baumann SL. The Syrian Refugee Crisis: What Nurses Need to Know. Nursing science quarterly. 2017;30(2):168-73.

43. Padela AI, Curlin FA. Religion and disparities: considering the influences of Islam on the health of American Muslims. Journal of religion and health. 2013;52(4):1333-45.

44. Inhorn MC, Serour GI. Islam, medicine, and Arab-Muslim refugee health in America after 9/11. Lancet (London, England). 2011;378(9794):935-43.

45. Viner Y, Braslavsky A, Zarka S. Multidisciplinary Care of a 13 Year Old Syrian Child. The Israel Medical Association journal : IMAJ. 2017;19(4):212-3.

46. Al-Omran H. Measurement of the knowledge, attitudes, and beliefs of Arab-American adults toward cancer screening and early detection: development of a survey instrument. Ethnicity & disease. 2005;15(1 Suppl 1):S1-15-6.

47. Jacobs E, Chen AHM, Karliner LS, Agger-Gupta N, Mutha S. The Need for More Research on Language Barriers in Health Care: A Proposed Research Agenda. The Milbank Quarterly. 2006;84(1):111-33.

48. Fox SA, Stein JA. The effect of physician-patient communication on mammography utilization by different ethnic groups. Medical care. 1991;29(11):1065-82.

49. Kirkman-Liff B, Mondragón D. Language of interview: relevance for research of southwest Hispanics. American journal of public health. 1991;81(11):1399-404.

50. Fiscella K, Franks P, Doescher MP, Saver BG. Disparities in health care by race, ethnicity, and language among the insured: findings from a national sample. Medical care. 2002;40(1):52-9.

51. Manson A. Language concordance as a determinant of patient compliance and emergency room use in patients with asthma. Medical care. 1988;26(12):1119-28.

52. Crane JA. Patient comprehension of doctor-patient communication on discharge from the emergency department. The Journal of emergency medicine. 1997;15(1):1-7.

53. Gandhi TK, Burstin HR, Cook EF, Puopolo AL, Haas JS, Brennan TA, et al. Drug complications in outpatients. J Gen Intern Med. 2000;15(3):149-54.

54. Freeman GK, Rai H, Walker JJ, Howie JGR, Heaney DJ, Maxwell M. Non-English speakers consulting with the GP in their own language: a cross-sectional survey. The British Journal of General Practice. 2002;52(474):36-8.

55. Bischoff A, Bovier PA, Rrustemi I, Gariazzo F, Eytan A, Loutan L. Language barriers between nurses and asylum seekers: their impact on symptom reporting and referral. Social science & medicine (1982). 2003;57(3):503-12.

56. Fassaert T, Hesselink AE, Verhoeff AP. Acculturation and use of health care services by Turkish and Moroccan migrants: a cross-sectional population-based study. BMC public health. 2009;9(1):332.

57. Green M. Language Barriers and Health of Syrian Refugees in Germany. Am J Public Health. 2017;107(4):486.

58. Sagar PL. Transcultural Nursing Theory and Models, Application in Nursing Education, Practice, and Administration: Springer publishing company; 2011.

59. Hunter-Adams J, Rother H-A. A Qualitative study of language barriers between South African health care providers and cross-border migrants2017. 97 p.

60. Smeekes A, Verkuyten M, Çelebi E, Acartürk C, Onkun S. Social identity continuity and mental health among Syrian refugees in Turkey. Social Psychiatry and Psychiatric Epidemiology. 2017;52(10):1317-24.

61. Wangdahl J, Lytsy P, Martensson L, Westerling R. Health literacy and refugees' experiences of the health examination for asylum seekers - a Swedish cross-sectional study. BMC public health. 2015;15:1162.

62. Bensing J. Doctor-patient communication and the quality of care. Social science & medicine (1982). 1991;32(11):1301-10.

63. Sarver J, Baker DW. Effect of Language Barriers on Follow-up Appointments After an Emergency Department Visit. Journal of General Internal Medicine. 2000;15(4):256-64.

64. Perez-Stable EJ, Napoles-Springer A, Miramontes JM. The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. Medical care. 1997;35(12):1212-9.

65. Bellamy K, Ostini R, Martini N, Kairuz T. Perspectives of resettled African refugees on accessing medicines and pharmacy services in Queensland, Australia. The International journal of pharmacy practice. 2016.

66. Abate N, Chandalia M. The impact of ethnicity on type 2 diabetes. Journal of diabetes and its complications. 2003;17(1):39-58.

67. C. M. R. Sulaiman-Hill SCT. “Thinking Too Much”: Psychological distress, sources of stress and coping strategies of resettled Afghan and Kurdish refugees. Muslim Mental Health. 2012;VI(2).

68. Beiser M, Hou F. Language acquisition, unemployment and depressive disorder among Southeast Asian refugees: a 10-year study. Social science & medicine (1982). 2001;53(10):1321-34.

69. Alderliesten ME, Vrijkotte TG, van der Wal MF, Bonsel GJ. Late start of antenatal care among ethnic minorities in a large cohort of pregnant women. BJOG : an international journal of obstetrics and gynaecology. 2007;114(10):1232-9.

70. Hemingway H, Saunders D, Parsons L. Social class, spoken language and pattern of care as determinants of continuity of carer in maternity services in east London. Journal of public health medicine. 1997;19(2):156-61.

71. Cheng IH, Drillich A, Schattner P. Refugee experiences of general practice in countries of resettlement: a literature review. The British journal of general practice : the journal of the Royal College of General Practitioners. 2015;65(632):e171-6.

72. Shah SM, Ayash C, Pharaon NA, Gany FM. Arab American immigrants in New York: health care and cancer knowledge, attitudes, and beliefs. Journal of immigrant and minority health. 2008;10(5):429-36.

