T.C.

REPUBLIC OF TURKEY

HACETTEPE UNIVERSITY

GRADUATE SCHOOL OF HEALTH SCIENCES

THE PERCEPTIONS OF HEALTHCARE PROFESSIONALS SERVING MIGRANT, REFUGEE AND ASYLUM SEEKERS IN THE PRIMARY HEALTHCARE CENTERS OF HATAY, ŞANLIURFA, GAZİANTEP AND İZMİR ABOUT HEALTHCARE PROVISION, AND THEIR LEVEL OF BURNOUT

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MASTER OF SCIENCE THESIS

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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 (Prof Dr Kerim Hakan ALTINTAŞ) and written according to the rules of thesis writing of Hacettepe University Institute of Health Sciences.

Nurtaç KAVUKCU

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ABSTRACT

Kavukcu N., The Perceptions of Healthcare Professionals Serving Migrant, Refugee and Asylum Seekers in the Primary Healthcare Centers of Hatay, Şanlıurfa, Gaziantep and İzmir About Healthcare Provision, and Their Level of Burnout, Hacettepe University Graduate School of Health Sciences, Public Health Department, Master of Science Thesis, Ankara, 2021. Objective: The purpose of this study is to investigate the level of burnout and perceptions of health professionals serving in primary healthcare centers in four provinces in Turkey, namely Gaziantep, Hatay, İzmir, Şanlıurfa, **Method:** The study was conducted in primary healthcare facilities in Gaziantep, Hatay, İzmir and Şanlıurfa. A survey with 85-items was used to collect data for demographic information, perceptions of healthcare professionals regarding their services and burnout. Maslach Burnout Inventory (MBI) was utilized to explore the level of burnout. A total of 236 healthcare professionals completed the survey, out of which 224 responses were used in the analyses. **Results:** The results showed that healthcare professionals serving migrant groups mainly face challenges linked to linguistic barriers. Most of them consider interpreter services to be essential and appreciate the importance of training. Among the three burnout subscales of the Maslach Burnout Inventory (MBI), particularly Emotional Exhaustion (EE) was found to have a relationship with a variety of factors like age, current workplace, training, number of children, profession, year of graduation, duration of work and knowledge of a common language, legal status and culture. Depersonalization (DP) was associated with age and knowledge of a common language, legal status and culture. Finally, Personal Achievment (PA) showed a relationship with the duration of work, gender and knowledge about culture. **Conclusion:** Evidence gathered in this study suggests that healthcare professionals serving migrant groups, particularly the ones working in in Family Health Centers and those with limited professional experience, need to be supported by interventions targeting linguistic and cultural barriers. Capacity building opportunities and effective human resource management in the health facilities need to be ensured for staff welfare and improvement of healthcare services.

Keywords: asylum seeker; challenges; burnout; delivery of health care; health care provider; Maslach Burnout Inventory; refugee

ÖZET

Kavukcu N., Hatay, Şanlıurfa, Gaziantep ve İzmir'deki Birinci Basamak Sağlık Merkezlerinde Göçmen, Mülteci ve Sığınmacılara Hizmet Veren Sağlık Çalışanlarının Tükenmişlik Düzeyleri ve Sağlık Hizmeti Sunumuna İlişkin Algıları, Hacettepe Üniversitesi Sağlık Bilimleri Enstitüsü Halk Sağlığı Ana Bilim Dalı, Yüksek Lisans Tezi, Ankara, 2021. Amaç: Bu çalışmanın amacı, Türkiye'de Gaziantep, Hatay, İzmir ve Şanlıurfa illerinde birinci basamak sağlık merkezlerinde görev yapan sağlık çalışanlarının sağlık hizmeti sunumuna ilişkin tükenmişlik düzeylerini ve algılarını incelemektir. **Yöntem:** Araştırma, Türkiye'de göçmen gruplarının yoğun olduğu Gaziantep, Hatay, İzmir ve Şanlıurfa'daki birinci basamak sağlık kuruluşlarında gerçekleştirilmiştir. Demografik bilgiler, sağlık çalışanlarının hizmetlere ilişkin algıları ile ilgili verileri toplamak amacıyla 85 maddelik bir anket kullanılmıştır. Tükenmişlik düzeyini araştırmak için Maslach Tükenmişlik Ölçeği'nden (MTÖ) yararlanılmıştır. Toplam 236 sağlık çalışanı içinden 224'ünün anket yanıtları analizlerde kullanılmıştır. **Bulgular:** Sonuçlar, sağlık çalışanlarının çoğunlukla dil ve iletişimle ilgili engellerle bağlantılı zorluklarla karşılaştığını göstermiştir. Çoğu katılımcı, tercümanlık hizmetlerinin gerekliliğini ve eğitimin sağlık çalışanları, tercümanlar ve hizmet kullanıcılar için önemli olduğunu vurgulamıştır. Maslach Tükenmişlik Ölçeği'nin (MTÖ) üç tükenmişlik alt ölçeğinden özellikle Duygusal Tükenmişliğin (DT) yaş, mevcut iş yeri, eğitim, çocuk sayısı, meslek, mezuniyet yılı, çalışma süresi, ortak bir dil bilme, yasal statü ve kültür hakkında bilgi sahibi olma gibi çeşitli faktörlerle ilişkisi olduğu ortaya çıkmıştır. Duyarsızlaşma (D), yaş ve ortak bir dil, yasal statü ve kültür hakkında bilgi sahibi olma ile ilişkili bulunmuştur. Son olarak, Kişisel Başarı (KB), çalışma süresi, cinsiyet ve kültür hakkında bilgi sahibi olma ile ilişki göstermiştir. **Sonuç:** Bu çalışma, özellikle Aile Sağlığı Merkezlerinde çalışanlar ve sınırlı mesleki deneyime sahip olan sağlık çalışanlarının dilsel ve kültürel engellerin üstesinden gelmek için hedefe yönelik müdahalelerle desteklenmesi gerektiğini göstermiştir. Çalışan refahı ve sağlık hizmetlerinin iyileştirilmesi için kapasite geliştirme olanakları ve etkin insan kaynakları yönetimi sağlanmalıdır.

Anahtar Kelimeler: Maslach Tükenmişlik Ölçeği; mülteci; sağlık hizmeti sunumu; sağlık hizmeti sağlayıcısı; sığınmacı; tükenmişlik; zorluklar

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ABBREVIATIONS

CDC Centers for Disease Control and Prevention

DP Depersonalization

EE Emotional exhaustion

EU Emergency Units

FHC Family Health Centers

FC Foreigner Clinics

HIV Human Immunodeficiency Virus

ICRC International Committee of the Red Cross

IOM International Office for Migration

MBI Maslach Burnout Inventory

MHC Migrant Health Centers (Migrant Health Training Centers/Strengthened Migrant Health Centers)

NHS National Health System

PA Personal accomplishment

PTSD Post-traumatic Stress disorder

SRH Sexual and reproductive health

TB Tuberculosis

WHO World Health Organization

FIGURES

TABLES

1. INTRODUCTION

1.1 Background of the Study

Migration is an ever-existing phenomenon affecting the lives of more than 244 million people in the world today, constituting over 3% of global population (1). It involves the movement of people from their original settlement to a new location temporarily or permanently for a variety of reasons that might be triggered by pull factors such as job prospects or more education opportunities in a developed country, to push factors like internal conflicts, natural disasters and complex emergencies.

International Office for Migration (IOM) defines migration as "the movement of a person or a group of persons, either across an international border, or within a State". This definition encompasses any movement regardless of its duration and causes, and therefore relates to "migration of refugees, displaced persons, economic migrants, and persons moving for other purposes" (2). A more specific definition; the definition of refugee, on the other hand, describes a refugee as "a person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country" (3). Within the overall migration figures, the number of people forced to move from their homes as refugees, asylum seekers and internally displaced persons reached an unprecedented level with 70.8 million people in 2018. This number is comprised of 25.9 million refugees, 41.3 million internally displaced people and 3.5 million asylum-seekers (4). The recent increase in numbers was mainly due to the persecution, conflicts, violence and human rights violations in the Middle East and North Africa, which has had unparalled forced movements to other countries in the region and Europe. Over one thirds of all refugees in the world (67 %) are the citizens of Syrian Arab Republic (6.7 million), Afghanistan (2.7 million), South Sudan (2.3 million), Myanmar (1.1 million), and Somalia (0.9 million) (4). Syrian Civil War, which started on March 15, 2011, has been one of the major contributors to the displacement of massive refugee populations, increasing the global migration figures extensively. The top recorded host countries in the world are respectively Turkey (3.5 million), Pakistan (1.4 million), Uganda (1.1 million), Sudan (1.07 million), and

Germany (1.06 million) (4). Turkey, the country hosting the largest number of refugees in the world, has received refugees mostly from Syria and Afghanistan.

Migration is a multifaceted concept which requires attention to vulnerabilities created or exacerbated during all phases of migration; pre-flight, flight, reception, settlement and resettlement, especially in the context of forced migration (5). As in many humanitarian crises, health of the uprooted is at the epicenter of all vulnerabilities, and therefore, should be managed thoroughly at social, cultural and policy levels.

The models which have been developed to specify the health effects of migration point out to three ways in which migration can influence health. The first one explains that migrants' health status becomes compatible with the health status of host communities, showing similarities in health indicators. The second states that the stress migrants have to go through during the settlement of a new environment poses great risk to their health. And finally, the third suggests that the health status of migrants is determined by the interplay of the stressors that motivated or forced people to migrate and the stressors that are caused by the settlement process in a host country (6). Although health problems that migrants have do not differ much from those of the rest of the population in the receiving country, the circumstances in the pre-, while- and post-migration periods may worsen the health status of individuals. According to World Health Organization (WHO), common health problems experienced during migration are "accidental injuries, hypothermia, burns, gastrointestinal illnesses, cardiovascular diseases, pregnancy and delivery- related complications, diabetes and hypertension" (7). In the European region, among many health risks which migrants are exposed to during the process of migration, the most common are tuberculosis (TB), Human Immunodeficiency Virus (HIV) infection and viral hepatitis, influenza and other common respiratory infections, vector-borne diseases, water-borne and food-borne diseases and noncommunicable diseases (7).

In terms of non-communicable diseases, forced migrants have difficulty in accessing healthcare services and continuous treatment in the form of regular follow-ups and proper medication. Degradation of living conditions and physical injuries also contribute to the occurrence and worsening of non-communicable diseases (7).

Abuse, sexual assault and violence are also common in the context of forced migration. Forced migrants are usually subject to sexual abuse, occupational illnesses, psychosocial problems, poverty and isolation due to illegal acts such as smuggling and human trafficking, which affects health to a great extent (8).

In most general terms, the obstacles which refugees encounter can be mainly associated with limited access to healthcare both in the country of origin and destination, torture and trauma during migration, and the impact of resettlement (9). A well-founded health response to the uprooted in these health matters urges collective efforts to encourage proper policy making, capacity building and resource mobilization through a country's own means and that of its partners. For many years, receiving countries, most of which are developing countries especially in the context of forced migration, have been developing systems to adjust their healthcare systems to the needs of refugee populations. Many models have been utilized to improve the health status of refugees in different contexts and these models involve a variety of public health interventions ranging from capacity building through the training of healthcare providers and employment of medical interpreters to the establishment of refugee friendly health centers. In all these initiatives, many aspects involving the perspective, view and attitudes of healthcare providers working with refugees seem to have been overlooked or subject to little scrutiny. This study, therefore, focuses on the perceptions and challenges of healthcare providers in the provision of healthcare targeting refugee and migrant populations in order to contribute to the current understanding of healthcare services for refugees.

1.2 The Purpose of the Study

The purpose of this study is to investigate the level of burnout and perceptions of health professionals serving in primary healthcare centers in four provinces in Turkey, namely Gaziantep, Hatay, İzmir, Şanlıurfa, about healthcare provision. It also aims to explore the challenges in service provision and perceived safety risks.

In the short term, the results of the study are expected to reveal some demographic characteristics of the health care professionals serving migrants, refugees and asylum seekers, identify the challenges they experience in service provision, measure their perceived level of burnout, and explore the associations between these

variables, if any. In the long term, it is expected that the outcomes of the study will contribute to the existing knowledge that would be potentially utilized to introduce new regulations that respond to the needs of health professionals as a group receiving little attention in the context of migration and health.

2. REVIEW OF RELATED LITERATURE AND STUDIES

2.1 Challenges of Healthcare Provision

Several articles focus on difficulties, particularly in-service provision when explaining challenges identified with healthcare delivery for migrants and refugees. These challenges can be discussed under the following headings: differences in culture and expectations, language barrier, time constraints, lack of knowledge and skills, and system-related obstacles.

2.1.1 Differences in Culture and Expectations

Cultural competence is central to proper healthcare provision in regular settings, not just relating to refugee context. However, its significance becomes even more obvious and compelling when healthcare is targeted at refugee populations in which beneficiaries mostly share no cultural background and understanding with service providers. Coupled with linguistic barriers, a lack of cultural competence may lead to frustration on the side of provider and inability to access healthcare on the side of user.

Literature reveals many examples of cases in which a lack of cultural competence and humility impedes an appropriate way of communication between providers and patients, resulting in challenges in everyday practice of healthcare providers. In some settings where refugees come from patriarchal cultures, healthcare providers report that they are unable to employ a holistic approach to addressing health problems since any attempt to take detailed medical history could be considered threatening and offensive in these cultures. This causes some undisclosed illnesses like stress and mental disorders, and cases like sexual violence to remain undiagnosed by health providers (10,11). In addition to the difficulties in taking proper medical history, the diagnosis of mental health problems is particularly a challenge because of the stigma about receiving treatment for mental health (12).

Differential understanding of healthcare due to cultural backgrounds is also a major challenge encountered by healthcare providers serving culturally diverse populations in day to-day practice. In a study conducted in Alaska with Hmong refugees it was observed that cross-cultural empathy is a key to proper service provision, and different beliefs of Hmong refugees towards healthcare should be

responded through empathy. To exemplify, one patient was reported not to allow CAT scan during her pregnancy as in her culture, 'spirit' could not be contacted before delivery, or another refugee patient felt uncomfortable with the medication prescribed since it was not "natural" and was unlike what his ancestors used. Hmong refugees also felt that a close relationship with the healthcare provider is vital and diagnosis must involve "touching" rather than just asking questions and listening to a patient (13).

Sexual and reproductive health (SRH) is, not surprisingly, one of the culturally sensitive areas of care that requires attention in refugee and migrant health. There are quite a few studies conducted in Australia that demonstrate the limited utilisation of SRH services by migrant and refugee women due to reasons varying from the cultural incompatibility and irrelevance of the services provided, to the inaccessibility of healthcare due to lack of funding and sources (50, 51, 52, 55). Health professionals reported that they lack the necessary understanding of culture as it relates to SRH services. This leads to disinterest and a feeling of dissatisfaction with their profession, which hinders proper access to services due to disengagement and limited allocation of time for SRH during examinations. To overcome this problem, SRH specific training programmes are reported to be needed (50). Furthermore, the cultural gap between the provider and patient is shown to result from a variety of factors built around the themes such as "being a migrant, gender roles and SRH decision making, and women's experience with the healthcare system" (51). Accordingly, the utilisation of SRH services by refugee and migrant women is highly determined by these women's experiences of SRH services in their countries of origin, the perceptions of gender roles, priorities during resettlement, and effectiveness and relevance of the healthcare systems in receiving countries (51). Attempts to overcome language barrier through interpreters also seems to be influenced by cultural challenges discussed so far. In settings where interpreters are employed to overcome the linguistic barrier, cultural differences remain to cause problems. To exemplify, some migrants and refugees feel uncomfortable with expressing their health problems in the presence of a male interpreter, or interpreters may not be competent and culturally sensitive enough to facilitate communication between healthcare provider and patient, which disrupts SRH services to a great extent. Hence, in addition to health professionals'

training, interventions focusing on the training and preparation of interpreters in SRH before their employment are also important to eliminate the cultural challenges healthcare providers face in delivering services (52).

It is observed that healthcare providers' attitudes towards refugee populations shape the way services are delivered and the extent to which access to healthcare is interrupted. In their day-to-day encounters with refugee patients, health professionals tend to be highly influenced by certain factors that determine their attitudes towards patients. One study, conducted in five hospitals and two primary healthcare centers in Montreal, Canada, suggests that healthcare professionals' personality, age and migration history have a great impact on the development of a positive attitude towards refugees and their entitlements, which create favourable outcomes both for providers and users of services. On the other hand, a lack of close contact with actual refugee groups and an overall negative perception at institutional level result in unfavourable provider attitudes which challenge not only the quality and accessibility of services, but also staff well-being and job satisfaction (54).

Refugees' differing expectations regarding healthcare is also reflected in their prioritization of health and willingness to collaborate with providers. For most refugees, prevention is an unfamiliar concept. Many refugees stated that they demand health care only when they really need it under life-threatening circumstances, which can be attributed to their considerable reliance on hospitals and other facilities prioritizing acute diseases before, during and after migration. Therefore, patient involvement can be a huge challenge for healthcare providers in the provision of preventive healthcare and proper follow-ups for refugee populations (12,13,14).

A study on Somalian immigrant women and their experiences with American doctors provides a good example of how expectations and different understandings can impact health providers' services to culturally diverse groups. To exemplify, the immediacy of diagnosis and prescription in Somalian healthcare system defines what healthcare should or should not be like for Somalian refugees and causes resistance towards a more involving and prolonged service delivery model in the United States (US) where a number of diagnostic tools are used before the onset of treatment. Disappointed by not getting immediate results, a Somalian patient complains by stating that "*At home [in Somalia] when I am sick, I go to the doctor, I get a shot and*

I'm fine. Here they keep telling me, 'Come back' and they're not doing anything. I'm getting worse!" (15). Similarly, medical practices change from culture to culture and the roles expected from providers may not match the roles assigned to health providers in the host country. In a context dominated by Western medical practice which depends on collaboration between patient and provider, refugees feel frustrated by the non-paternalistic approach of healthcare providers. They regard a healthcare provider as someone with authority and expect to be told what to do. Thus, they develop a sense of mistrust in a patient-centered system where this never happens (16).

Different understandings of healthcare could also stem from how the notions of illness and health are conceptualized in various cultures, which is also associated with the level of health literacy among refugees. And it can be said that refugees usually have lower levels of health literacy and limited knowledge on various aspects of healthcare (17).

Health seeking behavior is determined by culture, as well (18). In a study on healthcare providers serving Southeast Asian American immigrant and refugee parents, it was observed that children with mental health problems are taken to families, friends, and spiritual leaders in their community, instead of healthcare providers. Also, it was noted that parents have a tendency to use alternative traditional remedies instead of medical prescriptions (12). In the same fashion, in another study, physicians reported that refugees perceive depression as "sadness" which does not necessarily require formal treatment (19).

Mistrust is another issue connected to culture which manifests itself from the moment providers begin taking medical histories. Many refugee patients feel that they are asked too many questions or have too many blood tests during screenings, even worrying that their blood is being sold (14). Such an attitude certainly hinders providers' obtaining important clinical information and proceeding with the best possible service for refugees.

Cultural norms associated with gender may also pose a challenge to healthcare providers as they shape the health-seeking behavior and expectations of refugee patients. In most Islamic cultures, female patients prefer to see female doctors or nurses due to cultural and religious beliefs. A study with Iraqi, Afghan and Iranian refugees and immigrants in Melbourne, Australia shows that women coming from

these countries feel more comfortable with female doctors, and their husbands also express preference for them to see female providers (20). In emergency care in Sweden, migrant women are reported to have their husbands speak to healthcare providers on their behalf and not want male workers close to them when being undressed (21). Center for Disease Control and Prevention (CDC) report on Syrian Health Profile also addresses the same tendency in the form of a set of tips for clinicians by mentioning the preference of Syrian patients for same-gender healthcare providers and "long hospital gowns for modesty, particularly for female patients" (22).

Despite the high number of training programs available to equip healthcare professionals with a culturally sensitive approach to service provision, they may not fully address the issues and help providers in their practice to offer accessible and appropriate services since culture is a vast phenomenon which cannot be defined in a definite way. This puts the healthcare providers in a complex position where they must manage to 'understand' health issues and empower patients to ask questions, make comments, and express their culturally bound health-related fears, hopes and goals (18). In this regard, cultural competence is certainly a life-long goal as it takes a lot of time and experience with a particular cultural group. Nevertheless, cultural humility and openness can be keys to the initiation of proper communication with culturally diverse groups. Rapport building and active listening prove to be effective ways to gain trust and ensure the appropriateness of services for refugees. Also, increasing the ethnic diversity of healthcare providers whenever possible, providing services through healthcare providers who share the same ethnic background as refugee groups appears to help ensure cultural competence with less time and in a more efficient way (23,24).

2.1.2 Language Barrier

The most apparent and widely discussed challenge in serving refugee populations is perhaps related to communication problems due to language barrier. There is considerable amount of research showing the benefits and drawbacks of relying on relatives or utilizing interpreting services. Using relatives for interpreting is found to "improve patient comfort and facilitate communication", whereas it may also jeopardize the "accuracy of history taking and overall patient-provider interaction"

(14). This view is also supported by the argument that having family members translate for refugee patients does not comply with culturally competent care (25).

The importance of a professional interpreter, even when patients understand the language of the receiving country, was considered by frontline healthcare providers to be necessary in order for them to catch the nuances in the description of symptoms and support patients who have limited language proficiency (23). Medical residents serving Burmese refugees in Indianapolis mentioned the significance of easy availability of professional interpreting services through phone, video or in-person by commenting further on good use of these services with the help of techniques for how to use body language and establish eye-contact with the patient, not the interpreter, during communication (26). The challenges surrounding interpretation services vary according to the modality of interpretation. In-person interpretation is found to facilitate a detailed conversation with the involvement of nonverbal cues and the possibility to support the completion of paperwork before examinations (18). However, ensuring the quality of interpreting services through the employment of trained professionals is certainly a key to avoiding extra burden on healthcare providers (27). An example of poor quality can be observed in situations where interpreters add their own point of view during examinations. As an alternative or complementary to in-person interpreting, phone interpretation could be quite effective due to instantaneous service provision for 24-hours and the protection of women's preservation of anonymity (17, 28). On the other hand, interpretation services through phone are usually found to be "too impersonal" and carry a risk of cut-outs and other technological failures (17). An interesting aspect of interpreting services for refugees is that interpreters mostly find themselves acting in the roles beyond their medical interpreting functions. This is usually because of the compelling needs that many refugees have, which requires that interpreter relationships be based on longer-term care models (29).

As is the case with many other aspects of healthcare provision, interpretation services are not free from the influence of cultural norms. To elaborate, gender roles should be taken into consideration in translation services, as well. In maternity care services in Norway, for example, midwives and public health nurses do not prefer to work with male interpreters since they feel that female interpreters can relate to their

patients more easily. One nurse working in maternity care service expressed this preference by stating "*it is completely wrong to use men, they don't have the words we use in their vocabulary, I once had a male interpreter and it was a disaster*" (28).

In addition, notions that are non-existent in refugees' culture can be hard or even impossible to explain for healthcare providers. A medical director serving Somalian refugee women explained that it was a big challenge for him to tell the patient that she was depressed as there was no equivalent of the word "depression" in their language (23).

Despite the substantial benefits which professional interpreting services in healthcare provision offer, it is emphasized that it does not guarantee high standards of care (10). The reason for this is that usually interpreters only lift communication burden to a certain extent by overcoming the linguistic barrier between patient and provider. However, they may not be able to meet the needs of refugee populations, which are specific to a certain group and go beyond "speaking the same language" (10, 30). Therefore, it is crucial that interpreters be trained in appropriate ways to serve a certain refugee group in a culturally sensitive manner.

2.1.3 Time Constraints

Health visits and consultations create an extremely important opportunity for providers to respond to the healthcare needs of refugees, especially in terms of mental health. Since these vulnerable groups have additional disease burden compared to regular patients, they require specific attention to "past experience of healthcare, exposure to traumatic experiences, language and cultural differences" before and during appointments (9). Adopting an approach in which some important steps are incorporated into healthcare delivery necessitates more effort and time allotted to appointments with refugee populations. As recommended by the Victorian Foundation for Survivors of Torture, initial appointments must involve some crucial steps like the following:

• *arranging an interpreter*

• *familiarizing refugee patients with the appointment system*

• *calling refugee patients to remind her/him of the appointment*

• avoiding early morning appointments as sleeping problems are common among most traumatized refugee patients

• promoting overall health assessment

• having reception staff inform refugee patients about any delayed appointments

• learning about refugee patients, their background and possible health problems before the next appointment (9).

With the necessity to make so many arrangements, even for initial appointments, it can easily be stated that healthcare providers require much more time for proper service delivery to refugees. Adding the increased time with interpreting services during appointments, it is inevitable that healthcare providers struggle to find sufficient time to meet the specific needs of refugees in a system where their need for more time is not appreciated.

In one study, this problem made patients report that they cannot share the feelings of depression with their doctors as they are usually rushed, and therefore, their emotional issues were not covered in the check-ups (31). According to another study by Fang et al., a patient stated that the consultations did not last long enough for general practitioners to carry out a thorough assessment, taking the cultural situations into consideration properly (32).

There is plenty of research investigating consequences of not allotting extra time from the perspectives of refugee health seekers as mentioned above; however, working under time pressure certainly poses several challenges to healthcare providers, as well. A study conducted by Jessen reveals a lack of time for providers to "prepare for visits, educate patients or address mental health issues" (13). Time limitation can get so extreme that providers usually cannot know whether a refugee or non-refugee patient will show up for the next appointment (13).