73. Asgary R, Segar N. Barriers to health care access among refugee asylum seekers. Journal of health care for the poor and underserved. 2011;22(2):506-22.

74. Palmer D, Ward K. 'Lost': listening to the voices and mental health needs of forced migrants in London. Medicine, conflict, and survival. 2007;23(3):198-212.

75. O'Donnell CA, Higgins M, Chauhan R, Mullen K. "They think we're OK and we know we're not". A qualitative study of asylum seekers' access, knowledge and views to health care in the UK. BMC health services research. 2007;7:75.

76. Carroll J, Epstein R, Fiscella K, Gipson T, Volpe E, Jean-Pierre P. Caring for Somali women: implications for clinician-patient communication. Patient education and counseling. 2007;66(3):337-45.

77. Bhatia R, Wallace P. Experiences of refugees and asylum seekers in general practice: a qualitative study. BMC Family Practice. 2007;8(1):48.

78. Ahmed A, Bowen A, Feng CX. Maternal depression in Syrian refugee women recently moved to Canada: a preliminary study. BMC pregnancy and childbirth. 2017;17(1):240.

79. Gormez V, Kılıç HN, Orengul AC, Demir MN, Demirlikan Ş, Demirbaş S, et al. Psychopathology and Associated Risk Factors Among Forcibly Displaced Syrian Children and Adolescents. Journal of immigrant and minority health. 2017.

80. Morales LS, Cunningham WE, Brown JA, Liu H, Hays RD. Are Latinos Less Satisfied with Communication by Health Care Providers? Journal of General Internal Medicine. 1999;14(7):409-17.

81. JOANNE STIMPSON KM. Cultural Perceptions of Finnish Nursing Students Regarding People and Nurses of the United States: A Pilot Study. Transcultural Nursing. 2005;16(1):64-70.

82. Jirwe M, Gerrish K, Emami A. Student nurses' experiences of communication in cross-cultural care encounters. Scandinavian Journal of Caring Sciences. 2010;24(3):436-44.

83. Mitchell P, Malak A, Small D. Bilingual professionals in community mental health services. The Australian and New Zealand journal of psychiatry. 1998;32(3):424-33.

84. Riddick S. Improving Access for Limited English-Speaking Consumers: A Review of Strategies in Health Care Settings. Health Care for the Poor and Underserved. 1998;9 Supplement:S40-S61.

85. Hornberger J, Itakura H, Wilson SR. Bridging language and cultural barriers between physicians and patients. Public health reports (Washington, DC : 1974). 1997;112(5):410-7.

86. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature. Health Services Research. 2007;42(2):727-54.

87. Karliner LS, Perez-Stable EJ, Gildengorin G. The language divide. The importance of training in the use of interpreters for outpatient practice. J Gen Intern Med. 2004;19(2):175-83.

88. Brach C, Fraser I, Paez K. Crossing The Language Chasm: An in-depth analysis of what language-assistance programs look like in practice. Health affairs (Project Hope). 2005;24(2):424-34.

89. Flores G. The impact of medical interpreter services on the quality of health care: a systematic review. Med Care Res Rev. 2005;62(3):255-99.

90. Hassan G, Ventevogel P, Jefee-Bahloul H, Barkil-Oteo A, Kirmayer LJ. Mental health and psychosocial wellbeing of Syrians affected by armed conflict. Epidemiology and Psychiatric Sciences. 2016;25(2):129-41.

91. Jefee-Bahloul H, Moustafa MK, Shebl FM, Barkil-Oteo A. Pilot assessment and survey of Syrian refugees' psychological stress and openness to referral for telepsychiatry (PASSPORT Study). Telemedicine journal and e-health : the official journal of the American Telemedicine Association. 2014;20(10):977-9.

92. O'Mahony JM, Donnelly TT, Raffin Bouchal S, Este D. Cultural background and socioeconomic influence of immigrant and refugee women coping with postpartum depression. Journal of immigrant and minority health. 2013;15(2):300-14.

93. Cheng IH, Vasi S, Wahidi S, Russell G. Rites of passage: improving refugee access to general practice services. Australian family physician. 2015;44(7):503-7.

94. Care TNCoIiH. GUIDE TO INITIAL ASSESSMENT OF INTERPRETER QUALIFICATIONS2001.

95. Gaziantep WHOROftEWFOi. Turkey: Syria crisis. 2016.

96. Presidency A-RoTPMDaEM. Syrian Refugees in Turkey, Field Survey results. 2013.

97. Kilic SP, Besen DB, Tokem Y, Fadiloglu C, Karadag G. An analysis of the cultural problems encountered during caregiving by the nurses working in two different regions of Turkey. International journal of nursing practice. 2014;20(3):310-9.

98. Sevinc S. Nurses' Experiences in a Turkish Internal Medicine Clinic With Syrian Refugees. Journal of transcultural nursing : official journal of the Transcultural Nursing Society. 2017:1043659617711502.

99. Sağlık Bakanlığı. 2016 Yılı Değerlendirme Toplantısı [Internet]: 2017 [Access date 01.09.2017]. Available from: https://www.saglik.gov.tr/TR,12813/2016-yili-degerlendirme-toplantisi.html.

100. İdaresi G. 2016 goc raporu. Web page; 2016.

101. ILO Regional Office for Arab States US. National Study on Worst Forms of Child Labour in Syria2012 March 2012.

8. APPENDIX

Appendix-1: Confirmation Form (Turkish and Arabic)

Anket Formu

Sayın katılımcı,

Suriyeli sığınmacıların sağlık hizmetine erişirken yaşadıkları dil sorunun boyutlarını ve bu süreçte kullandıkları baş etme yöntemlerini incelemek içini bir çalışma yürütmekteyiz. Bu çalışma Hacettepe Üniversitesi Halk Sağlığı Anabilim dalı tarafından yürütülmektedir.

Sizlerin sağlık sistemlerinde dil sorunu ile ilgili fikirlerinizi ve deneyimlerinizi öğrenmek istiyoruz. Bu nedenle sizlere bir anket uygulayacağız. Anket uygulaması için Göç İdaresi Genel Müdürlüğü ve diğer kurumlardan izinler alınmıştır. Söz konusu izinleri incelemek isterseniz görüşmeciye bunu belirtmeniz yeterlidir. Katılımınız tamamen gönüllük esasına bağlıdır, katılıp katılmamakta serbestsiniz. Kendinizi rahat hissetmediğinizde veya istediğiniz zaman çalışmadan ayrılabilirsiniz. Burada konuşulan tüm bilgiler anonim kalacaktır. Sizin isminize veya adresinize ihtiyacımız yok. Analiz sırasında da sadece anketinize verilecek bir numara kullanılacaktır. Çalışma ile ilgili bilgi almak istediğinizde Hacettepe Üniversitesi Halk Sağlığı Enstitüsünde görevli Yard. Doç. Dr Sıdıka TEKELİ YEŞİL'e 0 312 3053141 numaralı telefondan veya sidika.tekeliyesil@hacettepe.edu.tr *adresinden ulaşabilirsiniz.*

Katılımınız ve işbirliğiniz için teşekkür ederiz.

Kararı işaretleyin.

Katılmayı Kabul ediyorum.	***Katılmayı Kabul etmiyorum.***
☐	☐

Lütfen katılmama nedenini belirtiniz:

Tarih:

İmza

استبيان

نحن نقوم بدراسة من اجل معاينة مشاكل اللغة للاجئين السوريين الذين يستطيعون الوصول إلى الخدمات الصحية في انقرة والطرق التي يتبعوها للتغلب على هذه المشاكل. هذه الدراسة تقوم بها جامعة هاجيتبه, قسم الصحة العامة.

نحن نريد تعلم تجاربكم وافكاركم حول مشكلة اللغة في الانظمة الصحية. لهذا السبب سنقدم هذا الاستبيان لكم. من اجل القيام بهذا الاستبيان اخذت جميع الاذون اللازمة من دائرة الهجرة. في حال اردتم رؤيتها بامكانكم ان تطلبوا ذلك من الشخص الذي يقدم الاستبيان لكم. الانضمام للاستبيان هو عمل تطوعي, انتم احرار في الانضمام او عدم الانضمام. بأمكانكم ان تتركوا الدراسة في حال لم ترتاحوا لها او في اي وقت تريدون. جميع المعلومات ستبقى سرية. نحن لسنا بحاجة لمعرفة اسمكم او عنوانكم. خلال عملية تحليل البيانات سيعطى للاستبيانات ارقام فقط.

في حال اردتم معرفة اي تفاصيل اضافية عن الدراسة بامكانكم الاتصال مع الدكتورة صديقة تيكيل يشيل بجامعة هاجيتبه, معهد الصحة العامة.

من خلال الهاتف: 0312 3053141

او البريد الالكتروني: sidika.tekeliyesil@hacettepe.edu.tr

شكرا لكم من اجل تعاونكم وانضمامكم

يرجى الاشارة على قراركم

اريد الانضمام ☐ ***لا اريد الانضمام*** ☐

يرجى تحديد سبب عدم القبول:

التاريخ:

التوقيع:

APPENDIX-2: Questionnaire (Turkish and Arabic)

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1. cinsiyet: (1) Erkek (2) Kadın

1. الجنس: (1) ذكر (2) انثى

2. Doğum tarihiniz (gün/ay/yıl) ……/……./……..

2. تاريخ الميلاد (يوم \ شهر \ عام) : .....\.....\.....

3. Medeni durumunuz nedir? (1) Evli, resmi nikâhlı (2) Evli, sadece dini nikâhlı

(3) Bekâr (4) Boşanmış/ayrı yaşıyor (5) Dul (6) Diğer …….

3. ما هي حالتك المدنية : (1) متزوج بعقد رسمي (2) متزوج بعقد ديني فقط (3) اعزب

(4) مطلق (5) ارمل (6) غير ذلك

4. Çocuğunuz var mı? (1) Hayır (2) Evet (sayısını belirtiniz) ……..

4. هل لديك اطفال ؟ (1) لا (2) نعم . في حال الاجابة بنعم , كم عددهم؟ .....

5. Çocuklarınız kaç yaşında? ……..

5. كم عمر اطفالك ؟ .....

6. Çocuklarınız sizinle yaşıyor mu?

(1) Evet, kaç kişi?..... (2) Hayır, kaç kişi? ……..

6. هل اطفالك يسكنون معك؟ (1) نعم , كم شخص ؟ ..... (2) لا, كم شخص ؟ .....

7. En son hangi okulu bitirdiniz (1) Okur- yazar değil, herhangi bir okul bitirmemiş

(2) Okuryazar, herhangi bir okul bitirmemiş (3) İlkokul mezunu (4) Ortaokul mezunu

(5) Lise mezunu (6) Üniversite/Yüksekokul mezunu

7. ما هي اخر مرحلة دراسية انهيتها ؟ (1) لا يقرا ولا يكتب ولم ينهي المدرسة

(2) اعرف القراءة والكتابة ولكن لم انهي المدرسة (3) المدرسة الابتدائية (4) المدرسة الاعدادية

(5) المدرسة الثانوية (6) جامعة/ معهد

8. Suriye'de yaşadığınız yerleşim yerini belirtiniz? (1) Köy (2) Kasaba (3) İlçe merkez

(4) İl merkez (5) Diğer (belirtiniz)……

8. ما هو المكان الذي كنت تعيش فيه في سوريا ؟ (1) ضيعة (2) ناحية (3) في مركز بلدة

(4) في مركز المدينة (5) غير ذلك , حدده .....