Another major contributor to time restriction is the fact that healthcare providers need to invest time in building trust with refugee population to be able to cover all their health-related needs. Also, it is important for them to take time to achieve cultural understanding and explain medical concepts and services made available to refugees in a way that is culturally sensitive (27). To improve communication during medical visits, providers must make sure that they employ appropriate strategies to inform refugees clearly about various topics of health

although they are certainly time-consuming. They must employ an effective approach to communication through the use of methods like teach-back, to monitor and check the understanding of patients or prefer open-ended questions during appointments to encourage patients to give feedback. Although time-consuming, the use of open-ended questions during appointments is extremely important, because it was observed that refugees tend to answer "yes" when asked questions that could simply be answered "yes" or "no" (14).

Many healthcare providers are aware that their day-to-day work does not only require extended time and duration, but also increased occurrences of appointments when patients are refugees. With the increased number of appointments which are lengthy and complex, the providers have to carry the burden of the "time taken away from other patient groups" (17). In one study by Pollock et al, refugee participants reported that they had been rejected by receptionists because of doctors' perception that serving them is "too time-consuming, emotionally overwrought and exceptionally demanding" (24). While analyzing comments like this, it is important to highlight that it would be unfair to interpret such reported cases as acts against code of conduct unless the underlying causes are explored and health care providers' perceptions and attitudes towards appointments with refugees are investigated.

Refugees' past experiences, culture and health literacy levels may also have an effect on increased time requirements because of the way they seek healthcare and utilize health systems. It was reported that time allocation can become an issue with refugees since they tend to miss appointments or arrive late and cause delays in appointment schedules due to their "unfamiliarity with the system, a lack of economic resources, shyness, inability to ask questions, transportation problems, memory issues, anxiety and mistrust of healthcare providers" (9, 33, 34). A health promotion officer in Australia expresses how these challenges can translate into obstacles in everyday practice in health centers by explaining *"...if a woman misses her appointments a couple of times, or comes extremely late for an appointment, sometimes that can be quite frustrating for receptionists who have to re-book their appointments, yet they don't actually understand the reasons why that might be occurring"* (35).

2.1.4 Lack of Knowledge and Skills

The importance of informing refugees about the healthcare system and their right to health in the receiving country is reiterated in many sources since the exchange of knowledge in these matters promotes positive encounters with refugees (36). Nonetheless, there is relatively less emphasis on healthcare providers' knowledge gap in these issues and the cultural dimensions of service provision to refugees as vulnerable groups. Furthermore, support through training and guidance for providers is usually neglected as shown in many articles discussing the need for more training for healthcare providers who are "ill-equipped to deal with difficulties in service provision" (27).

The following areas can be found in different sources as requiring training and/or support (14, 16, 17, 37, 38, 39):

• legal processes and entitlements underlying refugee status

• socio-political issues of refugees

• health systems for refugees

• awareness of available resources

• cultural sensitivity and competency

• understanding of ethnicity and culture and their impact on healthcare

• communicative competence

• working properly with interpreters

• social inclusion

• empathy and gender preferences

• trust and rapport building

• clinical knowledge and skills in diagnosis, referral and management of specific health issues of refugees

• mental health care

A lack of knowledge and skills in the areas mentioned above challenges healthcare providers in everyday practice. A report by Medact Manchester demonstrates that there is a gap in the knowledge of doctors, nurses and nonclinical staff working for refugees and asylum seekers in the North-West of England. According to the report, only 21% of the 198 National Health System (NHS) workers who participated in the study could confidently define the terms "asylum seeker",

"failed asylum seeker", "economic migrant" and "refugee". Only around 25% could explain which groups are entitled to healthcare services free of charge and 32% were unaware that failed asylum seekers were eligible for free emergency care. The majority expressed a lack of confidence in taking histories of trauma and torture and requested training on different aspects of refugee health and issues surrounding asylum seekers and refugees (40). Another study on resident physicians' perceptions shows that most of the residents are fond of serving refugee and migrants; however, they feel concerned about the quality of services. Besides, over half of the residents feel they are not knowledgeable enough about immigrant and refugee health (41).

Regarding the health coverage of refugees, providers can be totally unaware of the refugee entitlement of care in the reception country or they may be put in a difficult position where they have to decide whether to provide care or not (42). A study conducted in Canada to examine the health care providers' knowledge of healthcare coverage for refugees revealed that the overall level of awareness of refugees' healthcare coverage is quite low among providers with around 2% of the study population answering all the questions regarding entitlements correctly (43). Adding the frequently changing nature of health and legal systems concerning ethnically diverse populations in receiving countries, being and staying knowledgeable as healthcare providers requires a significant amount of time and effort.

Again, in Canada, legal limitations on healthcare provision to uninsured refugees are reported to raise concerns among most of the providers (44). Caught in dilemma between the legislations and the scarcity of resources at one extreme and the right to healthcare at the other, providers are confronted with ethical and practical considerations surrounding their practice every day. In contexts where universal access to healthcare is acknowledged and ensured through legislation, healthcare provision is smoother, and providers are under less pressure. On the other hand, in receiving countries where legislations do not allow free access to health care for undocumented individuals, healthcare providers still provide services based on humanitarian motives and moral obligations, overlooking legal obligations and risking their own careers (10).

The complexity of refugee status and the extent of vulnerabilities also create barriers for providers in healthcare provision when they are not made aware of these

with the help of proper training programmes. To exemplify, in the cases of sexual assault, coupled with patients' reluctance to share stories of violence due to traumatic and cultural experiences, healthcare providers are unable to execute proper follow-ups. A study on the healthcare providers for Sub-Saharan migrants in Morocco demonstrates that after confrontation with a victim, healthcare providers do not carry out long-term follow-up due to reasons such as a "*lack of time, difficulties in the country* and *a lack of control*" (11). Immunization is one of the essential services that is hindered by a lack of follow-up during and after migration. The interruptions increase the complexity of service provision by placing burden on health care providers' shoulders who mostly find themselves in a position where they are in charge of making major decisions on immunization needs. In Denmark, some providers have developed their own strategies to determine whether or not they should give vaccination to asylum-seeking children based on responses to interpreters about vaccination histories, WHO guidelines on immunization programmes, country vaccination programmes, and parents' background (56).

With limited time to prepare for medical encounters with culturally diverse groups and inadequate training opportunities, healthcare providers usually lack enough knowledge of refugee culture and good communication skills. As a consequence, they worry that in their encounters they may be misunderstood and offend refugee patients in certain ways that are unknown to them (33). This can even go as far as fearing accusations of racism due to miscommunication and a lack of cultural understanding.

It is important that healthcare providers are made aware of the entitlements of refugees especially at the initial phases of resettlement to eliminate possible obstacles to health coverage, and activate a timely referral system from general practices to various other services that may include secondary care or other wider services such as social care and livelihood (53).

2.1.5 System-Related Obstacles

Of all the issues discussed under the challenges that healthcare providers face in health service delivery to refugees, the most influential one is perhaps the health systems relating to refugee health care. This is because it is the health systems that determine the ways in which internal and external factors such as language barrier, a lack of knowledge or cultural incompetency can become strong enough to interfere with proper service provision. When the systems fall short of responding to the uniqueness of refugee needs, this is reflected in providers' avoidance of these cases and eventually leads to poor health outcomes (34).

One of the obstacles complicating healthcare providers' practice is the limited financial resources for refugee health support programmes, which hinders any attempts to improve care. Another obstacle is related to limited flexibility despite the heterogeneity of refugee groups. Unfortunately, it is impossible for healthcare providers to deliver the complex care required by refugee circumstances in rigid systems, and if the system does not allow for enough flexibility for innovative approaches and more time, providers have to bear the extra emotional and professional burden that the system creates. Finally, the difficulty of refugees in navigating the health system results in "compromised care" and "increased costs" which affect both health seekers and providers in an unfavorable way (45).

It is evident that standard clinical practices fall short in sustaining a system that is conducive to an efficient and effective work environment for providers working with refugees and migrants. Adjusting the healthcare delivery to the needs of the refugees who have considerably higher needs seems to be significant. Some essential adaptations may involve welcome sessions held outside normal consultation hours, short explanations on how to make appointments and what general practices cover, or sessions held by male or female practitioners based on culturally acceptable gender roles (53).

2.2 Challenges Threatening Healthcare Providers' Wellbeing

There is no doubt that the challenges discussed so far and beyond render healthcare providers susceptible to burnout and safety risks. It is argued in many studies that healthcare providers find it emotionally difficult to serve refugee patients

and hear their trauma experiences. Providers also feel a sense of helplessness due to their perceived lack of knowledge, skills and competency in responding to refugee sensitive healthcare needs, and inability to make a difference in the lives of refugees (17, 46).

A study conducted in the Midlands-based refugee center in the United Kingdom (UK) demonstrates that working with refugee and asylum seekers increases workload and causes stress as a consequence of time pressure and concerns regarding compromised services. The providers feel that refugee patients can be too demanding and expect too much from the staff as the system does not allow them to be empowered and increases their dependency on providers (46).

In addition, moral and legal dilemmas contribute to provider distress to a great extent. Since healthcare providers are among few people who come in contact with refugee populations especially at the transition or resettlement periods of movement, they may encounter individuals who have committed unlawful acts or who lack official documents. Having to use own judgement and make legal and moral calculations put healthcare providers under considerable pressure and lead to frustration and emotional distress (46).

The majority of work that healthcare providers have to accomplish for proper care is also quite invisible in migrant and refugee settings. They have to bear extra burden of responsibility for tasks ranging from relatively simple paper work to more complex efforts such as establishing a trust relationship with patients and adapting services to their unique needs, which leads to increased levels of stress and frustration over professional competence (53).

The emotional burden of caring for refugees can be put into perspective through a list of common descriptions of emotions that healthcare providers reported to express the impact that working with refugees has on them. These are the feelings of "frustration, anger, annoyance, sadness, depression, and feeling down, flat, helpless, and demoralized" (46).

Similarly, healthcare providers working with trauma survivors are also reported to experience so called vicarious traumatisation, which explains "the signs and symptoms of traumatization similar to those of the victim" (47). In one study, the mental health providers and other caregivers working with Mexican and Central

American refugees in the US were reported to experience "sleeplessness, nightmares, crying, trouble concentrating, arousal, avoidance, numbing, intrusive thoughts, and emotional distancing" (60).

Burnout, which is a state of "emotional exhaustion, increased depersonalization and a diminished sense of personal accomplishment due to chronic stress at work", is known to be common among high-stress jobs, and healthcare is certainly not an exception (57). Health professionals, particularly those working in relatively more stressful areas like intensive care and anesthesiology have been reported to experience burnout (58). In the same vein, it would not be unexpected that healthcare professionals in refugee and migrant health settings are highly susceptible to burnout. Evidence shows that health care providers working in the complex conditions of the Middle East experience high levels of burnout (59). The physicians, nurses and medical students in countries like Bahrain, Egypt, Iran, Israel, Lebanon, Oman, Qatar, Saudi Arabia, Turkey, United Arab Emirates, and Yemen were reported to be exposed to risk factors such as heavy workload, unstable and difficult working environments, work and private life imbalance, and income insufficiency. Coupled with these more common risk factors, their exposure to war, conflict, violence, terror and secondary trauma in refugee health context could be considered to be the worsening factors in burnout (59). Rescue workers, in Lesvos, Greece, consisting of professional and volunteer rescuers who have served in European refugee crisis, reported to suffer from self-assessed PTSD (Post-traumatic Stress disorder) associated with lower levels of perceived well-being and higher levels of burnout (Maslach Burnout Inventory- MBI) (61). In New South Wales, interviews with 5 refugee health nurses reveal that the nurses have difficulty maintaining work-life balance as they have to take on responsibilities that are nonclinical in nature on top of regular medical services by facilitating refugees' adaptation to Australian culture and providing social assistance. This increases their risk of overwork, and eventually, burnout (62).

Safety may also become an issue of concern for healthcare providers working with culturally diverse populations. Though not pertaining only to refugee healthcare settings, the International Committee of the Red Cross (ICRC) report provides data showing high incidences of violence against healthcare providers in the situations of armed conflict and other emergencies between 2012 and 2014 (48). Despite limited

data on the safety of healthcare in refugee contexts, it would not be totally irrelevant to assume a similar tendency in reception countries, although may be on a smaller scale. The staff members at Midlands-based refugee center in the UK reported that patients could behave in a violent and aggressive manner, threatening staff, shouting and throwing things at them (46). Also, in emergency care units serving immigrants in Sweden, staff described situations as threatening when husbands react to the discharge of their wives from hospitals or when patients are involved in drugs and violence. Uniforms are usually regarded as symbols of power in such encounters and make some refugees think that healthcare providers are actually police officers. In addition, patients' perceived hierarchy of healthcare staff leads to tensions between refugee patients and nurses when the patients have a lack of trust in staff members other than doctors. Nurses usually find such an attitude frustrating and irritating. Finally, refugee patients interpret waiting times in the emergency care as a form of racism and unfair treatment because of their ethnic background, which may again result in outrage and violence (49).

Regardless of the pessimism dominating most of the articles, it is also true that providers consider serving refugees "personally gratifying" and feel highly motivated by the professional satisfaction they get, enjoy the learning experience of working with multicultural groups, and establish fulfilling relationships with refugees (16, 33). A provider serving refugees in the United States (US) stated "*it is pretty awe-inspiring to be a part of and become a trusted resource for them and to be able to provide support and help along the way, it is really nice. It is very rewarding*" (16). Another mentioned the opportunity for developing professional skills by stating that it allowed him to practice global health locally with a mixture of infectious diseases he had to practice and also interaction with interesting cultural characteristics he got familiarized with (16). Guhan and Liebling-Kalifani also emphasize the positive outcomes that healthcare providers serving torture victims can achieve through positive changes in their personality and personal growth (46). They are reported to be impressed by patients' stories of "strength", "resilience" and "courage", which feeds their compassion satisfaction to a great extent (60). There are cases where vicarious traumatisation lends itself to vicarious resilience of both service providers and users through health professionals' efforts to empower refugee patients during their

resettlement. Supporting refugees to meet their resettlement needs through awareness-raising in demanding quality services and vital health information such as precautions during pregnancy or side effects of medicine, and some innovative initiatives like art projects and story-telling proves to improve patients' coping skills, empowerment and resilience, which, in return, contributes to the sense of achievement and satisfaction (64). This is supported by another study in which doctors reported to develop resilience when they serve disadvantaged populations due to the sense of meaning and satisfaction derived from "doing the right thing" despite potential risks of burnout (63).

2.3 Overcoming Challenges and Promoting Good Practices

Based on the evidence generated to understand and analyse barriers to proper health care provision in refugee and migrant health contexts, it is possible, if not imperative, to counteract the factors that interfere with proper service provision on all fronts to secure the right to health for all people.

To address the challenges stemming from cultural, linguistic, and systemic barriers, receiving countries need to adopt an integrated approach to health care through the adjustment of systems to the arising, specific needs of migrant and refugees while mainstreaming these services in the existing mechanisms for accountability and sustainability.

Cultural competence and linguistic support are two prominent areas that need to be ensured to remove barriers in health care provision to individuals with a migration background. When health care providers are able to establish communication and develop an understanding of the underlying motives and reasons behind certain preferences of migrant and refugee patients, their health-seeking behaviour, perceptions and beliefs about health care and level of health literacy, they can be more prepared to demand more flexibility to make systemic adaptations of health care so that they can customize their services according to the needs of their patients. Knowing what the needs are, health professionals can foresee any cultural issue with the potential to interfere with proper service provision, no matter how inevitable the cross-cultural misunderstandings can be (65). Such appreciation of cultural differences also eliminates the risk of racial discrimination by promoting

mutual understanding and care, and improves the ways interpreting services are utilized in the best possible arrangement sensitive to cultural expectations.

The empowerment of health professionals serving migrant and refugee populations is also vital in order to overcome everyday challenges such as lengthy examinations, social care needs, and difficulties in maintaining effective communication and establishing a trust relationship with service users. Their empowerment through professional competence in refugee and migrant health field makes it possible to adapt service provision and contributes to resilience since they feel in control of their work, having the flexibility to arrange their working hours and using the opportunity to receive supervision by more experienced colleagues (63).

3. METHODOLOGY

3.1 Study Setting

The study was conducted in the health facilities providing primary health care services to migrants, refugees and asylum seekers in Gaziantep, Hatay, İzmir and Şanlıurfa, Turkey. The selection of the provinces was made mainly based on the high density of Syrians under temporary protection (Gaziantep: 448,240, Hatay: 436,112, İzmir: 148,034 and Şanlıurfa: 423,583) and the importance of the locations of these provinces (74).

The Ministry of Health in Turkey has made remarkable efforts to expand its services and ensure access to healthcare for all persons without Turkish citizenship who have reached Turkey either through voluntary migration based on free will and initiative, or forced displacement due to the fear of persecution, conflict, violence, and human rights abuse.

All across Turkey, different types of health centers and institutions have been strengthened and established for uninterrupted access to a wide range of health care services, particularly at the primary health care level, with well-defined coverage schemes adjusted to the level of vulnerability. In the provinces where this study was conducted, primary health care services are predominantly made available to migrants, refugees and asylum seekers through the following health facilities:

- Foreigner Clinics (FC)
- Migrant Health Centers (Migrant Health Training Centers/Strengthened Migrant Health Centers) (MHC)
- Family Health Centers (FHC)
- Emergency Units (EU)

In each of these health facilities that function as primary health care centers, there is at least one "health unit" which consists of one doctor and one nurse.

In the Migrant Health Centers established in 29 provinces with the high population of Syrian refugees, some additional functions, such as psychosocial support and interpreting services, are put in place to respond to the increased need and vulnerability caused by conflict and migration. Besides, in these centers, along with the health professionals with a Turkish citizenship, Syrian doctors and nurses are

employed to provide services to their fellow citizens in a manner that helps to overcome cultural and linguistic barriers.

In the provinces, where the study was conducted, over 700 health professionals (doctors, nurses and midwives) were employed, mostly in the Migrant Health Centers and Family Health Centers, to serve hundreds of thousands of Syrians, Afghanis, Iraqis, Iranians, and people of other nations[1] (66).

3.1.1 İzmir

Figure 3.1. Location of İzmir on the map of Turkey (81)

Located in the west of Turkey, on the Aegean cost, İzmir is the third biggest city in Turkey with a population of 4,367,251 citizens (71, 72). There are 14,671 migrants and 147,348 registered Syrian refugees under temporary protection residing in Izmir (73, 74). The city has a geographical significance for most refugees and asylum seekers as it is situated in one of the main sea routes for migration to Greece, and ultimately to the rest of Europe.

There are several public and private health institutions for the provision of primary, secondary and tertiary level healthcare in İzmir. All healthcare services are accessible to migrants and refugees as they are to Turkish citizens based on varying referral mechanisms.

Primary healthcare services can be utilized in several state-run facilities available in different locations of İzmir, all provided based on an inclusive coverage scheme. These facilities include Emergency Healthcare Stations/Emergency Units,

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[1] Interview with the official working in the Department of Migration Health of the Ministry of Health, Turkey

Mother and Child Health Clinics, Family Health Centers, Integrated District Hospitals, Dermatological and Venereal Diseases Clinics, Migrant Health Centers, Healthy Life Centers, Community Health Centers, Rabies Treatment Clinics, Cancer Screening and Early Diagnosis Centers, Oral and Dental Health Clinics, Malaria Clinics, Smoking Cessation Centers and Tuberculosis Clinics (75).

Among all the other health facilities, the so-called Migrant Health Centers, which have been established to specifically serve migrants and refugees, receive the highest number of applications by most non-Turkish citizens[2]. There are eight Migrant Health Centers in İzmir, located in districts called Bayraklı (#1), Bornova (#2), Buca (#1), Karabağlar (#1), Konak (#2), and Torbalı (#1). There is a total of 62 health professionals serving in these centers with 1 obstetrician-gynecologist, 2 internal medicine specialists, 1 pediatrician, 21 general practitioners, and 37 nurses/midwives[2]. Although these health professionals are considered to be the main providers for migrant, refugee and asylum-seeking populations, other health professionals working in different health facilities than Migrant Health Centers certainly play a vital role in the overall healthcare provision for migrants, refugees and asylum seekers.

3.1.2 Hatay

Hatay is located in the south of Turkey, on the Mediterranean coast, and is a neighboring city to Idleb, Afrin and Latakia, Syria, which makes it one of the main refugee hosting cities in Turkey. There are 1,628,894 Turkish citizens with the addition of 7,307 migrants and 440,208 registered Syrian refugees under temporary protection 2, 73, 74). It is the third city that hosts the highest number of Syrian refugees in Turkey.

Figure 3.2. Location of Hatay on the map of Turkey (82)

Primary, secondary and tertiary level of healthcare services are available in public and private institutions. Primary healthcare services, which are based on a comprehensive coverage scheme, are delivered through health facilities such as Family Health Centers, Migrant Health Centers, Community Health Centers, Healthy Life Centers, Oral and Dental Health Clinics, Cancer Screening and Early Diagnosis Centers, Mother and Child Health Clinics, Smoking Cessation Centers, and Tuberculosis Clinics[2] (76). In Hatay, there are also three temporary shelter centers, i.e. camps, which host 10,701 Syrians under temporary protection in three different districts; namely Altınözü, Yayladağı and Apaydın (74). In each of these settlements, there is a healthcare center for primary healthcare level services, and an emergency unit which is supported by ambulances for the transfer of patients to secondary and tertiary level health facilities.

Migrants, refugees and asylum seekers residing in Hatay are entitled to receive primary healthcare services provided in all the healthcare facilities mentioned above. However, they mainly seek health in the 27 Migrant Health Centers located in the following districts: Altınözü (#2), Antakya (#7), Belen (#1), Dörtyol (#1), Erzin (#1), Hassa (#1), İskenderun (#1), Kırıkhan (#3), Kumlu (#1), Payas (#1), Reyhanlı (#6) and Yayladağı (#2). There are 258 healthcare providers working in these centers; 6 obstetrician-gynecologists, 6 internal medicine specialists, 6 pediatricians, 106 general practitioners, and 134 nurses/midwives[2]

3.1.3 Şanlıurfa

Figure 3.3. Location of Şanlıurfa on the map of Turkey (83)

Located in the southeast of Turkey, Şanlıurfa, a border town to Syria, has a population of 2,073,614 people with Turkish citizenship. There are 4,675 migrants and 425,812 registered Syrian refugees under temporary protection living in Şanlıurfa, which makes it the fourth city with the highest number of Syrian refugees in Turkey (72, 73, 74).

Healthcare services are delivered at primary, secondary and tertiary levels in both public and private health institutions. Primary healthcare services can be accessed through Integrated Emergency Healthcare Stations/Emergency Units, Family Health Centers, Migrant Health Centers, Community Health Centers, Healthy Life Centers, Oral and Dental Health Clinics, Smoking Cessation Centers, Rabies Treatment Clinics and Tuberculosis Clinics[2] (77).

Migrants, refugees and asylum seekers have access to healthcare services provided in various state-run facilities where the majority of services are free of charge. The healthcare facilities which most refugees, particularly Syrian refugees under temporary protection, prefer to visit are 17 Migrant Health Centers located in Akçakale (#1), Birecik (#1), Bozova (#1), Ceylanpınar (#1), Eyyübiye (#4), Haliliye (#4), Harran (#1), Karaköprü (#1), Siverek (#1), Suruç (#1), Viranşehir (#1) districts[2]. The total number of health professionals working in the Migrant Health Centers in these districts is 196, consisting of 4 obstetrician-gynecologists, 3 internal medicine specialists, 5 pediatricians, 67 general practitioners, and 117 nurses/midwives[2].

3.1.4 Gaziantep

Figure 3.4. Location of Gaziantep on the map of Turkey (84)

Gaziantep is located in the southeast of Turkey, and is a neighboring city to Aleppo, Syria. The population of the city is 2,069,364 citizens of Turkey, and 6,222 migrants and 453,499 registered Syrian refugees under temporary protection Gaziantep is the second city after Istanbul (485,265) which has the highest distribution of Syrian refugees in Turkey (72, 73, 74).

As in the other three provinces described above, migrants, refugees and asylum seekers hold the right to benefit from a variety of healthcare services at different levels of care available in private and non-private health institutions based on a quite inclusive coverage scheme established by the Ministry of Health. In Gaziantep, state-run primary healthcare centers consist of Integrated Emergency Healthcare Stations/Emergency Units, Public Health Laboratories, Family Health Centers, Mother and Child Health Clinics, Migrant Health Centers, Healthy Life Centers, Community Health Centers, Cancer Screening and Early Diagnosis Centers, Oral and Dental Health Clinics, Smoking Cessation Centers and Tuberculosis Clinics.

There are 10 Migrant Health Centers, which are mostly preferred by refugees and asylum seekers, in districts called Nizip (#2), Şahinbey (#6), and Şehitşamil (#2). A total of 180 health professionals - 5 obstetrician-gynecologists, 4 internal medicine specialists, 8 pediatricians, 55 general practitioners, and 108 nurses/midwives - are employed in these centers [2].

3.2 Population Frame

The population of this study consisted of health professionals, i.e. doctors, nurses, midwives, and emergency medical technicians (paramedics) who serve migrants, refugees and asylum seekers at primary health care level in the four provinces of Turkey, namely Gaziantep, Hatay, İzmir and Şanlıurfa. There was no sampling of the population as it was aimed to reach all the health care professionals working in family health centers, foreigner clinics, emergency services, and migrant health centers.