9. Türkiye'ye ne zaman geldiniz? ……/……/……(gün/ay/yıl)

9. متى جئت الى تركيا ؟ (يوم / شهر / عام) : .....\.....\.....

10. Türkiye’de ya da gittiğiniz başka ülkelerde hiç sığınma kampında kaldınız mı?

(1) Hayır (2) Evet (süresini belirtiniz) …… ay

10. هل اقمت في مخيم لجوء من قبل في تركيا او في أي دولة أخرى (1) لا (2) نعم

في حال الاجابة بنعم حدد المدة بالاشهر ..... شهر

11. Evde en çok hangi dil konuşulur? (1) Arapça (2) Kürtçe (3) Türkçe/Türkmence

(4) Diğer (belirtiniz) ……. (5) Yanıt vermek istemiyorum.

11. ما هي اللغة التي تتكلموها في المنزل؟ (1) العربية (2) الكردية (3) التركية/ التركمانية

(4) غير ذلك , حددها : ..... (5) لا أريد الإجابة

12.Türkçe biliyor veya öğreniyor musunuz? (1) Evet biliyorum (2) Evet öğreniyorum

(3) hiç bilmiyorum. (hiç bilmiyorsa 15. Soruyla devam ediniz)

12. هل تتكلم او تتعلم اللغة التركية ؟ (1) نعم اتكلم (2) نعم اتعلم (3) لا اعرف ابدا (في حال كان لا يعرف اكمل من السؤال 15)

13. Nerede Türkçe öğrendiniz? (1) İş yerinde (2) ücretsiz kursta (3)özel dershane

(4) sosyal ilişkilerle (5) diğer ……..

13. أين تعلمت اللغة التركية؟ (1) في العمل (2) دورة مجانية (3) دورة خاصة (4) العلاقات الاجتماعية

(5) غير ذلك .....

14. Ana diliniz dışında bildiğiniz dilleri ve ne düzeyde bildiğinizi belirtiniz (1: Hiç yok, 2: kötü, 3: orta, 4: iyi, 5: çok iyi).

Diller

a. ……

b. ……

14. حدد اللغات التي تعرفها ما عدا لغتك الام مع تحديد مستواها: (1: لا اعرف 2: سيء 3: وسط 4: جيد 5: جيد جدا)

اللغة

أ-.....

بـ - .....

15. Halen gelir getiren bir işte çalışıyor musunuz? (1) Hayır (18. sorudan devam ediniz)

(2) Evet, düzenli işim var (3) Evet, geçici işlerde çalışıyorum

15. هل تعمل حاليا في وظيفة مدفوعة الأجر؟ (1) لا (إنتقل إلى السؤال رقم 18.)

(2) نعم، لدي وظيفة منتظمة (3) نعم، وأنا أعمل في وظائف مؤقتة

16. Ne iş yapıyorsunuz? ……..

16. ماذا تعمل ؟ .....

17. Şu anda ailenizin ekonomik durumunu nasıl değerlendiriyorsunuz?

(1) Çok iyi (2) İyi (3) Orta (4) Kötü (5) Çok kötü

17. كيف تقيَم الوضع الإقتصادي لعائلتك حاليا ؟

(1) جيد جدا (2) جيد (3) متوسط (4) سيئ (5) سيئ جدا

18. Şu anda ailenizin ekonomik durumunu çevrenizdeki ailelerle karşılaştırttığınızda nasıl görüyorsunuz?

(1) Çevremize göre çok iyi (2) Çevremize göre iy (3) Çevremize göre normal

(4) Çevremize göre kötü (5) Çevremize göre çok kötü

18. بالمقارنة مع العائلات القريبة منك, كيف تقيَم وضع عائلتك الاقتصادي؟

(1) جيد جدا (2) جيد (3) عادي (4) سيئ (5) سيئ جد

19. Suriye'de iken bir işte çalışıyor muydunuz? (1) Hayır

(2) Düzenli işim vardı (belirtiniz ……) (3) Evet, geçici işlerde çalışırdım

(4) Düzenli gelirim yoktu, çiftçiydim

19. هل كنت تعمل عندما كنت في سوريا؟

(1) لا (2) كان لدي عمل منتظم (أذكره .....)

(3) نعم, عملت في وظائف مؤقتة (4) لم يكن لدي دخل منتظم, عملت كمزارع

20. Suriye'de bulunduğunuz zaman ailenizin ekonomik durumu nasıldı?

(1) Çok iyi (2)İyi (3) Orta (4) Kötü (5) Çok kötü

20. كيف كان الوضع الاقتصادي لأسرتك عندما كنت في سوريا؟

(1) جيد جدا (2) جيد (3) متوسط (4) ضعيف (5) سيئ جدا

21. Türkiye'de hiç Türk arkadaşınız veya komşunuz var mı?

(1) Yok (25. sorudan devam ediniz) (2) Var (kaç kişi ……)

21. هل لديك أي صديق او جار تركي في تركيا ؟

(1) لا يوجد (إنتقل الي السؤال رقم 25.) (2) نعم يوجد (كم شخص .....)

22. Türk arkadaşlarınız ve komşularınız ile ilişkileriniz nasıl?

(1) Çok kötü (2) Kötü (3) Orta (4) İyi (5) Çok iyi

22. كيف تقييم علاقتك بأصدقائك وجيرانك الاتراك ؟

(1) سيئة جدا (2) سيئة (3) متوسطة (4) علاقة جيدة (5) علاقة جيدة جدا

23. Dil konusunda ihtiyaç duyduğunuzda Türk arkadaşlarınız size yardım ediyor mu? (1) Evet

(2) Hayır (3) Bazen

23. هل يساعدك اصدقاء الاتراك في موضوع اللغة عندما تحتاجهم ؟ (1) نعم (2) لا (3) احيانا

24. Türk kültür ve geleneklerini sizinkine göre nasıl değerlendiriyorsunuz? (1) Biraz farklı

(2) Çok farklı (3) Benzer (4) Tamamen aynı (5) Fikrim yok

24. كيف تقييم الثقافة التركية في نظرك ؟

(1) مختلفة قليلا (2) مختلفة جدا (3) مشابهة (4) مشابهة تماما (5) لا أدري

25. Türkçe konuşabilen akrabalarınız var mı?

(1) Yok (29. sorudan devam ediniz) (2) Var

25. هل لديك اقارب يتكلمون اللغة التركية ؟

(1) لا يوجد (إنتقل الي السؤال رقم 29.) (2) نعم

26. Türkçe konuşabilen akrabalarınızdan, birinci derece akrabanız olan kaç kişi vardır? …….

İkinci derece akrabanız olan kaç kişi vardır? …….

26. من اقاربك الذين يتكلمون اللغة التركية, كم شخص هو قريب من الدرجة الاولى؟ .....

كم شخص هو قريب من الدرجة الثانية ؟ .....

27. Dil konusunda İhtiyaç duyduğunuzda akrabalarınız size yardım ediyor mu? (1) Evet

(2) Hayır (3) Bazen

27. هل يساعدك اقربائك في موضوع اللغة عندما تحتاجهم ؟ ؟ (1) نعم (2) لا (3) احيانا

28. Genel sağlık durumunuz hakkında aşağıdaki tanımlardan hangisi doğrudur?

(1) Çok iyi (2) İyi (3) Orta (fena değil) (4) Kötü

28. أي التعريفات الآتية هي الأصح عن وضعك الصحي العام؟

(1)جيد جداً (2) جيد (3) متوسط (لا بأس) (4) سيئ

29. Doktorun teşhis koyduğu bedensel veya ruhsal bir hastalığınız var mı?

(1) Hayır (2) Evet, Nedir?

29.هل لديك مرض عضوي او نفسي تم تشخيصه بواسطة الطبيب ؟

(1) لا (2) نعم, ماهو ؟

30. Suriyeli mültecilerin en önemli üç sağlık sorunu sizce nedir?

30. ما هي اهم ثلاثة مشاكل صحية تواجه اللاجئين السوريين في نظرك؟

31. Türkiye'de genel olarak sağlık hizmetlerine erişebiliyor musunuz?

(1) Evet (33e geçiniz) (2) Hizmet kullanmam gerekmedi (33 e geçiniz) (3) Hayır

31. هل يمكنك الوصول إلى الخدمات الصحية في تركيا عموما ؟

(1) نعم (إذهب السؤال رقم 33) (2) لم تدع الضرورة (إذهب السؤال رقم 33) (3) لا

31a. Aşağıdaki faktörlerin hangisi en fazla sağlık hizmetlerine erişiminizi engelledi?

a. Dil problemleri
b. Ulaşım problemleri
c. Sağlık hizmetlerinin veya ulaşımın pahalı olması
d. Damgalama endişesi, utanma
e. Verilen sağlık hizmetlerinin faydalı olmayacağı düşüncesi
f. Sağlık personelinin uygun olmayan davranışı
g. Sağlık hizmetini nasıl ve nerede alacağı ile ilgili bilgisinin olmaması
h. Diğer (belirtiniz)……

31أ. اي من العوامل أدناه اعاقت وصولك للخدمات الصحية اكثر؟

أ.مشاكل اللغة

ب.مشاكل الوصول

ج.غلاء الخدمة الصحية والمواصلات

د.القلق ، النسيان

ه.إعتقاد أن الخدمة الصحية المقدمة لن تكن مفيدة

و.تعامل الكادر الصحي غير المقبول

ز.عدم المعرفة بكيفية ومكان الحصول على الخدمة الصحية

ح.أخرى (وضح)

32. Türkiye'de sağlık hizmeti ihtiyaçlarınız için en sık hangi kuruluşlara başvuruyorsunuz?

(1) Aile hekimi (2) Devlet hastaneleri (3) Özel hastaneler

(4) Üniversite hastaneleri (5) Diğer (belirtiniz …..……

(6) Hizmet kullanmam gerekmedi

32.ماهي المؤسسات التي تقوم بالتسجيل فيها غالباً في تركيا بسبب إحتياجك للخدمة الصحية ؟

(1) طبيب الأسرة (2) المستشفيات الحكومية (3) المستشفيات الخاصة (4) المستشفيات البحثية والتعليمية

(5) أخرى (وضح) (6) لم تدع الضرورة لذلك

33. Sağlık hizmetlerine erişimde dil konusu sizi nasıl etkiliyor?

(Hiç etkilemiyorsa soru 39'ya geçiniz). (1) Hiçbir olumsuz etkisi olmuyor

(2) Kısmen etkiliyor (3) Çok olumsuz etkisi oluyor

33. كيف يؤثر عليكم موضوع اللغة في الوصول للخدمات الصحية؟ (في حال لا يؤثر ابدا اذهب للسؤال 39)

(1) لا يوجد له اي تاثير سلبي (2) يؤثر قليلا (3) يؤثر بشكل سلبي كثيرا.

34. Dil konusuyla baş etmek için ne tür yöntemler kullanıyorsunuz?

(1) Hastanenin tercümanı (2) Özel Tercüman

(3) Telefon aracılığı ile tercüman (4) Arkadaşlarınız yardımı

(5) akrabaların yardımı (6) diğer (belirtiniz) ……..

34. ماذا تستخدم من اجل حل مشكلة اللغة ؟ (1) مترجم المشفى (2) مترجم خاص (3) مترجم من خلال الهاتف

(4) مساعدة الاصدقاء (5) مساعدة الاقرباء (6) أخرى (حدد) .....