Although the information about the total number of health professionals working in migrant health centers and foreigner clinics could be accessed (a total of 704 providers), unfortunately it was impossible to get the same data for family health

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[2] Information shared by the official working in the Department of Migration Health of the Ministry of Health, Turkey

centers and emergency services due to the lack of access to information in medical record systems, and urgent and irregular nature of emergency health care.

Information about the number of family physicians who have migrant or refugee patients registered in their panel could not be retrieved as the medical record system does not allow personal patient data to be shared with third parties.

The number of emergency health care workers serving refugees and migrants was impossible to obtain since there is no official data showing emergency consultations only for migrant populations.

For these reasons, it was the authorized officials in the Provincial Health Directorates, not the researcher herself, who were in full control of channeling the survey to a group of health care providers that were thought to qualify as participants in this study according to the exclusion and inclusion criteria mentioned below.

The participants were included in the study based on the following set of criteria:

- Minimum 1-month experience in serving migrants, refugees or asylum seekers in a health care facility
- Working at primary health care level
- Agreeing to participate in the study

The respondents having the following characteristics were excluded from the study:

- Providing non-medical services in health facilities
- Having the same cultural background as the migrant, refugee and asylum seeker patients

As a result of the distribution of the survey by the officials working in the Provincial Health Directorates, a total of 236 health care professionals completed the survey.

3.3. Study Variables

3.3.1 Independent Variables

- Socio-demographic profiles of health professionals
- Years of professional experience

- Level of education in migration health

- Work location

- Type of health facility

- Knowledge of migrant, refugee and asylum seeker patients' language

- Level of understanding about the migrant, refugee and asylum seeker patients, i.e. their legal status and culture.

3.3.2 Dependent Variables

- Level of burnout among health professionals according to Maslach Burnout Inventory

- Perceptions of health professionals about health service provision to migrant, refugee and asylum seeker patients

3.4 Definition of Terms

The definitions of the main terms used in this study are given below:

Asylum seeker: "An individual who is seeking international protection and whose claim has not yet been finally decided on by the country where he or she submitted it" (67).

Burnout: Burnout is a syndrome which occurs when a professional is exposed to constant workplace stress that has not been effectively handled. It results in extreme exhaustion, reduced work efficacy, and mental distance and isolation from one's job. It is included in the 11th Revision of the International Classification of Diseases as an "occupational phenomenon", not as a medical condition (69).

Maslach Burnout Inventory (MBI): Maslach Burnout Inventory is a scale that is used to measure the three components of burnout syndrome, which are commonly described as "emotional exhaustion", "depersonalization" and "reduced personal accomplishment" (70). In this paper, MBI for Human Services Survey for medical professionals; i.e. MBI-HSS (MP), was utilized and referred as MBI. The inventory was integrated into the survey as translated and validated in Turkish (79). The MBI scale does not offer a cut-off point, and it is favorable to expect low scores for Emotional Exhaustion and Depersonalization subscales, and high scores for Personal Achievement subscale.

Migrant: "A person who moves away from his or her place of usual residence, whether within a country or across international border, temporarily or permanently, and for a variety of reasons" (67). In this study, a slightly limited scope of the term was used to refer to persons who have moved across international borders only.

Migration: "The movement of persons away from their place of usual residence, either across an international border or within a State" (67).

Migration health: "A public health topic which refers to the theory and practice of assessing and addressing migration associated factors that can potentially affect the physical, social, mental well-being of migrants and the public health of host communities" (67).

Migrant Health Center: Migrant Health Centers are health facilities providing primary healthcare level services to all migrants, asylum seekers, and particularly Syrian refugees all across Turkey. They were established in response to the refugee crisis that occurred after the Syrian Civil War to ensure uninterrupted access to services through migrant-sensitive healthcare, mainly targeting 4 million refugees in Turkey. The services provided in these centers include maternal and childcare, neonatal care, infant and child follow-up, immunization, outpatient, emergency, outreach, and homecare services. The centers vary slightly in terms of the scope of services and have additional functions such that in some centers called Migrant Health Training Centers, health professionals receive regular training in addition to their day-to-day jobs, and in some others called Strengthened Migrant Health Centers, more comprehensive healthcare services, internal medicine, oral and dental care, and psychosocial services are available. In this paper, the term Migrant Health Center will be used to refer to all centers with or without training function and extended services.

Refugee: "Refugees are people who have fled war, violence, conflict or persecution and have crossed an international border to find safety in another country" (68). This study aligns the term "refugee" with the legal status of "temporary protection" which was granted by the Republic of Turkey to all Syrians living in Turkey. Hence, in this paper Syrians under temporary protection are referred as refugees.

Temporary protection: "Arrangements developed by States to offer protection of a temporary nature, without prior individual status determination, to persons

arriving in the context of flight from situations of conflict, generalized violence, disasters or other humanitarian crises" (67). All the Syrians who are displaced due to the ongoing Syrian Civil War and fled to Turkey are entitled to temporary protection status provided that they are officially registered through the Directorate General of Migration Management of the Ministry of Interior.

3.5 Study Design and Implementation

The study began after the ethical committee and academic board approvals were granted, and necessary institutional permissions were obtained from the Ministry of Health and Ministry of Interior of Turkey. For data collection, a survey was used to gather demographic information and explore the perceptions and level of burnout among the health professionals serving migrants, refugees and asylum seekers in Gaziantep, Hatay, İzmir, and Şanlıurfa. The survey consisted of three types of questions: Multiple-choice, open-ended and Likert scale items to collect data on demographic information and perceptions, and Maslach Burnout Inventory to explore level of burnout (Annex 7).

The validity and reliability of the Maslach Burnout Inventory (MBI) were first assessed by Iwanicki and Schwab in 1981 (78). On the other hand, the validity and reliability in Turkish language, which is the version used in this survey, were tested by Ergin in 1992 (79). MBI for health professionals consists of three regular subscales and 22 items. The subscales are "emotional exhaustion (EE)" with 9 items, "depersonalization (DP)" with 5 items, and "personal accomplishment (PA)" with 8 items. The items formed in Likert Scale were scored based on a four-point scale ranging from 0=never to 4= every day. No cut-off point was identified in the Turkish version of the scale. Higher scores for EE and DP, and low scores for PA were considered to reflect the presence of burnout.

There were 85 items in the survey, the first section of which included 24 items collecting information on socio-demographic characteristics, work experience, medical specialty, patient profile, and level of language competency.

The second section consisted of 35 items exploring the perceptions of health professionals regarding the challenges and facilitators of their work with migrant, refugee and asylum-seeking patients. The items in this section were developed based

on the current knowledge, observations and experiences documented in the literature. The third section of the survey had 22 MBI items, and the fourth one examined the perceived need for training and recommendations with 4 items (Annex 7).

Before the survey was administered, it had been reviewed by two public health professionals and one refugee health project officer who had no interest or partnership in the study. It was also proofread by two Ministry of Health officials to check the items' relevance and validity in the field. Based on the reviews, required changes were made to 9 items in Section 2 through omission or paraphrasing of statements. The survey was also piloted in the Migrant Health Center in Ankara, the capital city of Turkey, among the health professionals who have no connection to the actual study population. No change in the survey items was found necessary after piloting.

After the institutional approval was granted by the Ministry of Health, the survey was emailed to the authorized officials in the Provincial Health Directorates in Gaziantep, Hatay, İzmir and Şanlıurfa as a Google Form web link. These officials who are in charge of migration health services in the province, were requested to disseminate the link to the health professionals who provide primary healthcare services in the health facilities such as Foreigner Clinics (FC), Migrant Health Centers (MHC), Family Health Centers (FHC), and Emergency Units (EU). Due to the rules and regulations about data privacy and confidentiality in the Republic of Turkey, health professionals' personal information such as their names and surnames, emails or phone numbers was not obtained. The link was distributed directly by the authorized official to the participants in all provinces except for Şanlıurfa where printed copies of the survey were requested as the Health Directorate considered the completion of survey through a web link on the Internet would be unfeasible in Şanlıurfa context.

The majority of the items were designed in a way that allowed for merely one response and were recorded as an excel sheet automatically. Anonymity was ensured in the collection, recording and analysis of all the responses, and all the information was protected from potential dissemination to third parties through encrypted input recording of Google Forms. The opening page of the online survey, and the first page of the printed version of it made a brief introduction to the survey with clear explanation on the background and purpose of the study. The introduction was

followed by an informed consent form for the health professionals to indicate their decisions about participating in the study.

3.6 Ethics

The study was approved by Hacettepe University Non-interventional Clinical Research Ethics Board (Reference 2020/01-01) before the commencement of the study. A WHO guideline on how to manage stress was translated into Turkish to be shared with the health professionals in four provinces that contributed to the study (Annex 6).

3.7 Statistical Analysis

The data were analyzed through SPSS Statistics 23 programme. Discrete data were represented as number, frequency and percentage analyses, and continuous data were examined through descriptive statistics. The tests utilized to explore the relationship between variables based on the assumptions for nonparametric tests were listed as Wilcoxon Rank-Sum Test, Kruskal Wallis Test, Pairwise Wilcox Test, Spearman's Rank Order Correlation, Kendall Rank Correlation Coefficient and Multilinear Regression Analysis.

For the Maslach Burnout Inventory, the frequency scale was used with labels assigned to a point, ranging from the lowest score of "0" for "never" to the highest one of "4" for "every day. In addition to the frequency of responses to each label (e.g. never, every day, a few times a week, etc.) for every item, mean scores and standard deviation for the overall study population and different provinces were measured. The total subscale scores were evaluated separately with the score range of 0-36 for emotional exhaustion, 0-20 for depersonalization, and 0-32 for personal accomplishment.

3.8 Study Timeframe

With the support of the Migration Health Department of the Ministry of Health of Turkey, the initial study was planned to target all the foreigner clinics across Turkey and the necessary ethical approval (GO 19/211) was granted on 28 February 2019 with the study title covering this target. However, due to an unexpected change in the approach of the Ministry of Health, the scope of the study had to be revised in a way

to include all the primary healthcare facilities serving migrants, refugees and asylum seekers in only four provinces (Gaziantep, Hatay, İzmir and Şanlıurfa). To accommodate this change, which was recommended for a smoother data collection process, the application for ethical committee review was renewed and approval was granted on 21 January 2020. Following the approvals of the Ministry of Health and the Ministry of Interior (08 January 2020), the officials working in the Provincial Health Directorates were contacted and briefed about the data collection method between 22-24 January 2020. Data collection started on 27 January 2020 and lasted until the end of March 2020. The data entry (only for the data coming from Şanlıurfa) and cleaning were completed on 30 April 2020. The analysis of the data took place in May 2020 and the preliminary findings were shared with the thesis advisor as a draft report in July 2020. The revisions of the report were completed between August 2020 and August 2021 with the final report submitted on 26 August 2021.

4. RESULTS

A total of 236 health professionals completed the survey; however, 224 respondents were included in data analysis since 12 were excluded due to the following reasons:

- The possibility of misinterpreting survey questions prepared in Turkish due to language barrier (6 participants gave answers to open-ended questions in Arabic, not in Turkish)
- Non-medical staff members (2 patient guides and 1 technician responded to the survey)
- Insufficient number of answers to survey items (3 participants responded to only about 20 % of the items).

4.1 Personal and Professional Characteristics of Respondents

Table 4.1. Distribution of health professionals according to province and some sociodemographic characteristics (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Characteristic	Gaziantep		Hatay		İzmir		Şanlıurfa		Total	
	n	%	n	%	n	%	n	%	n	%
Gender										
Male	16	61.5	35	60.3	36	60.0	37	46.2	124	55.4
Female	10	38.5	23	39.7	24	40.0	43	53.8	100	44.6
Total	26	11.6	58	25.9	60	26.8	80	35.7	224	100.0
Age										
20-29	3	13.0	2	3.5	15	26.3	17	22.4	37	17.4
30-39	13	56.5	24	42.1	20	35.1	39	51.3	96	45.1
40-49	4	17.4	18	31.6	14	24.6	19	25.0	55	25.8
50-59	2	8.7	8	14.0	6	10.5	-	-	16	7.5
60 ≤	1	4.4	5	8.8	2	3.5	1	1.3	9	4.2
Total	23	10.8	57	26.8	57	26.8	76	35.6s	213	100.0

Table 4.1. (continued)

Characteristic	Gaziantep		Hatay		İzmir		Şanlıurfa		Total*	
	n	%	n	%	n	%	n	%	n	%
Civil Status										
Married	24	92.3	55	94.8	38	63.3	58	72.5	175	78.1
Single	2	7.7	1	1.7	19	31.7	19	23.8	41	18.3
Divorced	-	-	1	1.7	2	3.3	2	2.5	5	2.2
Spouse deceased	-	-	1	1.7	1	1.7	1	1.2	3	1.3
Total	26	11.6	58	25.9	60	26.8	80	35.7	224	100.0
Children										
0	7	26.9	1	1.7	22	36.7	29	36.2	59	26.3
1	6	23.1	7	12.1	12	20.0	16	20.0	41	18.3
2	10	38.5	12	20.7	10	16.7	27	33.8	59	26.3
3	2	7.7	10	17.2	4	6.7	6	7.5	22	9.8
4 ≤	1	3.8	28	48.3	12	20.0	2	2.5	43	19.3
Total**	26	11.6	58	25.9	60	26.8	80	35.7	224	100.0

*: Column percentage   **: Row percentage

More than half of the respondents were men (55.4%, n=124) and 44.6% were women (n=100). Although the number of male respondents was higher in Gaziantep (61.5%, n=16), Hatay (60.3%, n=35), and İzmir (60%, n=36), it was slightly lower in Şanlıurfa (46.3%, n=37) (Table 4.1).

70.9% (n=151) of the respondents belonged to the age range of "30-39" (n=96) and "40-49" (n=55). Only 11.7% (n=25) was over the age of 50 and 17.4% (n=37) below 30 (Table 4.1).

In Gaziantep (56.5 %, n= 13) and Şanlıurfa (51.3%, n=39), more than half of the participants were between 30 and 39 years of age. In Hatay and İzmir, there was comparatively a wider distribution below age 49 although the 30-39 age range is still the most frequent in these provinces, as well (42.1%, n=24 in Hatay and 35.1%, n=20 in İzmir). The mean age of the overall respondents was observed to be 38.13±9.426 (Table 4.1).

The majority of respondents were married (78.1%, n=175) with the highest percentage of married respondents in Hatay (94.8%, n=55), which is followed by Gaziantep (92.3%, n=24), Şanlıurfa (72.5%, n=58), and İzmir (63.3%, n=38) (Table 4.1).

In terms of the number of children the participants have, Hatay has the highest mean with 3.36±1.63 children, and Şanlurfa has the lowest with 1.21±1.133 (Table 4.2). 26.3% (n=59) of participants do not have any children. In Hatay, the respondents without children represent the lowest percentage with 1.7% (n=1) of all the responses obtained in Hatay, which is followed by Gaziantep (26.9%, n=7), Şanlurfa (36.2%, n=29) and İzmir (36.7%, n=22).

Almost one fifth of all the respondents have 4 or more children (19.3%, n=43). This group represents almost half of the respondents from Hatay with 48.3% (n=28) (Table 4.1).

Table 4.2. Descriptive statistics showing some sociodemographic characteristics across provinces (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

	Age*				
Province	Mean	SD	Minimum	Maximum	Median
Gaziantep	38	8.795	26	60	37
Hatay	41.91	10.24	26	67	41.5
İzmir	38.67	10.305	20	65	36
Şanlıurfa	35.14	7.293	21	63	33
All	38.13	9.426	20	67	36
	Children**				
Province	Mean	SD	Minimum	Maximum	Median
Gaziantep	1.38	1.098	0	4	1.5
Hatay	3.36	1.63	0	7	3
İzmir	1.65	1.755	0	6	1
Şanlıurfa	1.21	1.133	0	5	1
All	1.91	1.69	0	7	2

*n=213, **n=224

Table 4.3. Distribution of health professionals according to province and some occupational characteristics (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Characteristic	Gaziantep n	%	Hatay n	%	İzmir n	%	Şanlıurfa n	%	Total* n	%
Health professional										
Doctor	25	96.2	23	39.7	23	38.3	45	56.2	116	51.8
Nurse	-	-	34	58.6	32	53.3	16	20.0	82	36.6
Midwife	1	3.8	1	1.7	4	6.7	16	20.0	22	9.8
Paramedic	-	-	-	-	-	-	3	3.8	3	1.3
Dentist	-	-	-	-	1	1.7	-	-	1	0.5
Total	26	11.6	58	25.9	60	26.8	80	35.7	224	100.0
Year of graduation										
2011-2019	10	38.5	9	18.4	18	34.0	34	51.5	71	36.6
2001-2010	9	34.6	17	34.7	16	30.2	25	37.9	67	34.5
1991-2000	6	23.1	17	34.7	14	26.4	7	10.6	44	22.7
1981-1990	1	3.8	6	12.2	4	7.5	-	-	11	5.7
1970-1980	-	-	-	-	1	1.9	-	-	1	0.5
Total	26	13.4	49	25.2	53	27.4	66	34	194	100.0
Specialty										
General practitioner	13	52.0	14	60.9	17	73.9	36	80.0	80	69.0
Family physician	12	48.0	1	4.3	2	8.7	9	20.0	24	20.7
Emergency medicine specialist	-	-	-	-	3	13.0	-	-	3	2.6
Forensic medicine specialist	-	-	2	8.7	-	-	-	-	2	1.7
Internal medicine specialist	-	-	2	8.7	-	-	-	-	2	1.7
Anesthesiologist	-	-	1	4.3	-	-	-	-	1	0.9
General surgeon	-	-	1	4.3	-	-	-	-	1	0.9
Ophthalmologist	-	-	1	4.3	-	-	-	-	1	0.9
Orthopaedist	-	-	1	4.3	-	-	-	-	1	0.9
Pediatrician	-	-	-	-	1	4.3	-	-	1	0.9
Total**	25	21.5	23	19.9	23	19.9	45	38.7	116	100.0

*: Column percentage   **: Row percentage

Of the total number of respondents, 51.8% (n=116) were doctors, 36.6 (n=82) were nurses, 9.8% (n=22) were midwives, 1.3% (n=3) were paramedics, and 0.5% (n=1) was dentist.

Disaggregated by province, the data shows that more than half of the respondents were nurses in Hatay (58.6%, n=34) and Izmir (53.3%, n=32). In Şanlıurfa, 16 nurses participated in the study (20.0%) and no data could be collected from nurses in Gaziantep (n=0).

Şanlıurfa is the province with the highest number and percentage of midwife respondents (20.0%, n=16) compared to 3.8% (n=1) in Gaziantep, 1.7% (n=1) in Hatay and 6.7% (n=4) in Izmir.

All the paramedics who participated in the study were from Şanlıurfa (1.3%. n=3) and one dentist was from İzmir (0.5%, n=1) (Table 4.3).

The majority of respondents completed their vocational education after 2001 (71.1%, n=138). More than half of the respondents from Şanlıurfa (51.5%, n= 34) graduated in or after 2011. Overall data collected for this item (194 responses out of 224 respondents in total) for all provinces suggest that almost all respondents received their vocational education in the last 30 years between 1991-2011 (93.8%, n=182) (Table 4.3).

General practitioners constituted the majority of doctors who participated in the study (69%, n=80). The analysis of data by provinces also shows that the majority of respondents in four provinces were general practitioners [52.0 % (n=13) in Gaziantep, 60.9% (n=14) in Hatay, 73.9 % (n=17) in İzmir and 80.0 % (n=36) in Şanlıurfa]. The second most frequent specialty was found to be family medicine across all four provinces (20.7%, n=24). In addition to these two specialties. 3 emergency medicine specialists and 1 pediatrician from İzmir and 4 other specialties from Hatay (anesthesiologist, general surgeon, ophthalmologist and orthopedist) participated in the study (Table 4.3).

Table 4.4. Distribution of health professionals according to province and previous work experience (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

	Gaziantep		Hatay		İzmir		Şanlıurfa		Total*	
	n	%	n	%	n	%	n	%	n	%
Institution of the longest service duration										
Primary healthcare center/outpatient institution (state)	20	76.9	21	36.2	27	45.0	63	78.8	131	58.5
State hospital	4	15.4	22	37.9	25	41.7	11	13.8	62	27.7
Private hospital	-	-	7	12.1	2	3.3	3	3.8	12	5.4
Private clinic	-	-	6	10.3	4	6.7	-	-	10	4.5
Provincial health directorate	2	7.7	-	-	1	1.7	1	1.2	4	1.8
University	-	-	-	-	1	1.7	1	1.2	2	0.9
Non-profit organization	-	-	2	3.5	-	-	-	-	2	0.9
Emergency healthcare	-	-	-	-	-	-	1	1.2	1	0.4
Total	26	11.6	58	25.9	60	26.8	80	35.7	224	100.0
Previous workplace										
Primary healthcare center/outpatient institution (state)	18	69.2	22	37.9	13	21.7	40	50.0	93	41.5
State hospital	7	26.9	19	32.8	25	41.7	21	26.3	72	32.1
Private hospital	-	-	8	13.8	4	6.7	10	12.5	22	9.8
University	-	-	4	6.9	7	11.7	2	2.5	13	5.8
Private clinic	-	-	3	5.2	4	6.7	-	-	7	3.1
Health directorate	1	3.8	-	-	1	1.7	5	6.2	7	3.1
Non-profit organization	-	-	1	1.7	2	3.3	-	-	3	1.3
Emergency healthcare	-	-	-	-	-	-	2	2.5	2	0.9
None	-	-	1	1.7	4	6.7	-	-	5	2.2
Total**	26	11.6	58	25.9	60	26.8	80	35.7	224	100.0

*: Column percentage   **: Row percentage

More than half of the respondents served in primary healthcare centers, which include family health centers and migrant health centers, for a longer period of time in their careers (58.5 %, n=131). In Gaziantep (76.9 %, n=20) and Şanlıurfa (78.8%, n=63), the majority of respondents could be said to have had more years of experience in primary healthcare. The percentage of respondents for the same variable was found to be lower in İzmir (45%, n=27) and (Hatay 36.2%, n=21).

Overall, the second most frequent institution of longer period of service was state hospitals (27.7%, n=62) followed by private hospitals (5.4%, n=12), private clinics (4.5%, n=10), health directorates (1.8%, n=4), universities (0.9%, n=2), non-profit organizations (0.9%, n=2), and emergency healthcare (0.4%, n=1).

In Hatay, half of the respondents (50.0%, n=29) had the longest work experience at secondary level healthcare settings (i.e. in state or private hospitals), which is close to the percentage in İzmir (45%, n=27). This is different from Gaziantep (76.9%, n=20) and Şanlıurfa (78.8%, n=63) where more respondents were experienced predominantly in primary healthcare settings (Table 4.4).

41.5% (n=93) of all the respondents worked in primary healthcare before their current job whereas 41.9% (n=94) used to serve in secondary healthcare (state or private hospitals). Again, when analyzed according to province, it can be observed that almost half of the respondents in Hatay (46.6%, n=27) and İzmir (48.4%, n=29) worked in state or private hospitals whereas the percentage is 26.9% (n=7) in Gaziantep and in 38.8% (n=31) Şanlıurfa.

2.2% (n=5) of the respondents had no previous work experience before their current job, and their current job was in Hatay and İzmir.

There were 7 respondents whose previous job involved administrative duties in provincial health directorates in Gaziantep (3.8%, n=1), İzmir (1.7%, n=1) and Şanlıurfa (6.2%, n=5) (Table 4.4).

Table 4.5. Distribution of health professionals according to province and previous experience in serving migrant, refugee and asylum seekers (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Experience	Gaziantep		Hatay		İzmir		Şanlıurfa		Total*	
	n	%	n	%	n	%	n	%	n	%
Previous experience										
No	13	50.0	17	29.3	47	78.3	40	52.6	117	53.2
Yes	13	50.0	41	70.7	13	21.7	36	47.4	103	46.8
Total	26	11.8	58	26.4	60	27.3	76	34.5	220	100.0
Duration of work (Month)										
1-10	3	23.1	3	10.0	3	23.1	12	33.3	21	22.8
11-20	2	15.4	12	40.0	1	7.7	2	5.6	17	18.5
21-30	2	15.4	5	16.7	2	15.4	2	5.6	11	12.0
31-40	2	15.4	3	10.0	4	30.8	6	16.7	15	16.3
41-50	3	23.1	2	6.7	2	15.4	4	11.1	11	12.0
>50	1	7.7	5	16.7	1	7.7	10	27.8	17	18.5
Total**	13	14.1	30	32.6	13	14.1	36	39.1	92***	99.9

*: Column percentage   **: Row percentage
***: 11 participants did not respond to this item.

More than half of the respondents had no previous experience of working with migrant, refugee and asylum seekers prior to their current job (53.2%, n=117). The percentage of respondents with no past experience is the highest in İzmir (78.3%, n=47) and the lowest in Hatay (29.3%, n=17). In Gaziantep (50.0%, n=13) and Şanlıurfa (52.6%, n=40), half of the respondents were not experienced in healthcare provision to refugee, migrant and asylum seekers (Table 4.5).

A total of 92 responses could be collected for the question about the amount of relevant experience. The responses show that the duration of experience varied from 1 month to over 50 months, and there is a relatively even distribution of respondents across ranges of 9 months, with the highest frequency for 1-10 months of experience (22.8%, n=21).

Table 4.6 represents some descriptive statistics related to previous professional experience with migrant, refugee and asylum seekers. Duration of experience by month does not seem to vary much among the provinces with the longest duration in Şanlurfa (35,75±30,760 months) and the shortest in Hatay (29,37±20,883 months).