35 En çok hangisinin etkili olduğunu düşünüyorsunuz?

(1) Hastanenin tercümanı (2) Özel Tercüman

(3) Telefon aracılığı ile tercüman (4) Arkadaşlarınızın yardımı

(5) Akrabaların yardımı (6) Diğer (belirtiniz)…….

35. أي واحدة تعتقد انها الاكثر تاثيرا ؟ (1) مترجم المشفى (2) مترجم خاص

(3) مترجم من خلال الهاتف (4) مساعدة الاصدقاء

(5) مساعدة الاقرباء (6) أخرى (حدد) .....

36. . En son sağlık hizmeti aldığınızda yukarıda belirtiğiniz yönetimlerden hangisini kullandınız?

(1) Hastanenin tercümanı (2) Özel Tercüman

(3) Telefon aracılığı ile tercüman (4) Arkadaşlarınız yardımı

(5) Akrabaların yardımı (6) Diğer (belirtiniz)…….

36. في اخر مرة ذهبت فيها اي واحدة استخدمت من الطرق المبينة في الاعلى ؟

(1) مترجم المشفى (2) مترجم خاص (3) مترجم من خلال الهاتف (4) مساعدة الاصدقاء

(5) مساعدة الاقرباء (6) أخرى (حدد) .....

37. En son sağlık hizmeti aldığınızda kullandığınız yöntem etkili oldu mu?

(1) Evet (2) Hayır (3) Kısmen

37. هل كانت فعالة الطريقة التي استخدمتوها في اخر زيارة لكم للمؤسسة الصحية ؟

(1) نعم (2) لا (3) قليلا

38. Türkiye'de bulunduğunuz sürece sağlık hizmetine ihtiyaç duymanıza rağmen dil sorunundan dolayı bir sağlık kuruluşuna başvurmadığınız bir durum oldu mu?

(1) Evet (2) Hayır (3) Hatırlamıyorum

38. هل سبق ولم تذهبوا الى المؤسسات الصحية على الرغم من حاجتكم لتلقي الخدمات الصحية بسبب مشكلة اللغة خلال فترة تواجدكم في تركيا؟

(1) نعم (2) لا (3) لا اتذكر

38.a Eğer evetse ne sıklıkla böyle bir durum yaşadınız?

(1) En az bir defa (2) Bir kaç defa (3) Sık sık (4) Her zaman

38.أ. في حال الاجابة بنعم, كم مرة حدثت هذه الحالة ؟

(1) على الاقل مرة واحدة (2) بضع مرات (3) غالبا (4) دائما

APPENDIX-3: Hacettepe University's Ethical Committee's Permission

T.C.
HACETTEPE ÜNİVERSİTESİ
Girişimsel Olmayan Klinik Araştırmalar Etik Kurulu

Sayı : 16969557 – 539
Konu : ARAŞTIRMA PROJESİ DEĞERLENDİRME RAPORU

Toplantı Tarihi : 4 NİSAN 2017 SALI
Toplantı No : 2017/09
Proje No : GO 17/230 (Değerlendirme Tarihi: 14.03.2017)
Karar No : GO 17/230- 03

Üniversitemiz Halk Sağlığı Enstitüsü öğretim üyelerinden Yrd. Doç. Dr. Sıdıka Tekeli YEŞİL' in sorumlu araştırmacı olduğu ve Ecz. Reshed ABOHALAKA' nın yüksek lisans tezi olan, GO 17/230 kayıt numaralı, ***"Ankara'da Yaşayan Suriyeli Sığınmacıların Sağlık Hizmetine Erişirken Yaşadıkları Dil Sorunu ve Bununla İlgili Kullandıkları Baş Etme Yöntemlerinin İncelenmesi"*** başlıklı proje önerisi araştırmanın gerekçe, amaç, yaklaşım ve yöntemleri dikkate alınarak incelenmiş olup, idari izinlerin tamamlanması kaydı ile etik açıdan uygun bulunmuştur.

1.Prof. Dr. Nurten AKARSU (Başkan)
2. Prof. Dr. Sevda F. MÜFTÜOĞLU (Üye)
3. Prof. Dr. M. Yıldırım SARA (Üye)
4. Prof. Dr. Necdet SAĞLAM (Üye)
5. Prof. Dr. Hatice Doğan BUZOĞLU (Üye)
6. Prof. Dr. R. Köksal ÖZGÜL (Üye)
7. Prof. Dr. Ayşe Lale DOĞAN (Üye)
İZİNLİ
8. Prof. Dr. Elmas Ebru YALÇIN (Üye)
9. Prof. Dr. Mintaze Kerem GÜNEL (Üye)
10 Prof. Dr. Oya Nuran EMİROĞLU (Üye)
11 Yrd. Doç. Dr. Özay GÖKÖZ (Üye)
12. Doç. Dr. Gözde GİRGİN (Üye)
13. Doç. Dr. Fatma Visal OKUR (Üye)
14.Yrd. Doç. Dr. Can Ebru KURT (Üye)
İZİNLİ
15. Yrd. Doç. Dr. H. Hüsrev TURNAGÖL (Üye)
16. Öğr. Gör. Dr. Müge DEMİR (Üye)
17. Öğr. Gör. Meltem ŞENGELEN (Üye)
18. Av. Meltem ONURLU (Üye)

Hacettepe Üniversitesi Girişimsel Olmayan Klinik Araştırmalar Etik Kurulu
06100 Sıhhiye-Ankara
Telefon: 0 (312) 305 1082 • Faks: 0 (312) 310 0580 • E-posta: goetik@hacettepe.edu.tr
Ayrıntılı Bilgi için:

APPENDIX-4: Republic of Turkey Ministry of Interior Directorate General of Migration Management's Permission

T.C.
İÇİŞLERİ BAKANLIĞI
Göç İdaresi Genel Müdürlüğü
Göç Politika ve Projeleri Dairesi Başkanlığı

Sayı : 62103649-000- 25767 02/06/2017
Konu : Anket Çalışması İzni

HACETTEPE ÜNİVERSİTESİ
(Rektörlük)

İlgi :22.05.2017 tarihli ve 35853172/150-1951 sayılı yazınız.

İlgide kayıtlı yazınız ile Üniversiteniz yüksek lisans öğrencilerinden Reshed Abohalaka tarafından yürütülen "Ankara'da Yaşayan Suriyeli Sığınmacıların Sağlık Hizmetine Erişirken Yaşadıkları Dil Sorunu ve Bununla İlgili Kullandıkları Baş Etme Yöntemlerinin İncelenmesi" başlıklı tez çalışması kapsamında anket yapılabilmesi için iznimiz talep edilmiştir.

Bilindiği üzere 6458 sayılı Yabancılar ve Uluslararası Koruma Kanununun 94 üncü maddesi gereğince uluslararası koruma başvuru/statü sahibi kişilerin ve 2014/6883 karar sayılı Geçici Koruma Yönetmeliğinin 51 inci maddesinde belirtilen geçici koruma kapsamındaki yabancıların tüm bilgi ve belgelerinde gizlilik esastır. Bu nedenle bahsi geçen kişilere ait kişisel verilerin veya diğer bilgilerin kendisinin veya menşe ülkede yaşayan aile üyelerinin özgürlüğünü ve güvenliğini tehlikeye atabileceğinden dolayı ne menşe ülke yetkilileri ne de üçüncü kişilerle paylaşılmaması; dahası çalışmaya konu kişilerden ve/veya aile üyelerinden adı-soyadı, ikamet adresi, imzası ve benzeri kimlik bilgilerinin istenmemesi; etnik köken, din/mezhep gibi hassas bilgilerin sorulmaması ve görüşme esnasında ses ya da video kaydı alınmaması gerekmektedir.

Bu kapsamda, yukarıda belirtilen hususlara hassasiyet gösterilmesi şartı ile anket çalışmasının yapılmasının uygun bulunduğu hususunda,

Bilgi ve gereğini rica ederim.

Salih BIÇAK
Bakan a.
Genel Müdür Yardımcısı

Lalegül Çamlıca Mahallesi 122. Sokak No:4 Yenimahalle / Ankara
Ayrıntılı bilgi için irtibat: Nilay Belat Karacaoğlu Telefon: (312)422 07 54 Faks: (312)422 09 00
e-posta: gocpolitikalari@goc.gov.tr Elektronik Ağ: http://www.goc.gov.tr

APPENDIX-5: Ankara Provincial Health Directorate's Permission

T.C. Sağlık Bakanlığı
Ankara Sağlık Müdürlüğü

ANKARA İL SAĞLIK MÜDÜRLÜĞÜ - ANKARA İL SAĞLIK MÜDÜRLÜĞÜ
12/10/2017 11:40 - 75252626 - 604.01.02 - E.1509
00054469939

T.C.
ANKARA VALİLİĞİ
İl Sağlık Müdürlüğü
Ankara 1. Bölge Genel Sekreterliği

Sayı : 75252626-604.01.02
Konu : Reshed ABOHALAKA- Araştırma İzni

HACETTEPE ÜNİVERSİTESİ
(Sağlık Bilimleri Enstitüsü Müdürlüğüne)

İlgi : Reshed ABOHALAKA'ın 08/08/2017 tarihli ve 5190 sayılı dilekçesi.

Enstitünüz Halk Sağlığı Ana Bilim Dalı Afetlerde Sağlık Yönetimi programında yüksek lisans öğrencisi olan Reshed ABOHALAKA tarafından yapılması planlanan "Ankara'da Yaşayan Suriyeli Sığınmacıların Sağlık Hizmetine Erişirken Yaşadıkları Dil Sorunu ve Bununla İlgili Kullandıkları Başetme Yöntemlerinin İncelenmesi" konulu tez çalışmasının Müdürlüğümüze bağlı Sağlık Bilimleri Üniversitesi Türkiye Yüksek İhtisas Eğitim ve Araştırma Hastanesi'nde ve Sağlık Bilimleri Üniversitesi Ankara Numune Eğitim ve Araştırma Hastanesi'nde yapılmasına ilişkin Hastane Yöneticiliği görüş yazısı ekte gönderilmiştir.

Tez çalışmasının onay yazısıyla birlikte Sağlık Bilimleri Üniversitesi Türkiye Yüksek İhtisas Eğitim ve Araştırma Hastanesi ve Sağlık Bilimleri Üniversitesi Ankara Numune Eğitim ve Araştırma Hastanesi' nin Ar-Ge Birimine başvurarak başlatılması, ilgili sağlık tesisinde hizmeti aksatmayacak şekilde yürütülmesi, araştırmaya katılımın gönüllülük esasına göre yapılması, araştırmanın amacı, yöntemi, kapsamı, süresi, araştırma metodu ve kavramsal çerçevesini açıklayan bilgiler göz önünde bulundurularak yapılması, çalışmanın sonucunun Müdürlüğümüz bilgisi dışında ilan edilmemesi, çalışma sonunda sonuç raporunun Müdürlüğümüze gönderilmesi hususunda;

Bilgilerinizi ve gereğini arz ederim.

Dr. Ali EDİZER
Genel Sekreter a.
İdari Hizmetler Başkanı

Belgenin Aslı
Elektronik İmzalıdır
13.10.2017
Yağmur BAHÇ
V.H.K.İ.