Table 4.6. Descriptive statistics showing duration of previous experience (months) with migrant, refugee and asylum seekers (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Province	Experience/ months*				
	Mean	SD	Min	Max	Median
İzmir	30.69	23.225	2	85	31.00
Hatay	29.37	20.883	3	84	21.00
Gaziantep	31.31	22.577	2	84	30.00
Şanlıurfa	35.75	30.760	1	96	36.00
All	32.33	25.481	1	96	29.00

*n=92

Table 4.7. Distribution of health professionals according to province and previous training characteristics relating to refugee health (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Training characteristics	Gaziantep		Hatay		İzmir		Şanlıurfa		Total*	
	n	%	n	%	n	%	n	%	n	%
Training relating to refugee health										
No	22	84.6	8	13.8	25	41.7	77	96.3	132	58.9
Yes	4	15.4	50	86.2	35	58.3	3	3.8	92	41.1
Total	26	11.6	58	25.9	60	26.8	80	35.7	224	100.0
Institution providing the training										
Ministry of Health	2	66.7	20	74.1	12	50.0	1	33.3	35	61.4
World Health Organization	-	-	-	-	8	33.3	-	-	8	14.0
Migrant Health Center	1	33.3	4	14.8	2	8.3	-	-	7	12.3
Public Health Presidency	-	-	2	7.4	1	4.2	2	66.7	5	8.8
Provincial Health Directorate	-	-	1	3.7	-	-	-	-	1	1.8
Other organizations	-	-	-	-	1	4.2	-	-	1	1.8
Total**	3	5.3	27	47.3	24	42.1	3	5.3	57	100.0

*: Column percentage   **: Row percentage

Table 4.7. (continued)

Training characteristics	Gaziantep		Hatay		İzmir		Şanlıurfa		Total*	
	n	%	n	%	n	%	n	%	n	%
Duration of training (day)										
1-20	2	100.0	15	38.5	19	70.4	2	100.0	38	54.3
21-40	-	-	-	-	3	11.1	-	-	3	4.3
41-60	-	-	19	48.7	5	18.5	-	-	24	34.3
>60	-	-	5	12.8	-	-	-	-	5	7.1
Total**	2	2.9	39	55.7	27	38.5	2	2.9	70	100.0

*: Column percentage   **: Row percentage

More than half of the respondents haven't received any training for health care provision to refugee populations (58.9%, n=132). The number of healthcare workers with relevant training is the highest in Hatay (86.2%, n=50), followed by İzmir (58.3, n=35) and Gaziantep (15.4%, n=4). The lowest percentage of training was in Şanlıurfa (3.8%, n=3) (Table 4.7).

61.4% (n=35) of all those who completed a training programme did so through Ministry of Health initiatives. (Table 4.7). Disaggregated by province, the percentage of the respondents in Hatay who completed the trainings provided by the Ministry of Health was the highest with 74.1% (n=20), followed by Gaziantep (66.7%, n=2), İzmir (50.0%, n=12) and Şanlıurfa (33.3%, n=1).

More than half of the respondents (54.3%, n=38) indicated that the duration of the trainings they received had taken from 1 to 20 days, and 34.3% (n=24) reported a duration between 41-60 days, latter of which was not mentioned in Gaziantep and Şanlıurfa provinces.

The descriptive statistics show that mean duration of training programmes was the highest in Hatay (36,10±28,418 days) and lowest in Şanlurfa (2,33±0,577 days). The overall response to this item from all four provinces shows that the majority took training that lasted less than 60 days (88.6%, n=62), with median 10.00 (Table 4.8).

Table 4.8. Descriptive statistics showing duration of previous training relating to refugee health according to provinces (Gaziantep, Hatay, İzmir, Şanlıurfa, January- March 2020)

| Province | Training/day* | | | | |
	Mean	SD	Min	Max	Median
İzmir	16.39	16.921	1	50	7.00
Hatay	36.10	28.418	3	121	45.00
Gaziantep	3.00	0.000	3	3	3.00
Şanlıurfa	2.33	0.577	2	3	2.00
All	26.51	26.104	1	121	10.00

*n=70

Table 4.9. Distribution of health professionals according to province and source of information about migrant, refugee and asylum seekers (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

| Source of information | Gaziantep | | Hatay | | İzmir | | Şanlıurfa | | Total* | |
	n	%	n	%	n	%	n	%	n	%
Internet	14	53.8	36	62.1	42	70.0	49	61.3	141	62.9
Television	14	53.8	19	32.8	23	38.3	58	72.5	114	50.9
Friends	7	26.9	29	50.0	28	46.7	33	41.3	97	43.3
Colleagues	15	57.7	21	36.2	15	25.0	33	41.3	84	37.5
Patients	13	50.0	14	24.1	17	28.3	35	43.8	79	35.3
Newspapers	7	26.9	4	6.9	11	18.3	30	37.5	52	23.2
Radio	6	23.1	3	5.2	5	8.3	21	26.3	35	15.6
Relatives	1	3.8	15	25.9	9	15.0	10	12.5	35	15.6
Training	3	11.5	10	17.2	16	26.7	-	-	29	12.9
Books	1	3.8	6	10.3	5	8.3	5	6.3	17	7.6
Articles	3	11.5	3	5.2	5	8.3	6	7.5	17	7.6
Travel abroad	-	-	-	-	1	1.7	1	1.3	2	0.9
Migrant health center	-	-	-	-	1	1.7	-	-	1	0.4
Ministry of Health	-	-	1	1.7	-	-	-	-	1	0.4
Observations	-	-	-	-	-	-	1	1.3	1	0.4
Health Directorate	-	-	-	-	-	-	1	1.3	1	0.4
Nonprofit organizations	-	-	-	-	1	1.7	-	-	1	0.4
Total**	84	11.8	161	22.7	179	25.3	283	40	707	-

* The numbers and percentages in the total column represent the number of respondents out of 224 selecting each option.

**The numbers and percentages in the total row represent the number of responses to the multiple selection item, not the number of respondents.

Internet was mentioned most frequently, by 62.9% (n=141) of all the 224 respondents, as a source used to access information related to migrant and refugee populations. The second and third most frequently utilized ways to reach information

were television (50.9%, n=114) and friends (43.3%, n=97) followed by colleagues (37.5%, n=84) and patients (35.3%, n=79) (Table 4.9).

Some sources such as newspapers (23.3%, n=52), radio (15.6%, n=35), relatives (15.6%, n=35), books (7.6%, n=17) and articles (7.6%, n=17) were mentioned less frequently than the top four sources indicated above, with trainings mentioned by only 12.9% (n=29) of the respondents.

Public institutions such as the ministry, health directorates and migrant health centers were indicated by few respondents (1.2%, n=3) (Table 4.9).

Table 4.10. Distribution of health professionals according to province and current workplace (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Current Workplace	Gaziantep		Hatay		İzmir		Şanlıurfa		Total*	
	n	%	n	%	n	%	n	%	n	%
Family health center	23	88.5	-	-	4	6.7	80	100.0	107	47.8
Migrant health center	-	-	57	98.3	45	75.0	-	-	102	45.5
Emergency healthcare	-	-	-	-	10	16.7	-	-	10	4.5
Cancer screening and early diagnosis center	3	11.5	-	-	1	1.7	-	-	4	1.8
Temporary shelter	-	-	1	1.7	-	-	-	-	1	0.4
Total**	26	11.6	58	25.9	60	26.8	80	35.7	224	100.0

*: Column percentage   **: Row percentage

Almost half of the respondents worked in family health centers (47.8%, n=107) and migrant health centers (45.5%, n=102).

In Şanlıurfa, the current workplace of all respondents (100.0%, n=80) was family health centers while in Hatay there was no respondent from these centers at all. A great number of respondents from Gaziantep also worked in family health centers (88.5%, n=23). Only 4 respondents (6.7%) from Izmir province mentioned that they work at family health centers.

Hatay had the highest percentage of respondents working in migrant health centers (98.3%, n=57), which was followed by İzmir (75.0%, n=45). No respondent from Gaziantep (and Şanlıurfa) worked in a migrant health center.

The only data available for respondents working in emergency healthcare centers is from İzmir (16.7%, n=10), and for temporary shelter from Hatay (1.7%, n=1).

There were 4 respondents in total, working in cancer screening and early diagnosis centers in Gaziantep (11.5%, n=3) and İzmir (1.7%, n=1) (Table 4.10).

Table 4.11. Distribution of health professionals according to province and duration of work in current workplace (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Duration (months)	Gaziantep		Hatay		İzmir		Şanlıurfa		Total*	
	n	%	n	%	n	%	n	%	n	%
1-12	5	19.2	9	17.0	17	28.8	16	20.0	47	21.6
13-24	7	26.9	28	52.8	15	25.4	11	13.8	61	28.0
25-36	1	3.8	16	30.2	16	27.1	9	11.3	42	19.3
37-48	3	11.5	-	-	1	1.7	10	12.5	14	6.4
>48 months	10	38.5	-	-	10	16.9	34	42.5	54	24.8
Total**	26	11.9	53	24.3	59	27.1	80	36.7	218	100.0

*: Column percentage   **: Row percentage

It could be stated that the respondents' months of experience in their current workplace vary widely across ranges. Almost half of the participants had up to 2 years (1-24 months) of experience (49.6%, n=108), and 24.8% (n=54) more than 4 years (Table 4.11).

In Gaziantep and Şanlıurfa, the number of respondents with more than 4 years of experience (>48 months) is the highest (38.5%, n= 10 and 42.5%, n=34, respectively). In Hatay, there are more respondents with the years of experience from 1 to 2 years (52.8%, n=28) and in İzmir from 1 month to 1 year (28.8%, n=17) (Table 4.11).

Similarly, Table 4.12 shows a higher number of months for Gaziantep (51,23±42,049; median=38.50) and Şanlıurfa (49,44±37,358; median= 41.00).

Table 4.12. Descriptive statistics showing duration of work in current workplace (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

| Province | Experience in current workplace/months* | | | | |
	Mean	SD	Min	Max	Median
Gaziantep	51.23	42.049	6	125	38.50
Hatay	20.17	8.557	2	32	20.00
İzmir	33.39	41.675	3	203	20.00
Şanlıurfa	49.44	37.358	1	123	41.00
All	38.19	36.698	1	203	25.00

*n=218

Table 4.13. Distribution of health professionals according to province and ability to speak a common language (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

| | Gaziantep | | Hatay | | İzmir | | Şanlıurfa | | Total* | |
	n	%	n	%	n	%	n	%	n	%
Ability to speak a common language										
Yes	5	19.2	51	87.9	36	60.0	17	22.4	109	49.5
No	21	80.8	7	12.1	24	40.0	59	77.6	111	50.5
Total	26	11.8	58	26.4	60	27.3	76	34.5	220	100.0
Proficiency level										
Advanced	1	33.3	49	96.1	30	96.8	-	-	80	85.1
Intermediate	1	33.3	-	-	-	-	1	11.1	2	2.1
Beginner	1	33.3	2	3.9	1	3.2	8	88.9	12	12.8
Total**	3	3.2	51	54.2	31	33.0	9	9.6	94	100.0

*: Column percentage **: Row percentage

50.5% of respondents (n=111) could not speak a common language with their migrant, refugee or asylum-seeking patients. When analyzed according to provinces, it can be observed that the majority of respondents in Gaziantep (80.8%, n=21) and Şanlıurfa (77.6, n=59) might have challenges in communication due to language barrier as opposed to Hatay (87.9%, n=51) where there was a great number of respondents who could communicate with patients through a common language, and İzmir (60.0%, n=36) where the number of respondents with the knowledge of patients' language (60.0%, n=36) is higher than those without (40.0%, n=24) (Table 4.13).

Regarding the level of proficiency among those who can speak a common language with migrant and refugee patients, the majority seems to have an advanced mastery (85.1%, n=80), with 12.8% (n=12) respondents declaring low levels of proficiency.

Table 4.14. Distribution of health professionals according to province, and number of consultations and working hours (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

	Working hours*			Consultations*		
Province	Median	Min	Max	Median	Min	Max
Gaziantep	8	1	8	60	1	140
Hatay	9	7	9	40	10	200
İzmir	8	0	24	50	0	90
Şanlıurfa	1.5	0	12	30	0	200

*n=189

The median score for the working hours did not vary much among the three provinces, namely Gaziantep, Hatay and İzmir with a higher median indicated by the respondents in Hatay than the rest of the provinces. Şanlıurfa reported the lowest median value for the working hours (Table 4.14).

With regard to the average number of consultations per day, the analyses showed a higher median score in Gaziantep compared to Hatay, İzmir and Şanlıurfa.

Table 4.15. Distribution of health professionals according to province and ethnicity of patients (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Ethnicity		Gaziantep		Hatay		İzmir		Şanlıurfa		Total*	
		n	%	n	%	n	%	N	%	n	%
Syrian	Very often	22	84.6	51	100.0	50	96,2	47	74.6	170	88.5
	Often	4	15.4	-	-	2	3,8	16	25.4	22	11.5
	Total**	26	13.5	51	26.6	52	27.1	63	32.8	192	100.0
Afghan	Often	-	-	-	-	6	40.0	-	-	6	40.0
	Sometimes	-	-	-	-	8	53.3	-	-	8	53.3
	Rarely	-	-	-	-	1	6.7	-	-	1	6.7
	Total**	-	-	-	-	15	10.0	-	-	15	100.0
Iraqi	Often	-	-	-	-	11	84.6	7	63.6	18	75.0
	Sometimes	-	-	-	-	2	15.4	3	27.3	5	20.8
	Rarely	-	-	-	-	-	-	1	9.1	1	4.2
	Total**	-	-	-	-	13	54.2	11	45.8	24	100.0
Turkish	Very often	4	66.7	-	-	3	100.0	21	95.5	28	90.3
	Often	2	33.3	-	-	-	-	1	4.5	3	9.7
	Total**	6	19.4	-	-	3	9.7	22	71.0	31	100.0

*: Column percentage **: Row percentage

Most respondents indicated Syrian, Turkish, Afghan, and Iraqi patients as the patients they saw **very often**, **often** or **sometimes**. A variety of other ethnicities were also mentioned by few participants which were given in a more detailed table in Annex 3.

The majority of responses indicate **very frequent** (**very often**) consultations with Syrian refugees (88.5%, n=170). This finding is consistent with province-disaggregated data which shows high numbers of respondents for **very frequent** and **frequent** consultations for Syrians in 4 provinces (n=192) (Table 4.15).

The number of responses for the same level of frequency (i.e. both very often and often scale) for Afghan (n=6), Iraqi (n=18), Turkish (n=31), Bulgarian (n=2), Libyan (n=3), Omani (n=1), Lebanese (n=1), and Iranian (n=1) consultations was relatively low as shown in Annex 3-Table 4.15.

The data in Table 4.15 also show that some respondents provided **occasional** (**i.e**. **sometimes**) primary healthcare services to Afghan (n=8), Iraqi (n=5), Libyan (n=2), Uzbekistani (n=1), Dutch (n=1), Palestinian (n=2), African (n=2), and Russian (n=1) patients (Annex 3-Table 4.15.).

Table 4.16. Distribution of health professionals according to province and patient characteristics (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Patient characteristics	Gaziantep		Hatay		İzmir		Şanlıurfa		Total*	
	n	%	N	%	n	%	n	%	n	%
The most prevalent patient group										
Children	22	25.3	40	26.3	43	23.2	62	26.8	167	25.5
Women	21	24.1	37	24.3	49	26.5	59	25.5	166	25.3
Infants	21	24.1	30	19.7	38	20.5	66	28.6	155	23.7
Adults	10	11.5	24	15.8	27	14.6	23	10.0	84	12.8
Older persons	13	14.9	21	13.8	27	14.6	18	7.8	79	12.1
Pregnant women	-	-	-	-	-	-	3	1.3	3	0.5
Homecare patients	-	-	-	-	1	0.5	-	-	1	0.2
Total**	87	13.3	152	23.2	185	28.2	231	35.3	655	100.0

* The numbers in the total column represent the number of respondents out of 224 selecting each patient group. The percentages indicate the frequency of each response out of 655 total responses.
**The numbers and percentages in the total row represent the number of responses to the multiple selection item, not the number of respondents.

Table 4.16. (continued)

Patient characteristics	Gaziantep		Hatay		İzmir		Şanlıurfa		Total*	
	n	%	n	%	n	%	n	%	n	%
The most challenging group to serve										
Infants	10	18.9	36	41.4	19	24.4	35	25.5	100	28.2
Women	14	26.4	20	23.0	13	16.7	27	19.7	74	20.8
Older persons	12	22.6	10	11.5	22	28.2	26	19.0	70	19.7
Children	6	11.3	14	16.1	10	12.8	21	15.3	51	14.4
Adults	9	17.0	3	3.4	10	12.8	28	20.4	50	14.1
Adolescents	1	1.9	2	2.3	2	2.6	-	-	5	1.4
Homecare patients	-	-	1	1.1	1	1.3	-	-	2	0.6
Patients with injury	-	-	1	1.1	1	1.3	-	-	2	0.6
Other	1	1.9	-	-	-	-	-	-	1	0.3
Total**	53	14.9	87	24.5	78	22.0	137	38.6	355	100.0
Challenges										
Language barrier	19	70.4	3	12.0	15	41.7	40	57.1	77	48.7
Negative/nonadaptive behavior	2	7.4	4	16.0	4	11.1	8	11.4	18	11.4
Lack of communication due to disability and old age	-	-	2	8.0	2	5.6	2	2.9	6	3.8
Vaccine noncompliance	-	-	1	4.0	1	2.8	4	5.7	6	3.8
Low level of education	-	-	1	4.0	2	5.6	2	2.9	5	3.2
Resistance to diagnosis and treatment	1	3.7	2	8.0	2	5.6	-	-	5	3.2
Difficulty of performing venipuncture	-	-	1	4.0	2	5.6	2	2.9	5	3.2
Cultural differences	1	3.7	-	-	-	-	4	5.7	5	3.2
Lack of drug compliance	-	-	1	4.0	2	5.6	1	1.4	4	2.5
Lack of specialty in infant healthcare	1	3.7	2	8.0	1	2.8	-	-	4	2.5
Unnecessary applications	2	7.4	-	-	-	-	2	2.9	4	2.5
Insufficient number of personnel and equipment	-	-	4	16.0	-	0.0	-	-	4	2.5
Low level of health literacy	-	-	-	-	1	2.8	2	2.9	3	1.9
Registration and ID problems	-	-	1	4.0	1	2.8	-	-	2	1.3
Timidity of female patients	-	-	-	-	-	-	2	2.9	2	1.3
Frequent pregnancies	1	3.7	1	4.0	-	-	-	-	2	1.3
Mental problems	-	-	1	4.0	1	2.8	-	-	2	1.3
No authority to prescribe medicine	-	-	-	-	1	2.8	-	-	1	0.6
Increased time for consultations	-	-	-	-	1	2.8	-	-	1	0.6
High number of NCDs***	-	-	-	-	-	-	1	1.4	1	0.6
Difficulty of reaching patients	-	-	1	4.0	-	-	-	-	1	0.6
Total**	27	17.1	25	15.8	36	22.8	70	44.3	158	100.0

***: Non-communicable diseases

As shown in Table 4.16, children (25.5%, n=167), women (25.3%, n=166) and infants (23.7%, n=155) constitute the most prevalent patient groups that the respondents served. Infants were mentioned to be the most challenging group by 28.2% (n=100) of respondents, which is followed by women (20.8%, n=74) and older people (19.7%, n=70). Analyzed according to province, Gaziantep is the only province that placed women (26.4%, n=14) before infants (18.9%, n=10) in terms of difficulty to serve.

48.7% (n=77) of the respondent indicated language barrier as a challenge in healthcare provision to migrant, refugee and asylum seekers. The percentages of the respondents mentioning this problem vary across provinces from higher numbers in Gaziantep (70.4%, n=19) and Şanlıurfa (57.1%, n=40) to Izmir (41.7%, n= 15) and Hatay (12.0%, n=3) (Table 4.16).

Table 4.17. Distribution of health professionals according to province and their self-reported knowledge of legal status and rights of migrant, refugee and asylum seekers (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

| | Sufficient level of knowledge | | | | | |
| | Yes | | No | | Total* | |
Province	n	%	n	%	n	%
Gaziantep	3	3.3	23	17.7	26	11.8
Hatay	45	49.5	13	10.0	58	26.2
İzmir	38	41.8	22	16.9	60	27.1
Şanlıurfa	5	5.5	72	55.4	77	34.8
Total**	91	41.2	130	58.8	221	100.0

*: Column percentage   **: Row percentage

As shown in Table 4.17, less than half of the participants (41.2%, n= 91) stated that they were knowledgeable about the legal entitlements and status of the refugee populations they were serving. The percentages of participants with self-reported, adequate knowledge were observed to be quite low particularly in Şanlıurfa (5.5%, n=5) and Gaziantep (3.3%, n=3) as opposed to Hatay (49.5%, n=45) and İzmir (41.8%, n=38) (Table 4.17).

Table 4.18. Distribution of health professionals according to province and the most significant challenges to care (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Challenges	Gaziantep		Hatay		İzmir		Şanlıurfa		Total	
	n	%	n	%	n	%	n	%	n	%
Most significant challenge										
Lack of communication/ language barrier	17	68.0	-	-	9	21.4	47	79.7	73	47.7
Heavy workload	-	-	6	22.2	6	14.3	1	1.7	13	8.5
Negative/nonadaptive behavior	3	12.0	4	14.8	2	4.8	1	1.7	10	6.5
Registration and ID problems	-	-	1	3.7	5	11.9	-	-	6	3.9
Poor hygiene	1	4.0	-	-	2	4.8	2	3.4	5	3.3
Vaccine noncompliance	-	-	-	-	2	4.8	3	5.1	5	3.3
Difficulty of reaching patients	2	8.0	-	-	-	-	2	3.4	4	2.6
Insufficient number of personnel and equipment	-	-	2	7.4	2	4.8	-	-	4	2.6
Adolescent pregnancy	2	8.0	-	-	-	-	-	-	2	1.3
Low salary	-	-	2	7.4	-	-	-	-	2	1.3
Ambiguity of legal entitlements	-	-	-	-	-	-	2	3.4	2	1.3
Low level of education	-	-	1	3.7	-	-	-	-	1	0.7
Cultural differences	-	-	-	-	1	2.4	-	-	1	0.7
No sense of security (health workers)	-	-	-	-	1	2.4	-	-	1	0.7
Mental health problems (patients)	-	-	-	-	1	2.4	-	-	1	0.7
Low socio-economic status	-	-	-	-	1	2.4	-	-	1	0.7
Lack of experience and trust (patients)	-	-	-	-	-	-	1	1.7	1	0.7
None	-	-	11	40.7	10	23.8	-	-	21	13.7
Total	25	16.3	27	17.6	42	27.5	59	38.6	153	100.0

As shown in Table 4.18, almost half of the respondents stated that communication problems resulting from language barrier were the most challenging aspect of their work with refugee populations (47.7%, n=73). While the percentages of respondents in this group are high in Şanlıurfa (79.7%, n=47) and Gaziantep

(68.0%, n=17), 21.4% (n=9) of the respondents from İzmir and none from Hatay mentioned language barrier as the most important issue.

13.7% (n=21) of the respondents mentioned that they had no major problems in service provision. They all worked in Hatay (40.7%, n=11) and İzmir (23.8%, n=10) (Table 4.18).

Heavy workload (8.5%, n=13) and negative/nonadaptive patient behaviour (6.5%, n=10) were respectively the second and third most frequently mentioned challenges after language barrier (Table 4.18).

In addition to the most significant challenges to care, the respondents were also inquired about the frequency of their experience with a variety of challenges relating to the healthcare delivery. Similar to the data available in Table 4.18, the extended table in Annex 4 shows that a lack of communication due to language barrier was mentioned by 97 respondents as a challenge faced "very often" and "often". The other issues reported with the same frequency (i.e. very often and often) were heavy workload (n=16), negative/nonadaptive patient behaviour (e.g. missing appointments, forcing prescription of certain drugs, disrespect) (n=13), difficulty in reaching patients (63.2%, n=12), cultural differences (n=10), vaccine noncompliance (n=9), Registration and ID card problems (n=8), poor hygiene (n=7), a lack of information (n=7), unnecessary application to centers (n=6), insufficient number of personnel and equipment (n=5), low level of education (n=4), mental health status of patients (n=3), a lack trust (n=2), drug noncompliance (n=2), ambiguity of legal entitlements (n=1) and low socio-economic status of patients (n=2). Among all these issues, linguistic barrier seemed to be the most common and frequent one which respondents have to deal with, especially in Şanlıurfa (n=63) and Gaziantep (n=20) (Annex 4-Table 4.18/extended).

4.2 Perceptions of Respondents About Healthcare Provision to Migrants, Refugees and Asylum Seekers

According to Table 4.19, 48.4% (n=108) of the respondents "strongly agreed" or "agreed" with the statement "*I am pleased to offer health care to migrants, refugees or asylum seekers*" while 33.6% (n=75) "strongly disagreed" or "disagreed" with it, with 17.9% (n=40) neutral response.

More than half of the respondents "strongly agreed" or "agreed" with the statement "*Speaking different languages when providing health care to migrants, refugees or asylum seekers makes my job difficult*" (61.6%, n=138), whereas 26.3% (n=59) "strongly disagreed" or "disagreed" with it. 12.1% (n=27) chose to provide a neutral response (Table 4.19.1).

The majority of the respondents (74.0%, n=165) chose options "strongly agree" or "agree" for the statement "*Being able to speak the language of migrants, refugees or asylum seekers improves the quality of the service provided*". On the other hand, only 15.7% (n=35) responded "strongly disagree" or "disagree", with 10.3% (n=23) neutral response (Table 4.19.1).