EK: 2 Sayfa

Emrah Mah. General Dr. Tevfik Sağlam Cad. Gülhane Eğitim ve Araştırma Hastane Külliyesi İçi 06010 Etlik/ANKARA
Faks No:0312 311 63 64
e-Posta:tuba.akca@saglik.gov.tr İnt.Adresi: http://ankara1bolge.khb.saglik.gov.tr/
Bilgi için:Tuba AKÇA
Unvan:HEMŞİRE
Telefon No:+90 312 306 37 20

APPENDIX-6: Numune Training and Research Hospital's Permission

T.C.
ANKARA VALİLİĞİ
İL SAĞLIK MÜDÜRLÜĞÜ
SBÜ Ankara Numune Eğitim Ve Araştırma Hastanesi

Sayı : 20796219-604.01.02
Konu : araştıma izni

ANKARA İLİ 1. BÖLGE KAMU HASTANELERİ BİRLİĞİ GENEL SEKRETERLİĞİ
(GEÇİCİ BİRİM)

İlgi : 09.08.2017 tarihli ve E.12458 sayılı yazınız

Hacettepe Üniversitesi Sağlık Bilimleri Enstitüsü yüksek lisans öğrencisi Reshed Abohalaka'nın ***"Ankara'da yaşayan Suriyeli sığınmacıların sağlık hizmetine erişirken yaşadıkları dil sorunu ve bununla ilgili kullandıkları baş etme yöntemlerinin incelenmesi"*** konulu tez çalışmasını hastanemizde uygulama talebiniz, Tuek Değerlendirme Komisyonu tarafından değerlendirilmiş ve bilimsel açıdan uygulanabilir olduğuna oy birliği ile karar verilmiştir.

Bilgilerinize arz ederizirsiniz.

Op.Dr.Özlem C. BAYRAMOĞLU
Hastane Yönetici a.
Başhekim Yrd.

Ankara Numune Eğitim ve Araştırma Hastanesi
Faks No:
e-Posta:emine.kadioglu2@saglik.gov.tr İnt.Adresi: emine.kadioglu2@saglik.gov.tr
Bilgi için:Emine KADIOĞLU
Unvan:Veri Hazırlama ve Kontrol İşlt.
Telefon No:0 312 508 51 58

APPENDIX-7: Ankara Training and Research Hospital's Permission

T.C.
SAĞLIK BAKANLIĞI
Türkiye Kamu Hastaneleri Kurumu
Ankara 1. Bölge Kamu Hastaneleri Birliği Genel Sekreterliği
Sağlık Bilimleri Üniversitesi Ankara Eğitim Ve Araştırma Hastanesi

Sayı : 93471371-805.99
Konu : Reshed ABOHALAKA - Araştırma İzni

ANKARA 1. BÖLGE KAMU HASTANELERİ BİRLİĞİ GENEL SEKRETERLİĞİNE

İlgi : 09/08/2017 tarihli ve 51700877-604.01.02-12458 sayılı yazınız.

Hacettepe Üniversitesi Sağlık Bilimleri Enstitüsü yüksek lisans öğrencisi Reshed ABOHALAKA' nın " Ankara' da Yaşayan Suriyeli Sığınmacıların Sağlık Hizmetine Erişirken Yaşadıkları Dil Sorunu ve Bununla İlgili Kullandıkları Baş Etme Yöntemlerinin İncelenmesi" konulu tez çalışması hakkında, hastanemizde anket yapma talebi tarafımızca uygun görülmüştür.

Bilgilerinize arz ederim.

e-imzalıdır.
Doç.Dr.Mevlüt Recep PEKCİCİ
Hastane Yöneticisi V.

SBÜ Ankara Eğitim ve Araştırma Hastanesi Şükriye Mah. Ulucanlar Cd. No:89 Altındağ/ANKARA
Faks No:
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Bilgi için:Ahmet DEMİRLENDİ
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9. CURRICULUM VITAE

Reshed Abohalaka, M.H.A

Ankara, Turkey
+90 (553) 1821090
Reshed.abohalaka@hacettepe.edu.tr
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Education

University of Hacettepe Institute of Health Sciences **Sep 2015-May 2018**
Master Degree in Health Management in Disasters

University of Hacettepe Institute of Health Sciences **Feb 2016-Aug 2018**
Master Degree in Pharmacology

University of Aleppo, School of Pharmacy **Sep 2009-Aug 2014**
Bachelor of Pharmacy and Pharmaceutical Chemistry

Research

University of Hacettepe Department of Public Health **Sep 2016-Apr 2018**
Researcher, Language barrier among Syrian Refugees

University of Hacettepe Department of Pharmacology **Sep 2016-Jul 2018**
Researcher, Endocannabinoids and airways inflammation

University of Hacettepe Department of Public Health **Sep 2016-Dec 2016**
Research Assistant, PTSD among Syrian Refugees.

Posters and Presentations

University of Hacettepe Institute of Health Sciences
Pharmacology Department Presentation Session
• Trabzon, October 2017
Analytical Chemistry Department Poster Session
• Erzurum, October 2017

Scholarships and Internships

University of A Coruña International Summer School (ISS)
Refugee Crisis and Contemporary Challenges in Migration Management in Europe Scholarship
• Jul 2018 – Sep 2018
World Health Organization
Refugees Program Mental Health and Psychological Support, Fellowship
• Apr 2018 – Jun 2018
World Health Organization
Preparing Educational Materials for Healthcare Provider Refugees, Fellowship
• Jan 2017 – Jun 2017

University of Hacettepe Institute of Health Sciences
European Union and Turkey Scholarships
- Awarded for the duration of master studies

Grand National Assembly of Turkey
Legislation Concepts, Internship
- Dec 2015 – Jan 2016

Languages

- **Arabic**: Native language
- **Spanish**: Basic proficiency
- **Turkish**: Good working proficiency
- **English**: Good working proficiency