65.2% (n=146) of the total respondents "strongly agreed" or "agreed" with the statement "*The fact that I speak different languages with migrant, refugee or asylum-seeker patients often causes me to not fully understand their health status*" while 19.6% (n=44) "strongly disagreed" or "disagreed" with it, with 15.2% (n=34) respondents chose the option "neutral" (Table 4.19.1).

Several respondents "strongly agreed" or "agreed" with the statement "*The support of interpreters is crucial in terms of providing appropriate services to migrants, refugees or asylum seekers*" (76.8%, n=172) while only 8.1% (n=18) "strongly disagreed" or "disagreed", with 15.2% (n=34) of neutral response (Table 4.19.1).

39.0% (n=85) of the respondents gave "strongly agree" or "agree" response to the statement "*Most of the interpreters I work with have the competence required for the service*" and 28.5% (n=62) responded "strongly disagree" or "disagree". The percentage of respondents providing a neutral response was 32.6% (n=71) (Table 4.19.1).

Table 4.19.1. Distribution of health professionals according to their responses to statements about healthcare provision to migrant, refugee and asylum seekers (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Statement		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
I am pleased to offer health care to migrants, refugees or asylum seekers.	n	50	25	40	50	58	223
	%	22.4	11.2	17.9	22.4	26.0	100.0
Speaking different languages when providing health care to migrants, refugees or asylum seekers makes my job difficult.	n	30	29	27	45	93	224
	%	13.4	12.9	12.1	20.1	41.5	100.0
Being able to speak the language of migrants, refugees or asylum seekers improves the quality of the service provided.	n	25	10	23	54	111	223
	%	11.2	4.5	10.3	24.2	49.8	100.0
The fact that I speak different languages with migrant, refugee or asylum-seeker patients often causes me to not fully understand their health status.	n	22	22	34	58	88	224
	%	9.8	9.8	15.2	25.9	39.3	100.0
The support of interpreters is crucial in terms of providing appropriate services to migrants, refugees or asylum seekers.	n	8	10	34	46	126	224
	%	3.6	4.5	15.2	20.5	56.2	100.0
Most of the interpreters I worked with have the competence required for the service.	n	27	35	71	34	51	218
	%	12.4	16.1	32.6	15.6	23.4	100.0

Table 4.19.2 (continued)

Statement		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
Working with interpreters leads to a prolonged period of consultations and examinations with the patient.	n	24	31	47	58	61	221
	%	10.9	14.0	21.3	26.2	27.6	100.0
The interpreters I work with greatly facilitate my communication with patients.	n	13	13	43	80	71	220
	%	5.9	5.9	19.5	36.4	32.3	100.0
Interpreters need to be familiar with medical terminology in order to provide a better service.	n	11	21	32	60	99	223
	%	4.9	9.4	14.3	26.9	44.4	100.0
Interpreters need to have detailed knowledge of the culture of the community they serve.	n	13	9	37	75	89	223
	%	5.8	4.0	16.6	33.6	39.9	100.0
My patient consultations with interpreters usually go smoothly.	n	13	28	53	80	44	218
	%	6.0	12.8	24.3	36.7	20.2	100.0
The presence of an interpreter in service delivery has a negative effect on patient privacy.	n	20	38	51	58	55	222
	%	9.0	17.1	23.0	26.1	24.8	100.0
Interpreters should receive training on issues relating to migrants, refugees or asylum seekers.	n	11	7	24	76	105	223
	%	4.9	3.1	10.8	34.1	47.1	100,0

Table 4.19.2 shows that more than half of the respondents (53.8%, n=119) "strongly agreed" or "agreed" with the statement "*Working with interpreters leads to a prolonged period of interviewing and examinations with the patient*" whereas 24.9% (n=55) "strongly disagreed" or "disagreed" with it. 21.3% (n=47) chose to respond neutrally.

68.7% (n=151) of the respondents gave "strongly agree" or "agree" response to the statement "*The interpreters I work with greatly facilitate my communication with patients*" and only 11.8% (n=26) of the responses were "strongly disagree" or "disagree", with 19.5% (n=43) neutral response (Table 4.19.2).

Many respondents (71.3%, n=159) "strongly agreed" or "agreed" with the statement "*Interpreters need to be familiar with medical terminology in order to provide a better service*" . It was 14.3% (n=32) of the total respondents who "strongly disagreed" or "disagreed" with it , and 14.3% (n=32) gave a neutral response (Table 4.19.2).

73.5% (n=164) of the respondents "strongly agreed" or "agreed" with the statement "*Interpreters need to have detailed knowledge of the culture of the community they serve*" whereas only 9.8% (n=22) "strongly disagreed" or "disagreed" with it and 16.6% (n=37) had a neutral stance (Table 4.19.2).

More than half of the respondents provided "strongly agree" or "agree" responses to the statement *"My patient consultations with interpreters usually go smoothly"* (56.9%, n=124), 18.8% (n=41) chose to "strongly disagree" or "disagree", and 24.3% (n=53) had a neutral attitude (Table 4.19.2).

Half of the respondents (50.9%, n=113) either "strongly agreed" or "agreed" with the statement "*The presence of an interpreter in service delivery has a negative effect on patient privacy*. 26.1% (n=58) of the responses were "strongly disagree" or "disagree", 23.0% (n=51) were neutral (Table 4.19.2).

The majority of the respondents (81.2%, n=181) "strongly agreed" or "agreed" with the statement "*Interpreters should receive training on issues relating to migrants, refugees or asylum seekers*". Only 8.0% (n=18) of the respondents chose options "disagree" or "strongly disagree" (Table 4.19.2).

Table 4.19.3 (continued)

Statement		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
Health workers should be trained in the methods of working with interpreters when communicating with migrant, refugee or asylum-seeking patients.	n	17	20	32	81	73	223
	%	7.6	9.0	14.3	36.3	32.7	100.0
I have sufficient knowledge of the culture of migrants, refugees or asylum seekers I serve.	n	37	48	55	38	45	223
	%	16.6	21.5	24.7	17.0	20.2	100.0
The difference in culture between me and migrant, refugee or asylum seeker patients is one of the important factors that raises my stress level in my daily work life.	n	23	42	49	58	51	223
	%	10.3	18.8	22.0	26.0	22.9	100.0
Migrant, refugee or asylum seeker patients talk about their illnesses comfortably with health workers.	n	25	38	46	67	45	221
	%	11.3	17.2	20.8	30.3	20.4	100.0
I have sufficient knowledge of the legal status of migrants, refugees or asylum seekers.	n	37	63	59	38	25	222
	%	16.7	28.4	26.6	17.1	11.3	100.0
I have sufficient knowledge of the health rights of migrants, refugees or asylum seekers.	n	33	63	44	52	30	222
	%	14.9	28.4	19.8	23.4	13.5	100.0

69% (n=154) of the respondents "strongly agreed" or "agreed" with the statement "*Health workers should be trained in the methods of working with interpreters when communicating with migrant, refugee or asylum-seeking patients*" while 16.6% (n=37) "strongly disagreed" or "disagreed" with it. 14.3% (n=32) of the respondents provided a "neutral" answer (Table 4.19.3).

The responses showing both agreement and disagreement with the statement "*I have sufficient knowledge of the culture of migrants, refugees or asylum seekers I provide services to*" were distributed quite evenly with 37.2% (n=83) of all the responses "strongly agreeing" and "agreeing", and 38.1% (n=85) "strongly disagreeing" and "disagreeing" with the statement. The respondents who neither agreed nor disagreed represented a quarter of the overall study population (24.7%, n=55) (Table 4.19.3).

Almost half of the respondents (48.8%, n=109) "strongly agreed" or "agreed" with the statement "*The difference in culture between me and migrant, refugee or asylum seeker patients is one of the important factors that raise my stress level in my daily work life*", 29.1% (n=65) "strongly disagreed" or "disagreed", and 22.0% (n=49) provided a neutral response (Table 4.19.3).

Half of the respondents (50.7%, n=112) "strongly agree" or "agree" with the statement "*Migrant, refugee or asylum seeker patients talk about their illnesses comfortably with health workers*", with 28.5% (n=63) "disagreeing" or "strongly disagreeing", and 20.8% (n=46) responding neutrally (Table 4.19.3).

Overall, there were more respondents who "disagreed" or "strongly disagreed" with the statement "*I have sufficient knowledge of the legal status of migrants, refugees or asylum seekers*" (45.1%, n=100) than those who "agreed" or "strongly agreed" with it (28.4%, n=63), with 26.6% (n=59) respondents providing a neutral comment (Table 4.19.3).

Although the percentages are close, there were more respondents who "strongly disagreed" or "disagreed" with the statement "*I have sufficient knowledge of the health rights of migrants, refugees or asylum seekers*" (43.3%, n=96) than those who "agreed" or "strongly agreed" with it (36.9%, n=82) (Table 4.19.3).

Table 4.19.4 (continued)

Statement		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
Migrant, refugee or asylum seeker patients have insufficient level of knowledge of health care in Turkey.	n	24	33	60	60	44	221
	%	10.9	14.9	27.1	27.1	19.9	100.0
The perception of illness of migrant, refugee or asylum-seeking patients is quite different from that of Turkish citizen patients.	n	21	29	69	59	43	221
	%	9.5	13.1	31.2	26.7	19.5	100.0
Health workers should be aware of the customs and traditions of the migrants, refugees or asylum seekers they provide services to.	n	23	28	45	81	43	220
	%	10.5	12.7	20.5	36.8	19.5	100.0
Providing health care to migrants, refugees or asylum seekers is easy.	n	64	59	38	38	21	220
	%	29.1	26.8	17.3	17.3	9.5	100.0
Diagnosis of mental health problems in migrant, refugee or asylum seeker patients is more difficult than in patients who are citizens of Turkey.	n	16	22	62	50	70	220
	%	7.3	10.0	28.2	22.7	31.8	100.0
Conducting laboratory tests on migrant, refugee or asylum-seeking patients is more difficult than that of Turkish citizens.	n	34	59	55	37	35	220
	%	15.5	26.8	25.0	16.8	15.9	100.0

Table 4.19.4 shows that almost half of the respondents (47.0%, n=104) chose to "agree" or "strongly agree" with the statement "*Migrant, refugee or asylum seeker patients have insufficient knowledge of health care in Turkey*" whereas 25.8% (n=57) disagreed or strongly disagreed with it.

Almost half of the respondents (46.2%, n=102) gave an "agreeing" or "strongly agreeing" response to the statement "*The perception of illness of migrant, refugee or asylum-seeking patients is quite different from that of Turkish citizen patients*" and 22.6% (n=50) chose to disagree or strongly disagree with it, with 31.2% (n=69) of the respondents providing a neutral stance (Table 4.19.4).

Over half of the respondents (56.3%, n=124) "agreed" or "strongly agreed" with the statement "*Health workers should be aware of the customs and traditions of the migrants, refugees or asylum seekers they provide services to*". 20.5% (n=45) preferred to respond neutrally and 23.2% (n=51) "disagreed" or "strongly disagreed" with the idea of becoming knowledgeable about the customs and traditions of the migrants, refugees or asylum seekers they serve (Table 4.19.4).

More than half of the respondents chose to "disagree" or "strongly disagree" with the statement "*Providing health care to migrants, refugees or asylum seekers is easy*" (55.9%, n=123), with 26.8% (n=59) agreeing or strongly agreeing (Table 4.19.4).

Over half of the respondents (54.5%, n=120) "agreed" or "strongly agreed" with the statement "*Diagnosis of mental health problems in migrant, refugee or asylum-seeking patients is more difficult than in patients who are citizens of Turkey*". 17.3% (n=38) chose to respond "disagree" or "strongly disagree" and 28.2% (n=62) gave a neutral response (Table 4.19.4).

42.3% (n=93) of all the responses to the statement "*Conducting laboratory tests on migrant, refugee or asylum-seeking patients are more difficult than those of Turkish citizens*" was "disagree" or "strongly disagree", and 32.7% (n=72) was "agree" or "strongly agree", which was followed by 25.0% (n=55) "neutral" responses (Table 4.19.4).

Table 4.19.5 (continued)

Statement		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
Convincing migrants, refugees or asylum seekers to a certain treatment method is more difficult than for patients who are citizens of Turkey.	n	21	46	57	50	47	221
	%	9.5	20.8	25.8	22.6	21.3	100.0
Migrant, refugee or asylum seeker patients act in accordance with the rules such as application, appointment times, queue-taking.	n	48	42	50	50	31	221
	%	21.7	19.0	22.6	22.6	14.0	100.0
Migrant, refugee or asylum seeker patients have a high level of confidence in medical staff.	n	22	35	72	53	39	221
	%	10.0	15.8	32.6	24.0	17.6	100.0
The number of staff in the working environment where I serve migrants, refugees or asylum seekers is sufficient.	n	44	66	47	39	25	221
	%	19.9	29.9	21.3	17.6	11.3	100.0
Reproductive health counseling materials are sufficient in the working environment where I serve migrants, refugees or asylum seekers.	n	30	42	67	51	31	221
	%	13.6	19.0	30.3	23.1	14.0	100.0

Table 4.19.5 shows that 43.9% (n=97) of the respondents "agreed" or "strongly agreed" with the statement "*Convincing migrants, refugees or asylum seekers to a certain treatment method is more difficult than for patients who are citizens of Turkey*". The percentage of respondents who "disagreed" or "strongly disagreed" with it was 30.3% (n=67). 25.8% (n=57) of the respondents chose to provide a neutral response to the item.

40.7% (n=90) of the respondents chose to "disagree" or "strongly disagree" with the statement "*Migrant, refugee or asylum seeker patients act in accordance with the rules such as application, appointment times, queue-taking*" while 36.6% (n=81) agreed" or "strongly agreed" with it. There were 50 respondents (22.6%) who responded to this item neutrally (Table 4.19.5).

41.6% (n=92) of all the respondents either "agreed" or "strongly agreed" with the statement "*Migrant, refugee or asylum seeker patients have a high level of confidence in their medical staff*" whereas 32.6% (n=72) responded to it neutrally. The percentage of the respondents who chose to "disagree" or "strongly disagree" with the statement was 25.8% (n=57) (Table 4.19.5).

Almost half of the respondents (49.8%, n=110) expressed their "disagreement" or "strong disagreement" with the statement "*The number of staff in the working environment where I serve migrants, refugees or asylum seekers is sufficient*". On the other hand, 28.9% (n=64) "agreed" or "strongly agreed" with it, and 21.3% (n=47) responded neutrally (Table 4.19.5).

The responses to the statement "*Reproductive health counseling material is sufficient in the working environment where I serve migrants, refugees or asylum seekers*" were observed to be quite distributed across the scale, with the most frequent single response being "neutral" (30.3%, n=67). In total, 32.6% (n=72) of the respondents chose to "strongly disagree" or "disagree" with the statement, and 37.1% (n=82) "agreed" or "strongly agreed" with it (Table 4.19.5).

Table 4.19.6 (continued)

Statement		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
The physical conditions of the working environment in which I serve migrants, refugees or asylum seekers are sufficient.	n	33	44	62	58	24	221
	%	14.9	19.9	28.1	26.2	10.9	100.0
Providing services to migrants, refugees or asylum seekers is exhausting in terms of the mental health of the service provider.	n	15	31	53	56	66	221
	%	6.8	14.0	24.0	25.3	29.9	100.0
When providing services to migrants, refugees or asylum seekers, there are times I feel under threat (e.g. threat of physical violence).	n	39	58	48	52	24	221
	%	17.6	26.2	21.7	23.5	10.9	100.0
If I had other opportunities, I would still like to serve migrants, refugees or asylum seekers.	n	41	28	61	48	43	221
	%	18.6	12.7	27.6	21.7	19.5	100.0
I feel professionally satisfied when serving migrants, refugees and asylum seekers.	n	34	31	59	58	39	221
	%	15.4	14.0	26.7	26.2	17.6	100.0

According to Table 4.19.6, the responses to the statement "*The physical conditions of the working environment in which I serve migrants, refugees or asylum seekers are sufficient*" were distributed widely, with 34.8% (n=77) of the respondents "disagreeing" or "strongly disagreeing" with the statement, 37.1% (n=82) "agreeing" or "strongly agreeing", and 28.1% (n=62) providing a neutral response.

More than half of the respondents (55.2%, n=122) chose to "agree" or "strongly agree" with the statement "*Providing services to migrants, refugees or asylum seekers is exhausting in terms of the mental health of the service provider*" while 20.8% (n=46) "disagreed" or "strongly disagreed" with it and 24.0% (n=53) showed a neutral stance (Table 4.19.6).

43.8% (n=97) of the respondents "disagreed" or "strongly disagreed" with the statement "*When providing services to migrants, refugees or asylum seekers, there are times I feel under threat (e.g. threat of physical violence)*" whereas 34.4% (n=76) "agreed" or "strongly agreed" with it (Table 4.19.6).

41.2% (n=91) of the respondents "agreed" or "strongly agreed" with the statement "*If I had other opportunities, I would still like to serve migrants, refugees or asylum seekers*", and 31.3% (n=69) "disagreed" or "strongly disagreed" with it. There were 61 respondents (27.6%) who did not indicate a preference by choosing the option "neutral" (Table 4.19.6).

Overall, 43.8% (n=97) of the respondents gave "strongly agree" or "agree" response to the statement "*I feel professionally satisfied when serving migrants, refugees and asylum seekers*" while 29.4% (n=65) "disagreed" or "strongly disagreed" with the statement with 26.7% (n=59) responding "neutrally" (Table 4.19.6).

4.3 Responses to the Maslach Burnout Inventory

Table 4.20 shows that overall, the distribution of responses to Emotional Exhaustion (EE) subscale items across the frequency scale was observed to be quite extended. The items that were reported to be most frequently experienced (i.e. "every day" and "a few times a week") by relatively more respondents were as follows:

"*I feel used up at the end of the workday.*" (every day: 28.4%, n=63, a few times a week: 27.0%, n=60)

"*I feel I'm working too hard on my job.*" (every day: 31.2%, n=69)

Items less frequently experienced (i.e. "a few times a month") by proportionately the highest number of respondents included the following:

"I feel emotionally drained from my work." (32.0%, n=71)

"I feel fatigued when I get up in the morning and have to face another day on the job." (30.6%, n=68)

"Working with people all day is really a strain for me." (27.9%, n=62)

"I feel burned out from my work." (32.4%, n=72)

In terms of the least frequently experienced items, it was observed that the items *"I feel frustrated by my job"* and *"I feel like I'm at the end of my rope."* were "never" experienced by the highest percentage of respondents (29.9%, n=66; 38.7%, n=86, respectively).

Table 4.20. Distribution of health professionals according to the frequency of their experience of emotional exhaustion subscale* (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Statement		Never	A few times a year	A few times a month	A few times a week	Every day	Total
I feel emotionally drained from my work.	n	51	38	71	33	29	222
	%	23.0	17.1	32.0	14.9	13.1	100.0
I feel used up at the end of the workday.	n	17	27	55	60	63	222
	%	7.7	12.2	24.8	27.0	28.4	100.0
I feel fatigued when I get up in the morning and have to face another day on the job.	n	33	30	68	44	47	222
	%	14.9	13.5	30.6	19.8	21.2	100.0
Working with people all day is really a strain for me.	n	47	44	62	35	34	222
	%	21.2	19.8	27.9	15.8	15.3	100.0
I feel burned out from my work.	n	48	28	72	31	43	222
	%	21.6	12.6	32.4	14.0	19.4	100.0

* Maslach Burnout Inventory

Table 4.20 (continued)

Statement		Never	A few times a year	A few times a month	A few times a week	Every day	Total
I feel frustrated by my job.	n	66	46	54	31	24	221
	%	29.9	20.8	24.4	14.0	10.9	100.0
I feel I'm working too hard on my job.	n	32	28	54	38	69	221
	%	14.5	12.7	24.4	17.2	31.2	100.0
Working with people directly puts too much stress on me.	n	47	59	55	27	34	222
	%	21.2	26.6	24.8	12.2	15.3	100.0
I feel like I'm at the end of my rope.	n	86	62	39	15	20	222
	%	38.7	27.9	17.6	6.8	9.0	100.0

* Maslach Burnout Inventory

The responses to the depersonalization subscale (DP) of the Maslach Burnout Inventory show that the highest percentage of respondents "never" experiencing the feelings described in the items (Table 4.21).

More than half of the respondents reported that they "never" feel "they don't really care what happens to their patients" (56.1%, n=124). Similarly, 45.0% of the respondents chose the option never for the item "I feel I treat some patients as if they were impersonal objects" (45.0%, n=100).

Compared to the items above, relatively fewer respondents chose "never" as the most frequent response to the other items as shown in Table 4.21.

Table 4.21. Distribution of health professionals according to the frequency of their experience of depersonalization subscale* (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Statement		Never	A few times a year	A few times a month	A few times a week	Every day	Total
I feel I treat some patients as if they were impersonal 'objects'.	n	100	37	54	21	10	222
	%	45.0	16.7	24.3	9.5	4.5	100.0

* Maslach Burnout Inventory

Table 4.21. (continued)

Statement		Never	A few times a year	A few times a month	A few times a week	Every day	Total
I've become more callous toward people since I took this job.	n	67	39	52	33	30	221
	%	30.3	17.6	23.5	14.9	13.6	100.0
I worry that this job is hardening me emotionally.	n	66	53	59	24	20	222
	%	29.7	23.9	26.6	10.8	9.0	100.0
I don't really care what happens to some patients.	n	124	42	35	10	10	221
	%	56.1	19.0	15.8	4.5	4.5	100.0
I feel patients blame me for some of their problems.	n	77	53	60	19	12	221
	%	34.8	24.0	27.1	8.6	5.4	100.0

* Maslach Burnout Inventory

Table 4.22. Distribution of health professionals according to the frequency of their experience of personal accomplishment* (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Statement		Never	A few times a year	A few times a month	A few times a week	Every day	Total
I can easily understand how my patients feel about things.	n	13	14	44	75	76	222
	%	5.9	6.3	19.8	33.8	34.2	100.0
I deal very effectively with the problems of my patients.	n	13	9	27	55	117	221
	%	5.9	4.1	12.2	24.9	52.9	100.0
I feel I'm positively influencing other people's lives through my work.	n	15	15	41	56	95	222
	%	6.8	6.8	18.5	25.2	42.8	100.0
I feel very energetic.	n	22	25	68	63	44	222
	%	9.9	11.3	30.6	28.4	19.8	100.0
I can easily create a relaxed atmosphere with my patients.	n	11	17	62	46	83	219
	%	5.0	7.8	28.3	21.0	37.9	100.0

Table 4.22. (continued)

Statement		Never	A few times a year	A few times a month	A few times a week	Every day	Total
	n	20	18	56	66	62	222
I feel exhilarated after working closely with my patients.	%	9.0	8.1	25.2	29.7	27.9	100.0
I have accomplished many worthwhile things in this job.	n	6	27	54	57	77	221
	%	2.7	12.2	24.4	25.8	34.8	100.0
In my work, I deal with emotional problems very calmly.	n	22	25	62	56	55	220
	%	10.0	11.4	28.2	25.5	25.0	100.0

* Maslach Burnout Inventory

The data for the subscale of Personal Accomplishment (PA) show that the most frequent response was "every day" for 6 out of 8 items (Table 22.1). More than half of the respondents (52.9%, n=117) reported that they feel "*they deal very effectively with the problems of their patients*" "every day". Likewise, 42.8% (n=95) of the respondents felt that they are positively influencing other people's lives through their work "every day" and 37.9% (n=83) felt they could easily create a relaxed environment with the patients everyday (Table 4.22).

The two items with "a few times a month" and "a few times a week" as the most frequent responses were "*I feel very energetic*" (30.6%, n=68) and "*In my work, I deal with emotional problems very calmly*" (28.2%, n=62) (Table 4.22).

According to Table 4.23, the mean scores of the MBI subscales were calculated to be 17.189 ±9.202 for emotional exhaustion, 6.274±4.767 for depersonalization, and 21.783±6.431 for personal accomplishment (Table 4.23). Analyzed according to province, the scores showed slight increase in emotional exhaustion subscale in Gaziantep and Şanlıurfa.

Table 4.23. Means and standard deviations of Maslach Burnout Inventory scores (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Province		Emotional Exhaustion	Depersonalization	Personal Accomplishment
Gaziantep	Mean	23.153	8.038	21.654
(n=26)	SD	7.893	3.638	4.638
Hatay	Mean	13.017	6.552	20.483
(n=58)	SD	7.624	4.787	7.890
İzmir	Mean	12.983	4.783	22.517
(n=60)	SD	8.292	4.723	7.167
Şanlıurfa	Mean	21.538	6.628	22.230
(n=70)	SD	8.308	4.888	4.938
Total	Mean	17.189	6.274	21.783
(n=214)	SD	9.202	4.767	6.431

4.4 Perceptions of Respondents About Training Needs and Recommendations for Better Service Delivery

Respondents were divided almost equally into two groups who want (49.3%, n=105) and do not want (50.7%, n=108) to receive training in migration health matters (Table 4.24).

It was observed that the percentages of respondents who are interested in training were quite high in İzmir (62.1%, n=36) and Hatay (74.1%, n=40). On the other hand, in Gaziantep and Şanlıurfa, there were a few respondents who would like to receive training (30.8%, n=8, 28.0%, n=21, respectively) as opposed to those who wouldn't like (69.2%, n=18; 72.0%, n=54).

Table 4.24. Distribution of health professionals according to province and their interest in receiving training (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

	Gaziantep		Hatay		İzmir		Şanlıurfa		Total*	
	n	%	n	%	n	%	n	%	n	%
Interest in training										
No	18	69.2	14	25.9	22	37.9	54	72.0	108	50.7
Yes	8	30.8	40	74.1	36	62.1	21	28.0	105	49.3
Total**	26	12.2	54	25.3	58	27.2	75	35.2	213	100.0

*: Column percentage   **: Row percentage

Overall, the most frequently preferred training topics were language (12.2%, n=9), mental health (10.8%, n=8), reproductive health/family planning (9.5%, n=7), the culture of migrant, refugee and asylum seeking populations (9.5%, n=7), noncommunicable diseases (NCD) (8.1%, n=6) and vaccination (8.1%, n=6) (Table 4.25).

Analyzed by province, the data show that in Hatay, the most frequently mentioned training topics were NCD (20.0%, n=5), mental health (16.0%, n=4), vaccination (12.0%, n=3) and reproductive health/family planning (8.0%, n=2). There was no respondent in Hatay that indicated "language training" as a preference. In İzmir, mostly preferred training topics were reproductive health/family planning (18.2%, n=4), mental health (13.6%, n=3), and the culture of migrant, refugee and asylum-seeking populations (13.6%, n=3).

Table 4.25. Distribution of health professionals according to province and their topic of interest in receiving training (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Preferred training topics	Gaziantep		Hatay		İzmir		Şanlıurfa		Total	
	n	%	n	%	n	%	n	%	n	%
Language	2	66.7	-	-	1	4.5	6	25.0	9	12.2
Mental health	-	-	4	16.0	3	13.6	1	4.2	8	10.8
Reproductive health	-	-	2	8.0	4	18.2	1	4.2	7	9.5
Culture of migrants	-	-	-	-	3	13.6	4	16.7	7	9.5
Noncommunicable diseases	-	-	5	20.0	1	4.5	-	-	6	8.1
Vaccination	-	-	3	12.0	1	4.5	2	8.3	6	8.1
Legal rights	1	33.3	-	-	2	9.1	2	8.3	5	6.8
Health system	-	-	1	4.0	3	13.6	-	-	4	5.4
Infant follow-up	-	-	2	8.0	-	-	2	8.3	4	5.4
Emergency care	-	-	-	-	1	4.5	1	4.2	2	2.7
Pregnancy follow-up	-	-	1	4.0	1	4.5	-	-	2	2.7
Health center administration	-	-	2	8.0	-	-	-	-	2	2.7
Computer literacy	-	-	2	8.0	-	-	-	-	2	2.7
Social issues	-	-	-	-	-	-	2	8.3	2	2.7
Illnesses with high risk	-	-	-	-	-	-	2	8.3	2	2.7

Table 4.25. (continued)

	Gaziantep		Hatay		İzmir		Şanlıurfa		Total	
Preferred training topics	n	%	n	%	n	%	n	%	n	%
USG	-	-	-	-	1	4.5	-	-	1	1.4
Oral and dental health	-	-	-	-	1	4.5	-	-	1	1.4
Gerontology	-	-	1	4.0	-	-	-	-	1	1.4
Homecare	-	-	1	4.0	-	-	-	-	1	1.4
Medical training	-	-	1	4.0	-	-	-	-	1	1.4
Communicable diseases	-	-	-	-	-	-	1	4.2	1	1.4
Family medicine	-	-	-	-	-	-	-	-	-	-
Total	3	4.1	25	33.8	22	29.7	24	32.4	74*	100.0

*The number represents respondents who expressed a need for training

In terms of the respondents' preference over the method of potential training programmes, conference and symposiums were mentioned by 37.6% (n=82) of the respondents (Table 4.26). Two other frequently indicated methods of instruction were theoretical (24.3%, n=53) and distance trainings (22.9%, n=50).

Table 4.26. Distribution of health professionals according to province and preferred training method (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

	Gaziantep		Hatay		İzmir		Şanlıurfa		Total*	
	n	%	n	%	n	%	N	%	n	%
Method										
Conference-Symposium	7	35.0	31	44.9	25	42.4	19	27.1	82	37.6
Theoretical	6	30.0	17	24.6	13	22.0	17	27.1	53	24.3
Distant	5	25.0	12	17.4	14	23.7	19	24.3	50	22.9
Training material	2	10.0	8	11.6	6	10.2	14	20.0	30	13.8
Other	-	-	1	1.4	1	1.7	1	1.4	3	1.4
Total*	20	9.2	69	31.7	59	27.1	70	32.1	218	100.0

*: Column percentage   **: Row percentage

The overall data for the recommendations of respondents to improve healthcare provision to migrant, refugee and asylum-seeking populations reveal that the employment of more health personnel was mentioned most frequently, by 25.9% (n=21) of respondents. It was followed by the employment of bilingual staff members

(12.3%, n=10), establishment of more migrant health centers (11.1%, n=9), and language courses for health workers (11.1%, n=9) (Table 4.27).

When analyzed according to province, it was observed that in Hatay, the respondents mentioned the strengthening of system as often as the increased number of personnel (26.7%, n=4). In Gaziantep, besides language courses for health workers, enforcing the same rules as Turkish citizens for migrant, refugee and asylum-seeking patients in access to healthcare was also the most frequent response (25.0%, n=2) (Table 4.27).

Table 4.27. Distribution of health professionals according to province and recommendation for the improvement of healthcare to migrant, refugee and asylum seekers (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Recommendation	Gaziantep		Hatay		İzmir		Şanlıurfa		Total*	
	n	%	n	%	n	%	n	%	n	%
More personnel	1	12.5	4	26.7	7	58.3	9	19.6	21	25.9
Bilingual staff	-	-	-	-	-	-	10	21.7	10	12.3
Health centers for migrants	1	12.5	-	-	1	8.3	7	15.2	9	11.1
Language courses for healthcare workers	2	25.0	-	-	-	-	7	15.2	9	11.1
Strengthening of the system	-	-	4	26.7	1	8.3	3	6.5	8	9.9
Balancing workload	1	12.5	-	-	-	-	3	6.5	4	4.9
Establishment of new hospitals	-	-	2	13.3	1	8.3	1	2.2	4	4.9
Improved infrastructure	-	-	3	20.0	-	-	-	-	3	3.7
Salary increase	1	12.5	-	-	-	-	1	2.2	2	2.5
Restrictions on services/entitlements	2	25.0	-	-	-	-	-	-	2	2.5
Training of patients	-	-	1	6.7	-	-	1	2.2	2	2.5
Language courses for migrants/refugees	-	-	-	-	-	-	2	4.3	2	2.5
Awareness raising of migrants/refugees	-	-	-	-	1	8.3	-	-	1	1.2
Education of refugee/migrant children	-	-	1	6.7	-	-	-	-	1	1.2
Oral and dental health programmes	-	-	-	-	1	8.3	-	-	1	1.2
Ensuring security of health workers	-	-	-	-	-	-	1	2.2	1	1.2
Psychosocial services in mother tongue	-	-	-	-	-	-	1	2.2	1	1.2
Total**	8	9.9	15	18.5	12	14.8	46	56.8	81	100.0

*: Column percentage   **: Row percentage

Table 4.28 shows a variety of additional comments by the respondents to advance the services provided to migrants, refugees and asylum seekers. There were a total of 27 responses to this item, with the most frequent comments focusing on strengthening migrant health centers (26.0%, n=7), training patients (19.0%, n=5), and imposing restrictions on refugee population's applications in the same way as Turkish citizens (11.0%, n=3).

Table 4.28. Distribution of health professionals according to province and other comments regarding healthcare provision to migrant, refugee and asylum seekers (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Other comments/ recommendations	Gaziantep	Hatay	İzmir	Şanlıurfa	Total
	n	n	n	n	n
Migrant health units should be strengthened	1	-	-	6	7
Patients should be trained	-	1	1	3	5
Applications should be restricted	2	-	-	1	3
Health workers should be entitled to vouchers and shuttle services	-	-	2	-	2
Trainings should be more often	-	1	-	1	2
Workload should be optimized	1	-	-	1	2
Sufficient equipment should be provided	-	-	1	-	1
Salaries should be increased	-	-	1	-	1
Learning Turkish language should be mandatory	1	-	-	-	1
Access to services should be fast and simple	-	-	-	1	1
Interpreters should be hired	-	-	-	1	1
Syrians' low levels of SES should be considered	-	-	-	1	1
Total	5	2	5	15	27

4.5 Comparative Analysis of Responses with Maslach Burnout Inventory Scores

The Shapiro-Wilk Test was utilized to examine whether the data are normally distributed or not. Table 4.29 shows that the data for all the three MBI subscales (Emotional Exhaustion, Depersonalization and Personal Achievement) deviate from normal distribution with the p values below 0.01, verifying the null hypothesis that the distribution of data is different from normal distribution (Annex 5, Figure 4.1). Hence, the statistical significance of the relationships between variables were tested through non-parametric tests.

Table 4.29. Shapiro-Wilk Normality Test for Maslach Burnout Inventory sub-scales (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Statistic	p value
Emotional exhaustion	0.9781256	0.0016079
Personal achievement	0.9452401	0.0000002
Depersonalization	0.9418478	0.0000001

Shapiro-Wilk Normality Test

4.5.1 Maslach Burnout Inventory Scores and Gender

The analyses of each sub-scale with Wilcoxon Rank-Sum Test showed that there was no statistically significant difference in the emotional exhaustion (p=0.244) (Table 4.30, Figure 4.2), personal achievement (p=0.545) (Table 4.31, Figure 4.3) and depersonalization scores (p= 0.983) (Table 4.32, Figure 4.4) between female and male respondents.

Emotional Exhaustion

Table 4.30. Emotional Exhaustion scores of Maslach Burnout Inventory Scale according to gender (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Gender	n	Mean	Median	IQR
Male	124	16.43902	17	13.5
Female	100	18.12121	17	16.0
				p= 0.244

Wilcoxon Rank-Sum Test
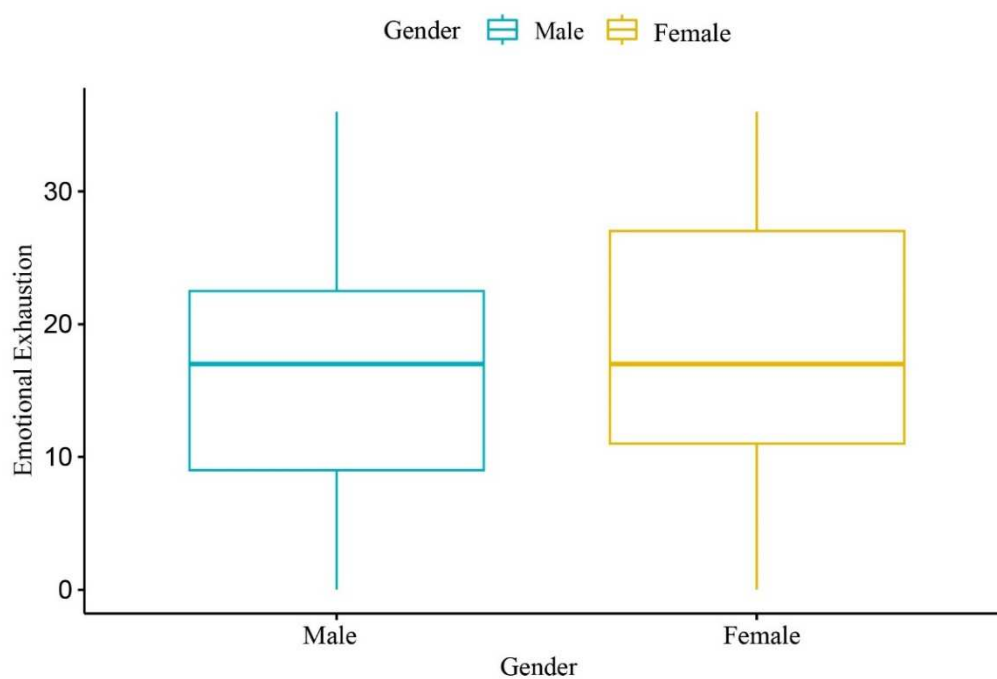
Figure 4.2. Emotional Exhaustion and Gender, Maslach Burnout Inventory Scale
(Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March
2020)

Personal Achievement
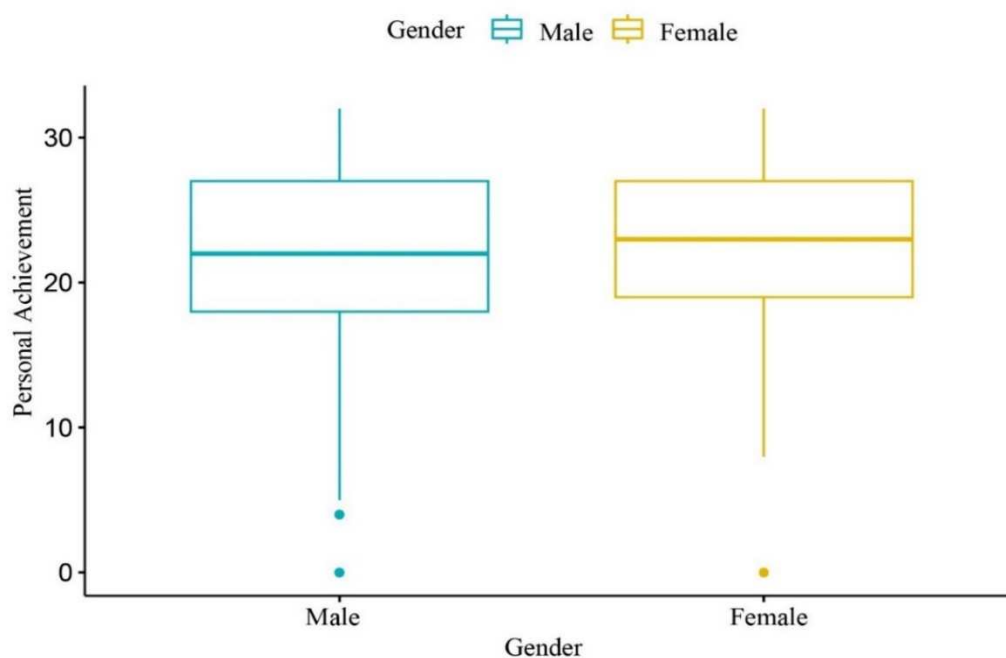
Figure 4.3. Personal achievement and Gender, Maslach Burnout Inventory Scale
(Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March
2020)

Table 4.31. Personal Achievement scores of Maslach Burnout Inventory Scale according to gender (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Gender	n	Mean	Median	IQR
Male	124	21.38211	22	9
Female	100	22.28283	23	8
				p= 0.545

Depersonalization
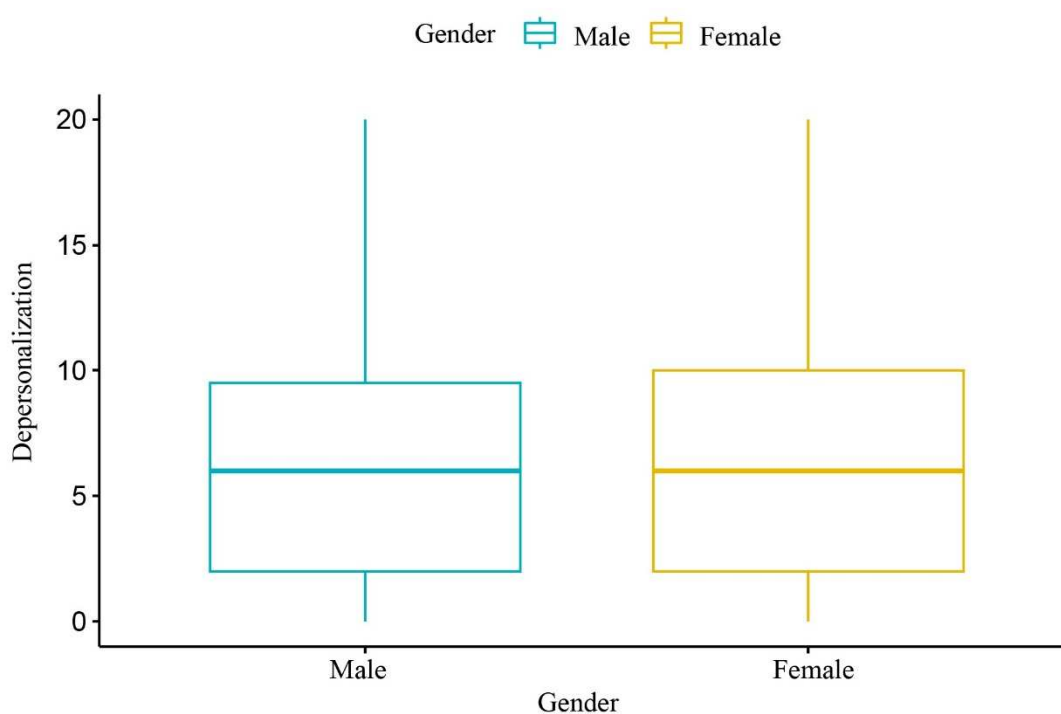
Figure 4.4. Depersonalization and Gender, Maslach Burnout Inventory Scale (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Table 4.32. Depersonalization scores of Maslach Burnout Inventory scale according to gender (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Gender	n	Mean	Median	IQR
Male	124	6.260163	6	7.5
Female	100	6.292929	6	8.0
				p= 0.983

4.5.2 Maslach Burnout Inventory Scores and Age

According to the Shapiro-Wilk test for the age variable, it was observed that the data were distributed differently than normal distribution (p<0.01) (Table 4.33). Based on this finding, nonparametric correlation tests, Kendall's tau-b and Spearman's rank correlation coefficient were utilized for the analysis of the association between MBI subscores and age variables.

Table 4.33. Shapiro-Wilk Normality Test for Age (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Statistic	p value
Age	0.9518372	0.0000008

Shapiro-Wilk Normality Test

The results of the Spearman's rank correlation coefficient test showed a weak, statistically significant negative correlation between the variables age and Emotional Exhaustion scores (r_s= -0.242, p=0.00), and no statistically significant correlation was found between age and other MBI subscales, namely, depersonalization and personal achievement (Table 4.34).

According to the Kendall's tau-b test, it was observed that there was a weak statistically significant negative correlation between age and Emotional Exhaustion (T_b= -0.19, p=0.00), and between age and Depersonalization (T_b= -0.148, p=0.005) (Table 4.34).

Table 4.34. Correlation between age and Maslach Burnout Inventory scores (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Age	
	Spearman's rho	Kendall's tau-b
Emotional Exhaustion	-0.242*	-0.19*
Depersonalization	-0.186	-0.148*
Personal Achievement	0.024	0.018

* weak association

4.5.3 Maslach Burnout Inventory Scores and Number of Children

The analysis of the data using Kruskal-Wallis Test showed a statistically significant difference only between the subscale of Emotional Exhaustion and the categories of having one, two and three or more children, and none ($p<0.01$) (Table 4.35).

Table 4.35. The relationship between Maslach Burnout Inventory scores and number of children (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January -March 2020)

Variable	Number of children			
	n	statistic	df	p
Emotional Exhaustion	224	31.60208	3	0.0000006
Depersonalization	224	5.210736	3	0.157
Personal Achievement	224	2.695265	3	0.441

Pairwise Wilcox Test

Pairwise Wilcox Test was utilized to understand between which categories there is a statistically significant difference. Accordingly, the difference in the Emotional Exhaustion scores could be observed between the respondents with 1 child and those with 3 and more, the respondents with 2 children and those with 3 and more, and finally the respondents with no children and those having 3 and more (Table 4.36, Figure 4.5).

Table 4.36. Pairwise Wilcox Test for Emotional Exhaustion scores of Maslach Burnout Inventory according to number of children (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

				Emotional Exhaustion			
Group 1	Group 2	n1	n2	Statistic	P	p.adj	p.adj.signif
1 child	2 children	41	59	1152.5	0.847	0.847	ns
1 child	3 and more	41	65	1941.5	0.0000229	0.000114	***
1 child	none	41	59	1302.5	0.304	0.608	ns
2 children	3 and more	59	65	2912.5	0.000000600	0.00000380	****
2 children	none	59	59	1984.5	0.136	0.408	ns
3 and more	none	65	59	1160.5	0.000240	0.000960	***

Pairwise Wilcox Test
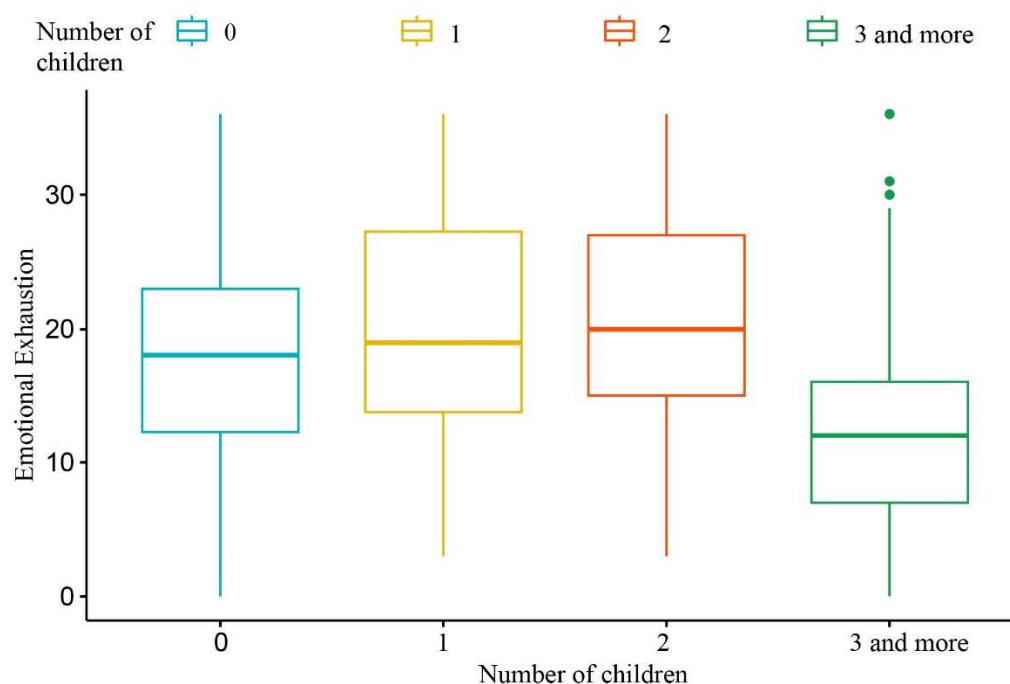
Figure 4.5. Emotional Exhaustion scores of Maslach Burnout Inventory and number of children (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

4.5.4 Maslach Burnout Inventory Score and Profession

There was a statistically significant difference between Emotional Exhaustion and the respondents' profession according to the Kruskal-Wallis Test ($p < 0.05$) (Table 4.37). The subscales Depersonalization and Personal Achievement were not found to be statistically different.

Table 4.37. The relationship between profession and Maslach Burnout Inventory scores (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Profession			
	n	statistic	df	p
Emotional Exhaustion	224	10.61845	2	0.00495
Depersonalization	224	0.8367138	2	0.658
Personal Achievement	224	0.8811739	2	0.644

Kruskal-Wallis Test

In order to identify the pairs showing a statistically significant difference, Pairwise Wilcox Test was run, and the results indicated that the difference stemmed from the Emotional Exhaustion scores of doctors and nurses (Table 4.38, Figure 4.6).

Table 4.38. Pairwise Wilcox Test for Emotional Exhaustion scores of Maslach Burnout Inventory according to profession (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Emotional Exhaustion							
Group 1	Group 2	n1	n2	Statistic	p	p.adj	p.adj.signif
Other	Doctor	26	116	1481.0	0.943	0.943	Ns
Other	Nurse	26	82	1307.0	0.065	0.131	Ns
Doctor	Nurse	116	82	5902.5	0.001	0.004	**

Pairwise Wilcox Test
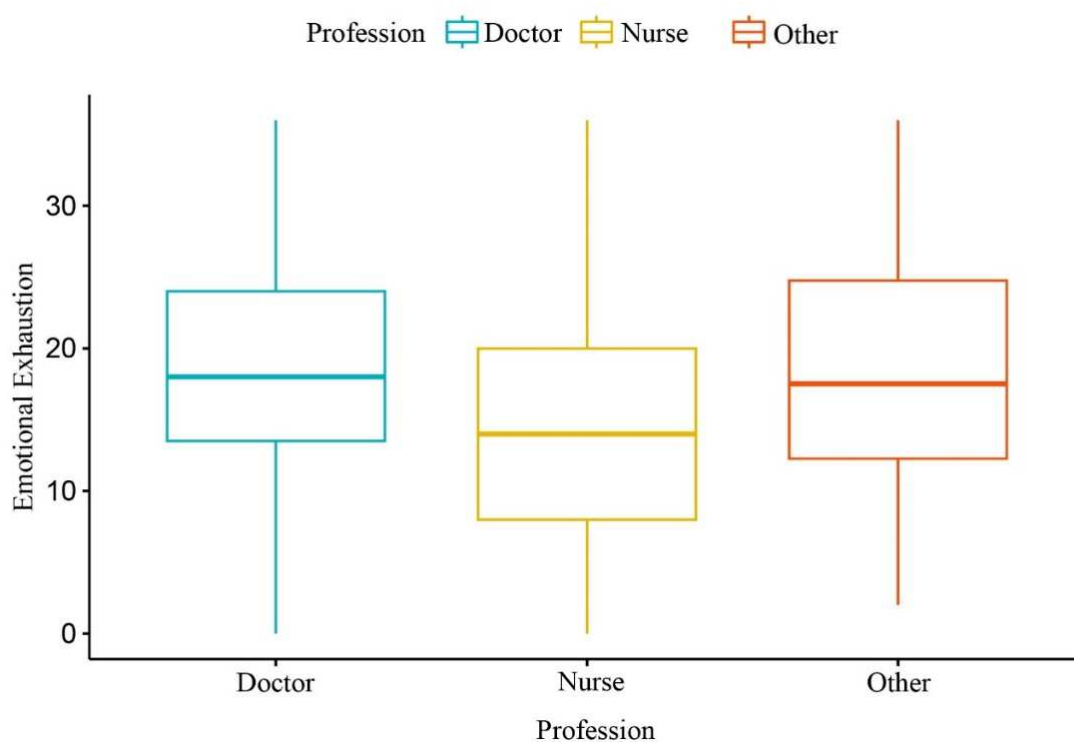
Figure 4.6. Emotional Exhaustion scores of Maslach Burnout Inventory and profession (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

4.5.5 Maslach Burnout Inventory Score and Year of Graduation

According to the Kruskal-Wallis Test, there was a statistically significant difference between Emotional Exhaustion and the respondents' year of graduation ($p<0.05$) (Table 4.39). The scores for the subscales Depersonalization and Personal Achievement were not found to be statistically different.

Table 4.39. The relationship between year of graduation and Maslach Burnout Inventory scores (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Profession			
	n	statistic	df	p
Emotional Exhaustion	192	18.24021	2	0.000109
Depersonalization	192	3.708601	2	0.157
Personal Achievement	192	0.6346628	2	0.728

Kruskal-Wallis Test

In order to identify the pairs indicating a statistically significant difference, Pairwise Wilcox Test was utilized, according to which the Emotional Exhaustion scores of the participants who graduated before 2000 differed from the those who graduated between 2001-2010, and those who graduated after 2011 (Table 4.40, Figure 4.7).

Table 4.40. Pairwise Wilcox Test for Emotional Exhaustion scores of Maslach Burnout Inventory according to year of graduation (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

				Emotional Exhaustion			
Group 1	Group 2	n1	n2	Statistic	p	p.adj	p.adj.signif
2000 and before	2001-2010	56	67	1261.5	0.003000	0.005000	**
2000 and before	2011 and after	56	71	1096.0	0.000022	0.000066	****
2001-2010	2011 and after	66	71	2098.0	0.357000	0.357000	ns

Pairwise Wilcox Test
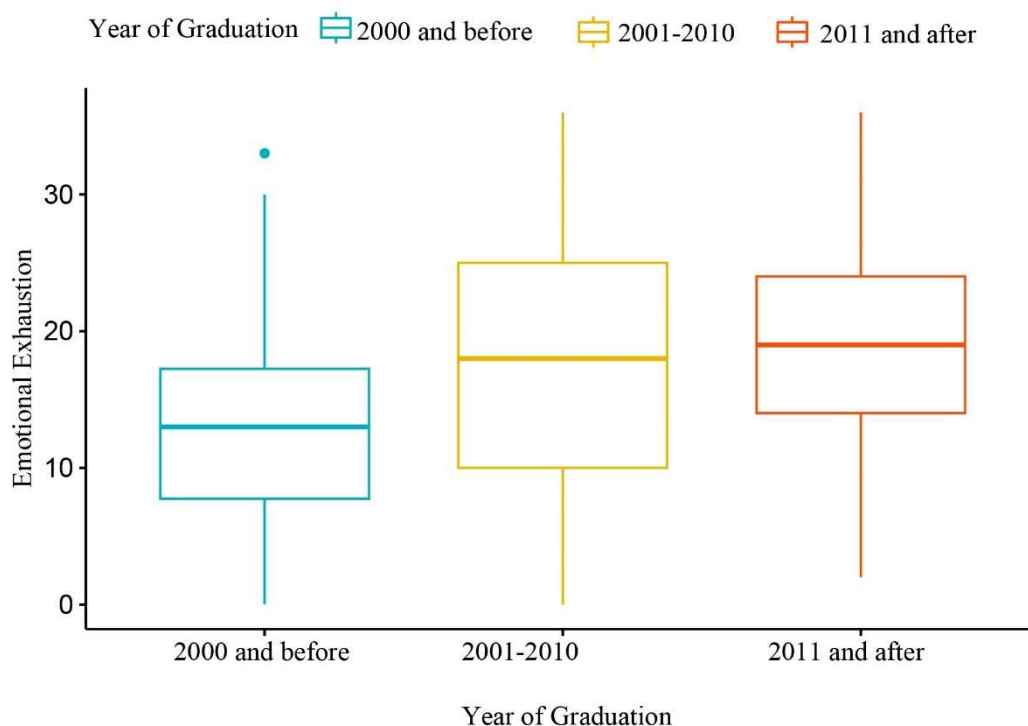
Figure 4.7. Emotional Exhaustion scores of Maslach Burnout Inventory and year of graduation (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

4.5.6 Maslach Burnout Inventory Score and Training on Migrant and Refugee Health

The analyses of each sub-scale with Wilcoxon Rank-Sum Test showed that there is a statistically significant difference in the Emotional Exhaustion scores of the respondents who received training about migrant and refugee health (p=0.0000001). Personal achievement (p=0.958) and depersonalization scores (p=0.188) were not observed to be different based on whether the respondents received a training or not (Table 4.41).

Table 4.41. Maslach Burnout Inventory Scale Scores according to respondents' previous training in migrant and refugee health (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Group 1	Group 2	n1	n2	statistic	p value
Emotional Exhaustion	Yes	No	92	132	3484	0.0000001
Depersonalization	Yes	No	92	132	5360.5	0.188
Personal Achievement	Yes	No	92	132	5954.5	0.958

Wilcoxon Rank-Sum Test
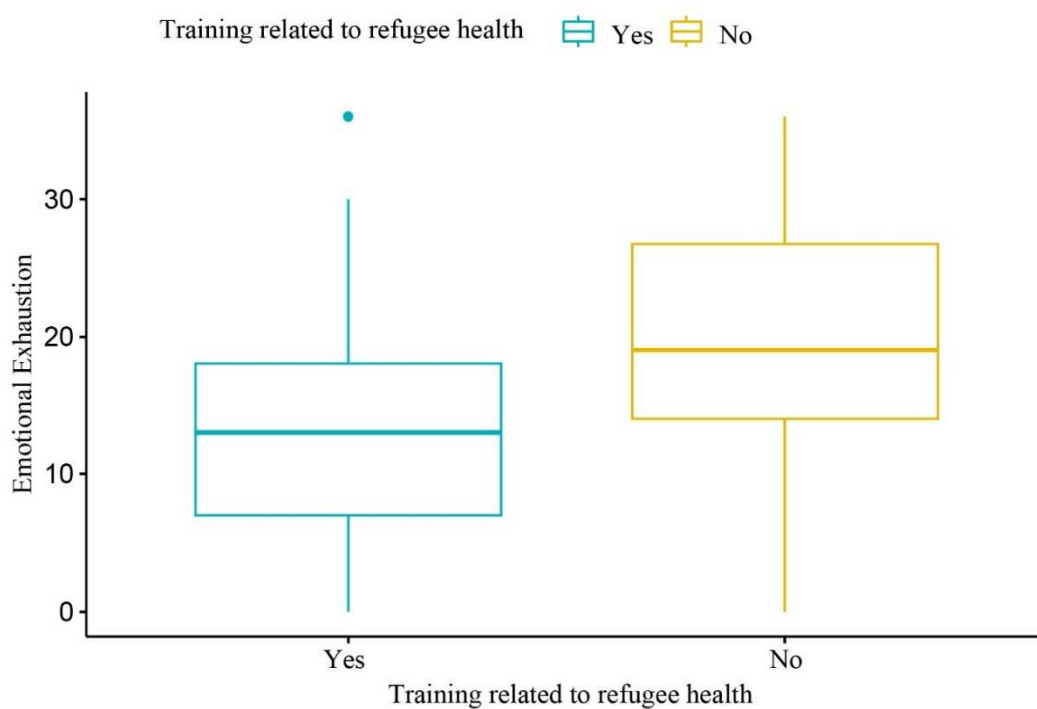
Figure 4.8. Emotional Exhaustion scores of Maslach Burnout Inventory and previous training in migrant and refugee health (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)
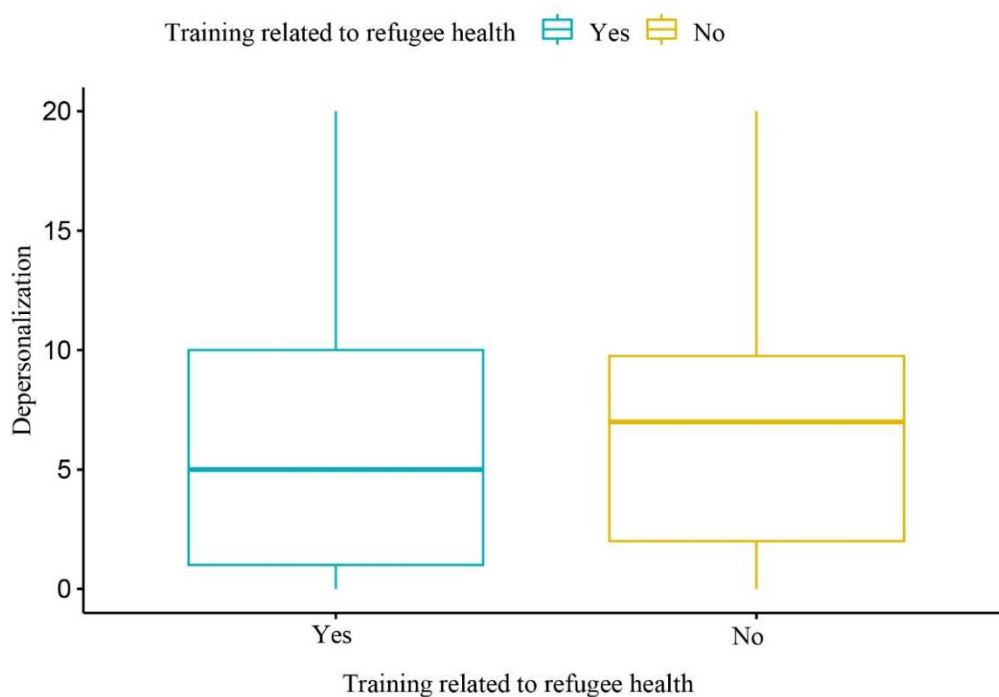
Figure 4.9. Depersonalization scores of Maslach Burnout Inventory and previous training in migrant and refugee health (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)
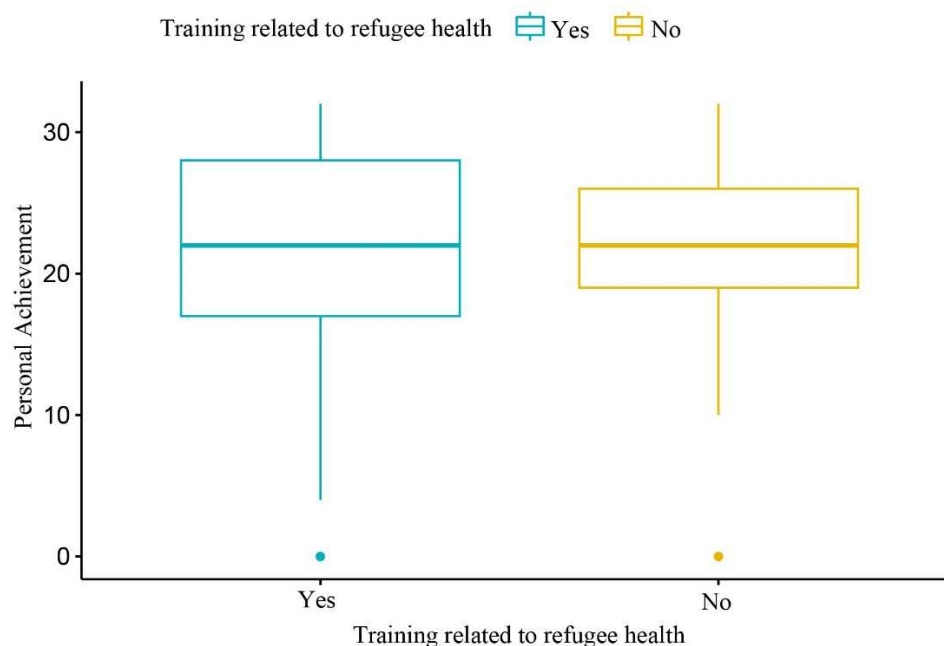
Figure 4.10. Personal Achievement scores of Maslach Burnout Inventory and previous training in migrant and refugee health (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

4.5.7 Maslach Burnout Inventory Score and the Institution of the Longest Service Duration

Kruskal-Wallis Test was utilized to understand the relationship between the MBI scores and the institutions (i.e. hospital, primary healthcare facility, and other) where the respondents served the longest period of time. According to the analysis, there was no statistically significant difference in the scores based on the institutions of the longest service duration (Table 4.42).

Table 4.42. The relationship between the institution of the longest service duration and Maslach Burnout Inventory scores (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Institution of the longest service duration			
	n	statistic	df	p
Emotional Exhaustion	222	3.593568	2	0.166
Depersonalization	222	0.0800271	2	0.961
Personal Achievement	222	3.290186	2	0.193

Kruskal-Wallis Test
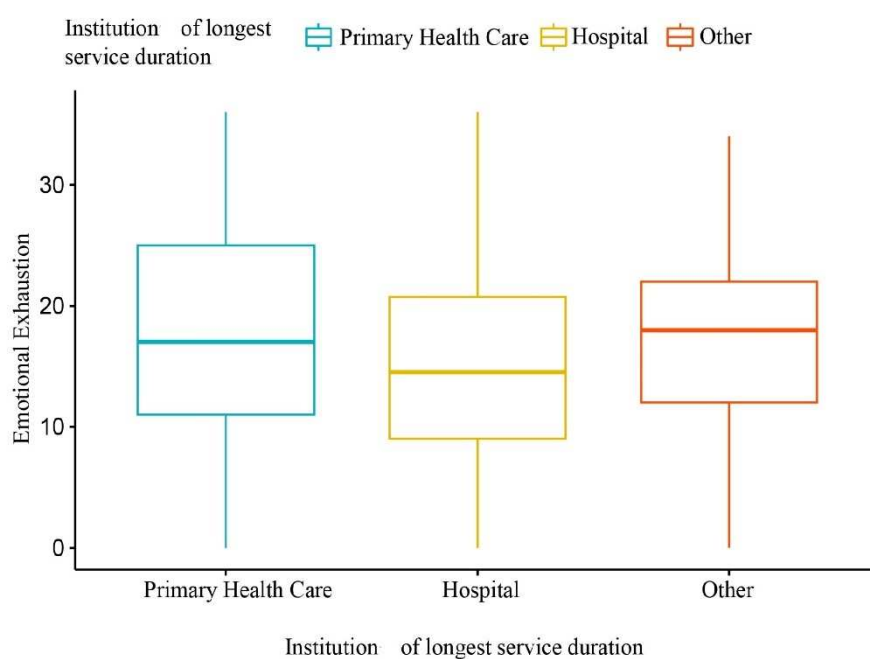
Figure 4.11. Emotional Exhaustion scores of Maslach Burnout Inventory and the institution of the longest service duration (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)
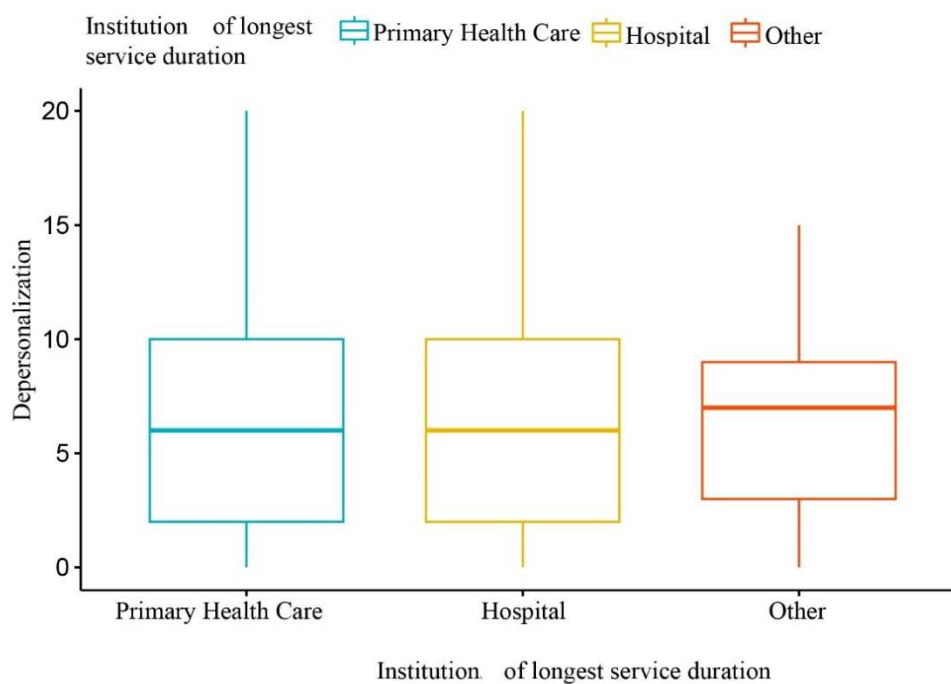
Figure 4.12. Depersonalization scores of Maslach Burnout Inventory and the institution of the longest service duration (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)
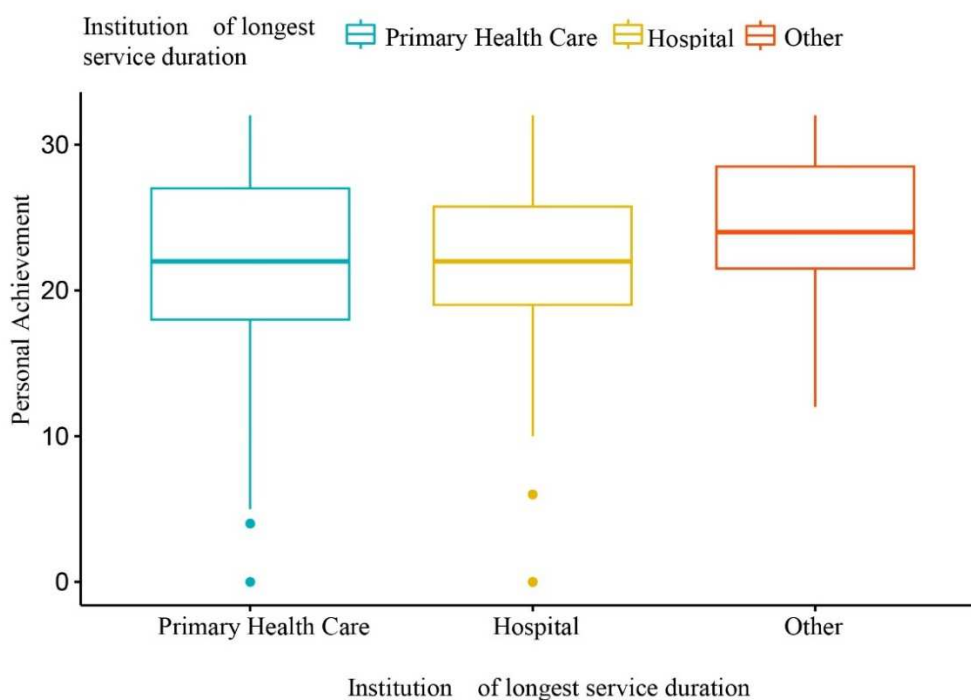
Figure 4.13. Personal Achievement scores of Maslach Burnout Inventory and the institution of the longest service duration (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

4.5.8 Maslach Burnout Inventory Score and the Previous Experience in Serving Migrant, Refugee and Asylum seekers

According to the Wilcoxon Rank-Sum Test there was no statistically significant difference between the MBI scores of the respondents and their previous experience in working with migrant, refugee and asylum seeker patients (Table 4.43).

Table 4.43. Maslach Burnout Inventory Scale Scores according to respondents' previous experience in serving migrant, refugee and asylum seekers (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Group 1	Group 2	n1	n2	statistic	p value
Emotional Exhaustion	Yes	No	103	117	6115.5	0.958
Depersonalization	Yes	No	103	117	6573	0.308
Personal Achievement	Yes	No	103	117	5428	0.163

Wilcoxon Rank-Sum Test
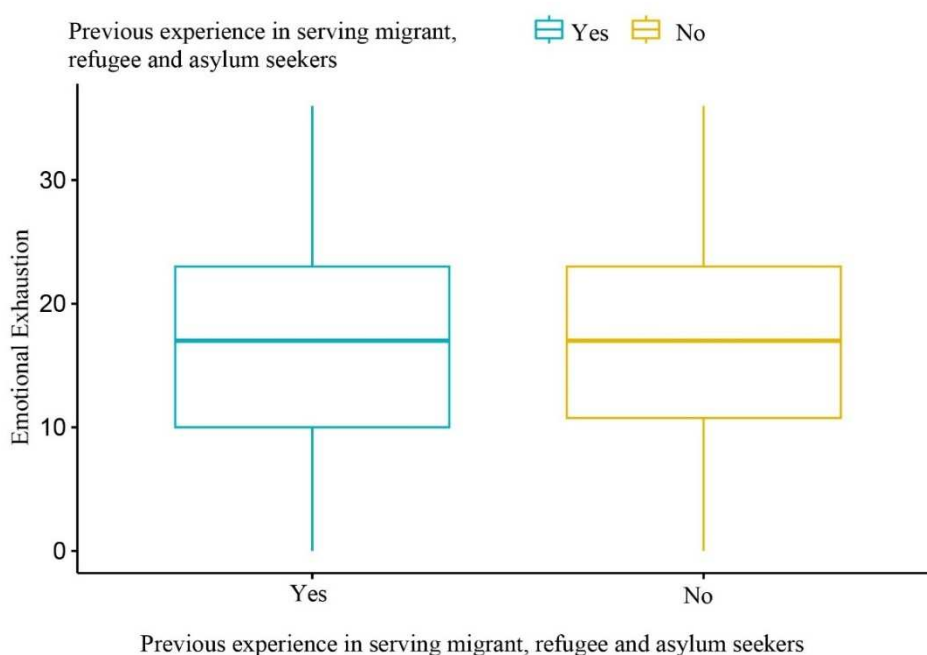
Figure 4.14. Emotional Exhaustion scores of Maslach Burnout Inventory and the previous experience in serving migrant, refugee and asylum seekers (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)
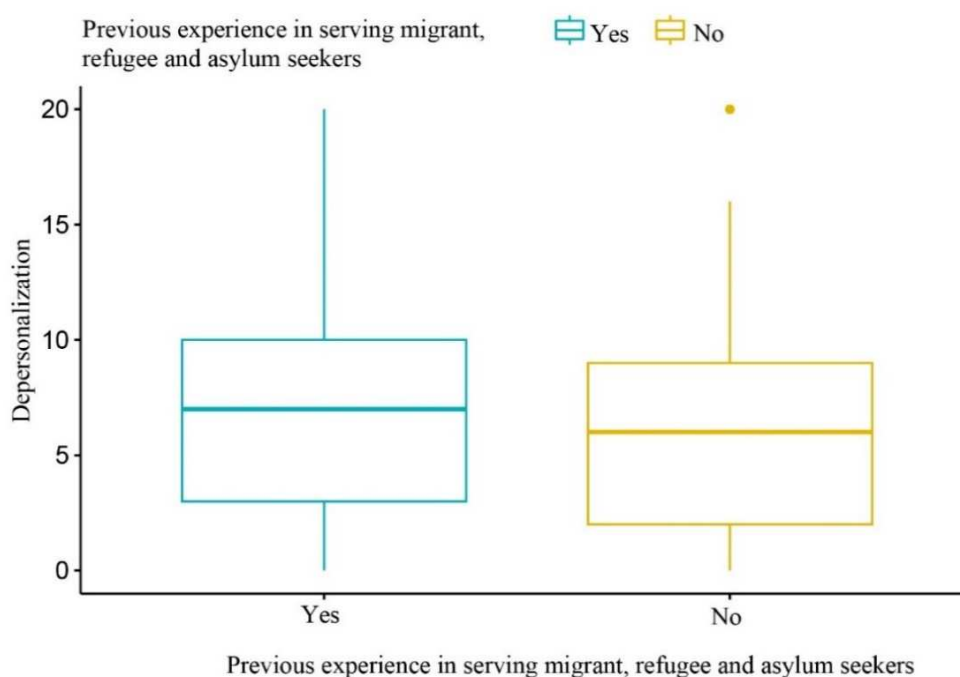
Figure 4.15. Depersonalization scores of Maslach Burnout Inventory and the previous experience in serving migrant, refugee and asylum seekers (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)
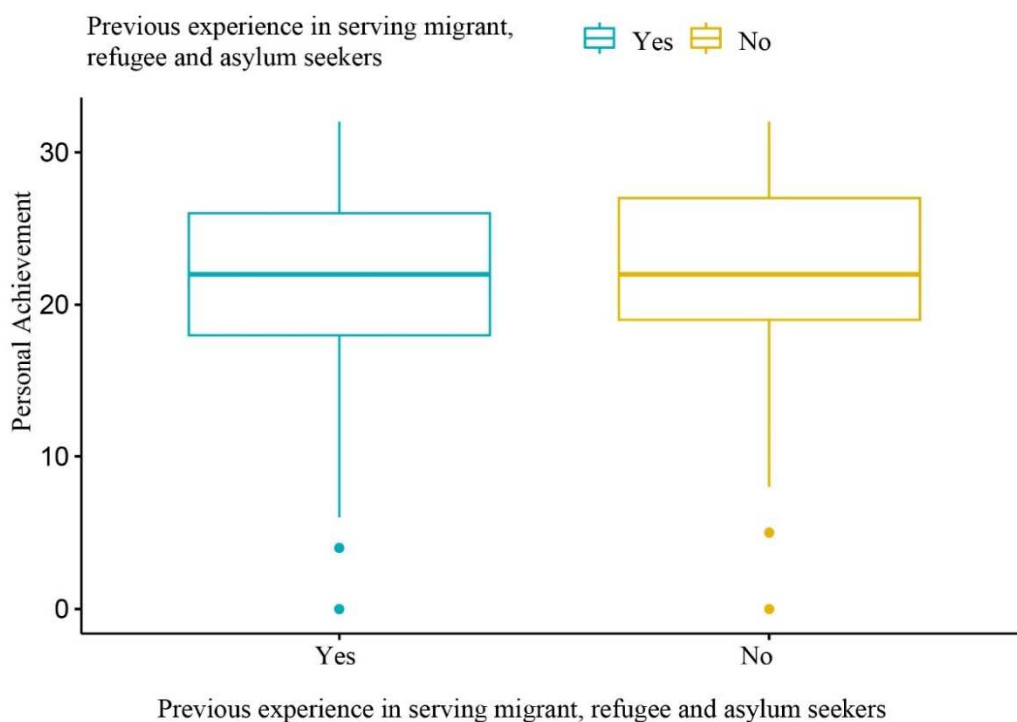
Figure 4.16. Personal Achievement scores of Maslach Burnout Inventory and the previous experience in serving migrant, refugee and asylum seekers (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

### 4.5.9 Maslach Burnout Inventory Score and the Duration of Work with Migrant, Refugee and Asylum Seeker Patients

Kruskal-Wallis test was executed to analyse the relationship between the MBI scores and the categories of duration of work with migrant, refugee and asylum seeker patients, i.e. 20 months and less, 21-40 months and 41 months and more. The results showed that there was a statistically significant difference in the MBI Personal Achievement subscale scores of the respondents ($p=0.0223$) (Table 4.44).

Table 4.44. The relationship between the Duration of Work with Migrant, Refugee and Asylum Seeker Patients and Maslach Burnout Inventory scores (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Duration of Work With Migrant Groups			
	n	statistic	df	p
Emotional Exhaustion	91	1.336522	2	0.513
Depersonalization	91	4.168121	2	0.124
Personal Achievement	91	7.604973	2	0.0223

Kruskal-Wallis Test

To understand between which categories there was a statistically significant difference, Pairwise-Wilcox Test was utilized. Accordingly, there was a difference between the respondent groups that had been working for migrant, refugee and asylum seekers for less than 20 months and more than 41 months (Table 4.45).

Table 4.45. Pairwise Wilcox Test for Personal Achievement scores of Maslach Burnout Inventory according to Duration of Work with Migrant, Refugee and Asylum Seeker Patients (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

				Personal Achievement			
Group 1	Group 2	n1	n2	statistic	p	p.adj	p.adj.signif
20 months and less	21-40 months	38	26	364.0	0.076	0.152	ns
20 months and less	41 months and more	38	27	308.5	0.006	0.020	*
21-40 months	41 months and more	26	27	329.5	0.708	0.708	ns

Pairwise Wilcox Test
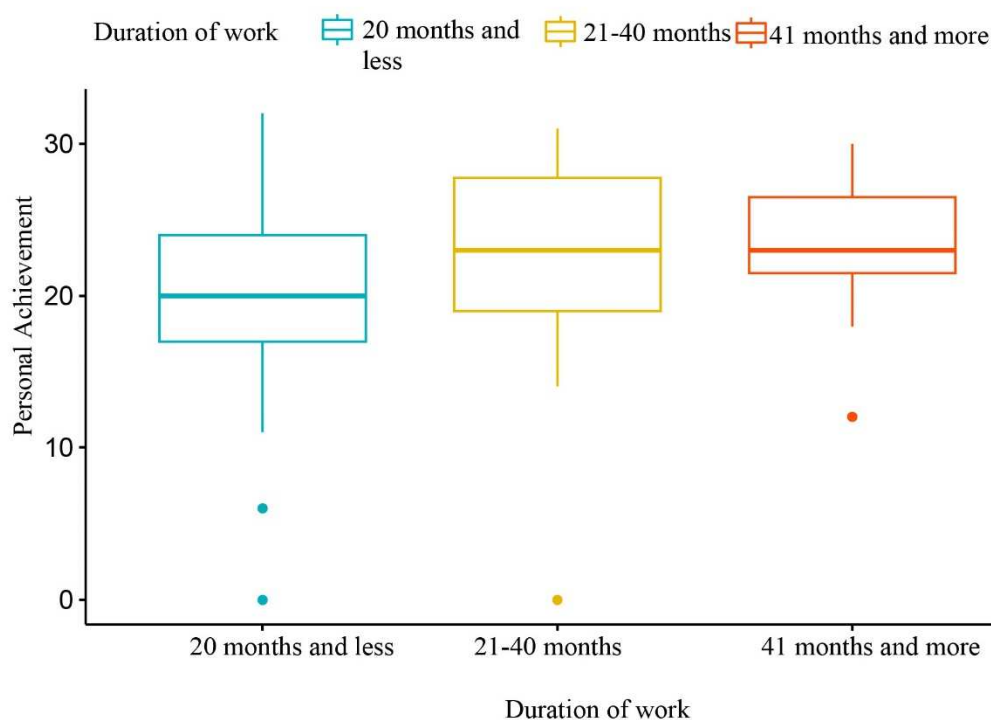
Figure 4.17. Personal Achievement scores of Maslach Burnout Inventory and the duration of work with Migrant, Refugee and Asylum Seeker Patients (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

4.5.10 Maslach Burnout Inventory Score and the Current Workplace

According to the Kruskal-Wallis test, there was a statistically significant difference between the Emotional Exhaustion scores and respondents' current workplace, which was categorized as "Family Health Center", "Migrant Health Center" and "other, i.e. Emergency Healthcare, Cancer Screening and Early Diagnosis Center, and Temporary Shelter" (p=0.000) (Table 4.46).

Table 4.46. The relationship between the Current Workplace and Maslach Burnout Inventory scores (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Current Workplace			
	n	statistic	df	p
Emotional Exhaustion	222	55.0447	2	0.000
Depersonalization	222	4.946391	2	0.0843
Personal Achievement	222	0.3774225	2	0.828

Kruskal-Wallis Test

No statistically significant relationship was found between current workplace and Depersonalization scores and Personal Achievement scores.

In order to understand between which groups the Emotional Exhaustion scores differed, Pairwise-Wilcox test was used. According to the test, the Emotional Exhaustion scores of the respondents working in Migrant Health Centers were different from those working in Family Health Centers and other health facilities (Table 4.47).

Table 4.47. Pairwise Wilcox Test for Emotional Exhaustion scores of Maslach Burnout Inventory according to Current Workplace (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

		Emotional Exhaustion					
Group 1	Group 2	n1	n2	statistic	p	p.adj	p.adj.signif
Family Health Center	Other	105	15	990.0	0.109	0.109	ns
Family Health Center	Migrant Health Center	105	102	8488.0	0.000	0.000	****
Other	Migrant Health Center	15	102	1119.5	0.004	0.008	**

Pairwise Wilcox Test
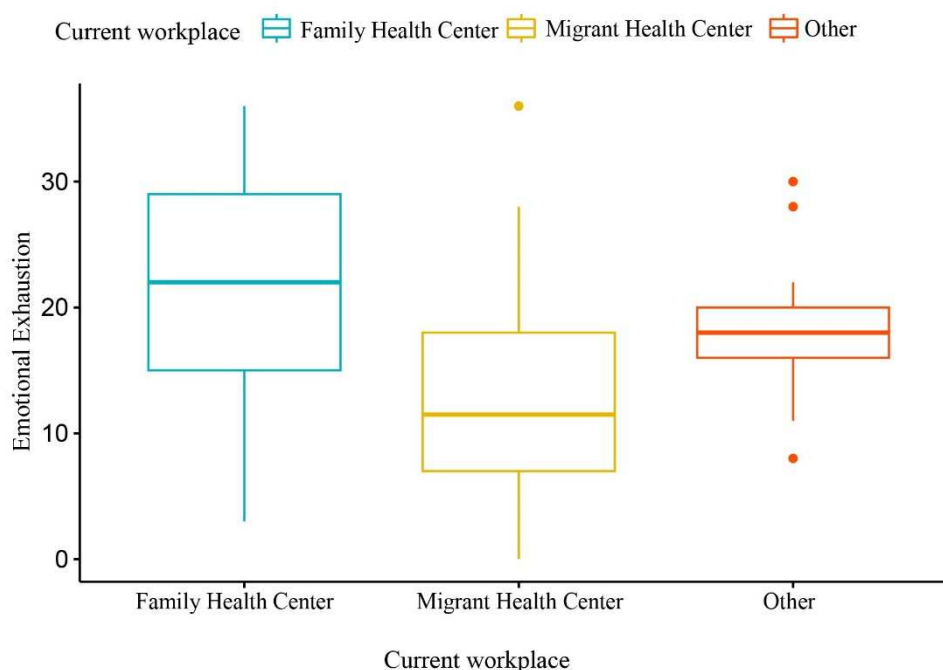
Figure 4.18. Emotional Exhaustion scores of Maslach Burnout Inventory and the current workplace (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

4.5.11 Maslach Burnout Inventory Score and the Duration of Work in Current Workplace

Kruskal Wallis Test showed that there was a statistically significant difference between the respondents' Emotional Exhaustion scores and their duration of work in current workplace, i.e. 1-12 months, 13-24 months, 25-36 months and 37 months and longer (p= 0.0000132) (Table 4.48).

Table 4.48. The relationship between the Duration of Work in Current Workplace and Maslach Burnout Inventory scores (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Duration of Work in Current Workplace			
	n	statistic	df	p
Emotional Exhaustion	216	25.3334	3	0.0000132
Depersonalization	216	2.073218	3	0.557
Personal Achievement	216	2.675128	3	0.444

Kruskal Wallis Test

Pairwise-Wilcox test was utilized to explore between which groups the Emotional Exhaustion scores showed difference. In line with the test results, scores of the respondents were found to be different between the groups with the durations of 37 months and longer and 13-24 months, and between 37 months and longer and 25-36 months (Table 4.49).

Table 4.49. Pairwise Wilcox Test for Emotional Exhaustion scores of Maslach Burnout Inventory according to Duration of Work in Current Workplace (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

				Emotional Exhaustion			
Group 1	Group 2	n1	n2	statistic	p	p.adj	p.adj.signif
1-12 months	13-24 months	47	61	1721.5	0.0740000	0.2230000	ns
1-12 months	25-36 months	47	41	1130.5	0.1630000	0.3260000	ns
1-12 months	37 months and longer	47	67	1171.0	0.0200000	0.0810000	ns
13-24 months	25-36 months	61	41	1181.5	0.6400000	0.6400000	ns
13-24 months	37 months and longer	61	67	1124.0	0.0000114	0.0000684	****
25-36 months	37 months and longer	41	67	720.5	0.0000355	0.0001780	***

Pairwise Wilcox Test
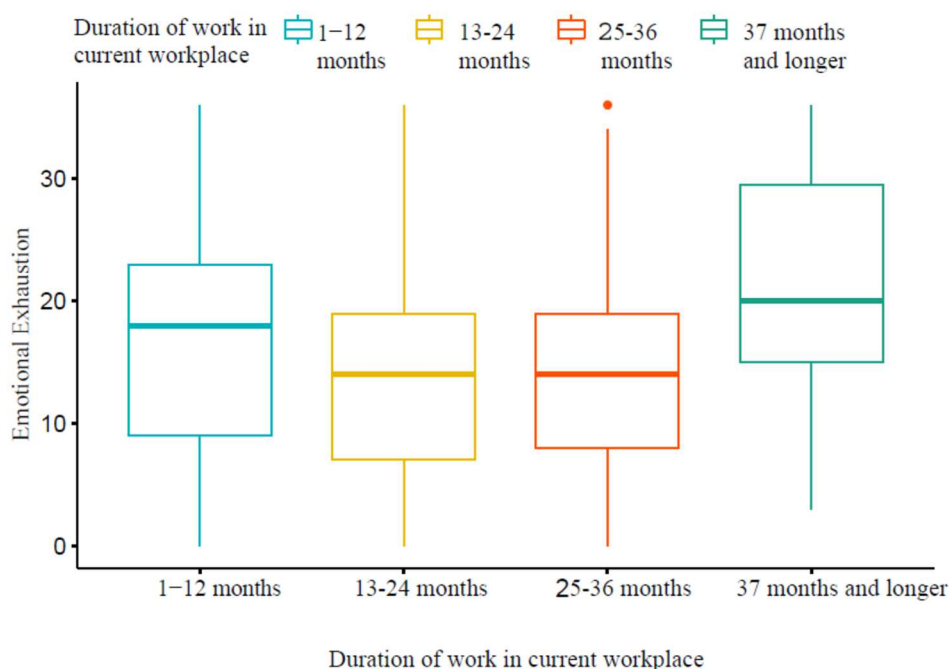
Figure 4.19. Emotional Exhaustion scores of Maslach Burnout Inventory and the duration of work in current workplace (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

The relationship between the variable "duration of work in current workplace" and Maslach Burnout Inventory scores was also analyzed with Kendall's tau-b and Spearman's rank correlation coefficient tests after Shapiro-Wilk Normality Test showed the data for duration of work were not distributed normally (Shapiro-Wilk Test statistic: 0.8006888, p= 0.000).

The Spearman's rank correlation coefficient test results showed a moderate-weak, statistically significant positive correlation between the variables duration of work in current workplace and Emotional Exhaustion scores ($r_{s=}$ -0.206, p=0.002), and no statistically significant correlation was found between the duration of work and other MBI subscales, namely, depersonalization and personal achievement (Table 4.49).

Similarly, according to the Kendall's tau-b test, it was observed that there was a moderate-weak statistically significant positive correlation between duration of work in current workplace and Emotional Exhaustion ($T_{b=}$ 0.161, p=0.002) (Table 4.50).

Table 4.50. Correlation between duration of work in current workplace and Maslach Burnout Inventory scores (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Duration of work in current workplace	
	Spearman's rho	Kendall's tau-b
Emotional Exhaustion	0.206**	0.161**
Depersonalization	-0.011	-0.005
Personal Achievement	0.109	0.077

**moderate-weak association

4.5.12 Maslach Burnout Inventory Score and the Ability to Speak a Common Language

The analyses of each sub-scale with Wilcoxon Rank-Sum Test according to the respondents' ability to speak a common language with the migrant, refugee and asylum seeker patients showed that there is a statistically significant difference in the Emotional Exhaustion ((p= 0.0000007) and Depersonalization scores (p= 0.0372) of the respondents. Personal achievement scores (p= 0.169) were not observed to be different in relation to the ability to speak a common language (Table 4.51).

Table 4.51. Maslach Burnout Inventory Scale Scores according to respondents' ability to speak a common language (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Group 1	Group 2	n1	n2	statistic	p value
Emotional Exhaustion	Yes	No	109	111	3637.5	0.0000007
Depersonalization	Yes	No	109	111	4973	0.0372
Personal Achievement	Yes	No	109	111	5301	0.169

Wilcoxon Rank-Sum Test
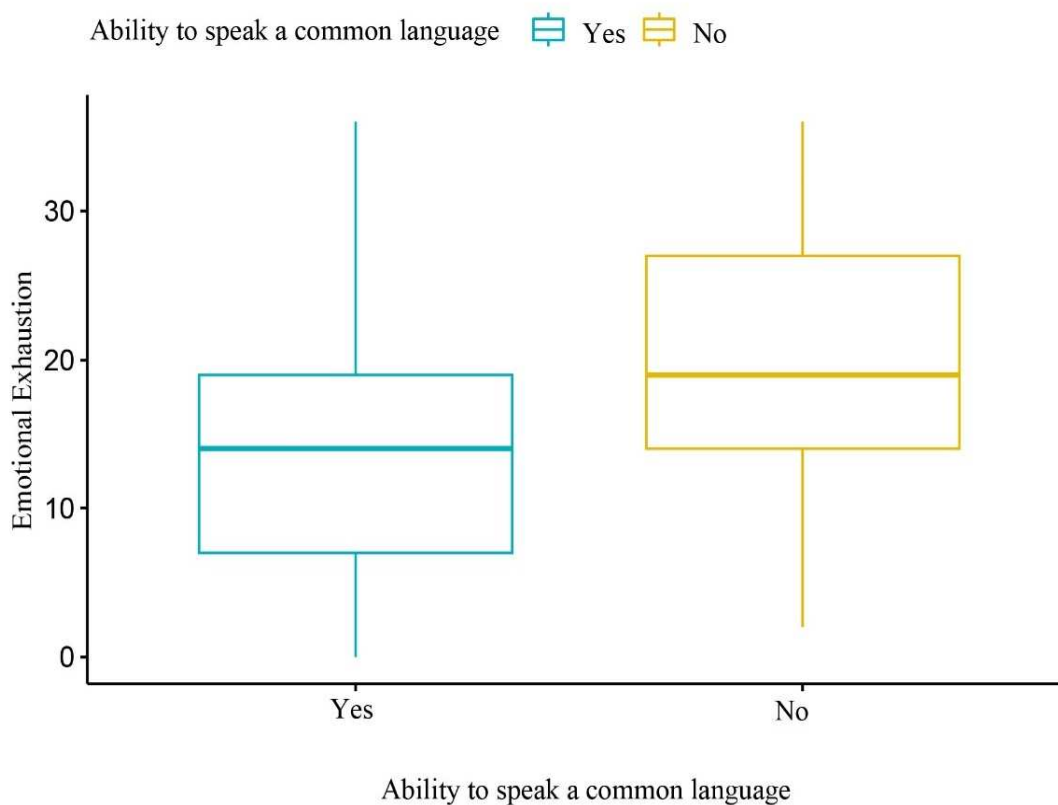
Figure 4.20. Emotional Exhaustion scores of Maslach Burnout Inventory and ability to speak a common language (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)
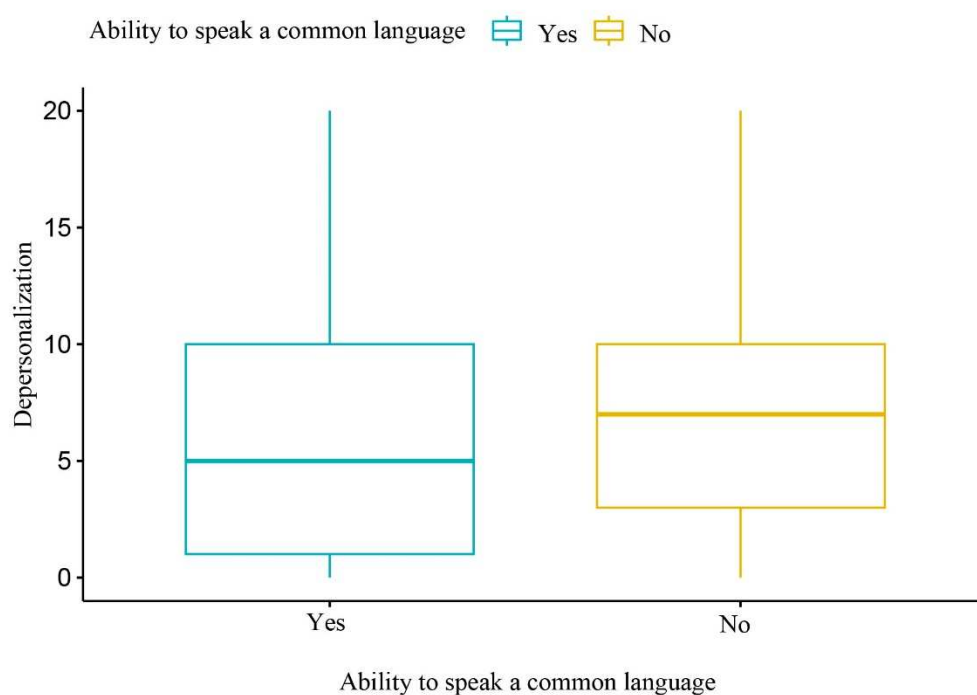
Figure 4.21. Depersonalization scores of Maslach Burnout Inventory and ability to speak a common language (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)
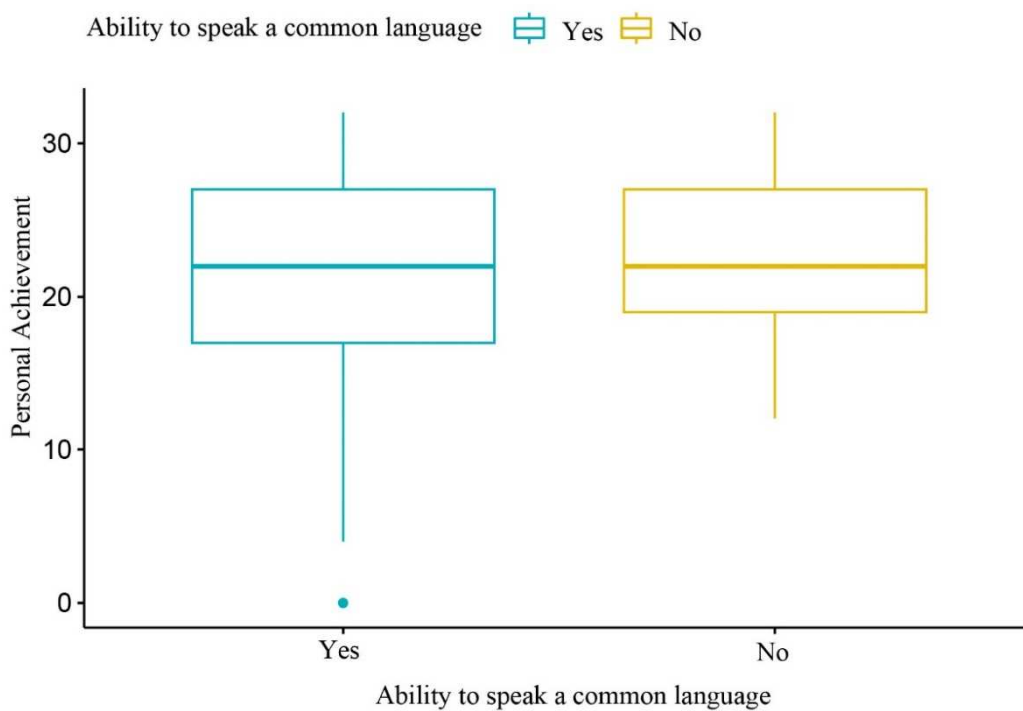
Figure 4.22. Personal Achievement scores of Maslach Burnout Inventory and ability to speak a common language (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

4.5.13 Maslach Burnout Inventory Score and Daily Working Hours

According to the Shapiro-Wilk test for the daily working hours variable, it was observed that the data were distributed differently than normal distribution (p<0.01) (Table 4.52). Based on this finding, nonparametric correlation tests, Kendall's tau-b and Spearman's rank correlation coefficient were utilized for the analysis of the association between MBI subscores and working hour variables.

Table 4.52. Shapiro-Wilk Normality Test for Daily Working hours (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Statistic	p value
Working hours	0.7260561	0.0000

Shapiro-Wilk Normality Test

The results of the Spearman's rank correlation coefficient test showed a moderate statistically significant negative correlation between the variables daily working hours and Emotional Exhaustion scores ($r_s=$ -0.393, p=0.00), and no statistically significant correlation was found between working hours and other MBI subscales, namely, depersonalization (rs= -0.071, p=0.331) and personal achievement (rs= -0.106, p= 0.147) (Table 4.53).

Similarly, the Kendall's tau-b test revealed a moderate-strong statistically significant negative correlation between daily working hours and Emotional Exhaustion ($T_{b=}$ --0.299, p=0.00), and no relationship between working hours and Depersonalization ($T_{b=}$ -0.057, p=0.313) and Personal Achievement scores ($T_{b=}$ -0.068, p=0.221) (Table 4.53).

Table 4.53. Correlation between daily working hours and Maslach Burnout Inventory scores (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Daily Working Hours	
	Spearman's rho	Kendall's tau-b
Emotional Exhaustion	-0.393***	-0.299***
Depersonalization	-0.071	-0.057
Personal Achievement	-0.106	-0.068

*** moderate association

4.5.14 Maslach Burnout Inventory Score and Daily Number of Consultations

The Shapiro-Wilk test was utilized to test the normality of data representing the daily number of consultations. The test results showed that the data were not normally distributed (p<0.01) (Table 4.54). Based on this finding, nonparametric correlation tests, Kendall's tau-b and Spearman's rank correlation coefficient were used to understand the association between MBI subscores and daily number of consultations.

Table 4.54. Shapiro-Wilk Normality Test for Daily Number of Consultations (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Statistic	p value
Consultations	0.8400143	0.0000

Shapiro-Wilk Normality Test

According to both Spearman's rank correlation coefficient test and Kendall's tau-b test, there was no statistically significant relationship between the MBI scores and the number of consultations that the respondents had on a daily basis (p>0.05) (Table 4.55).

Table 4.55. Correlation between daily number of consultations and Maslach Burnout Inventory scores (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Daily Consultations			
	Spearman's rho	p value	Kendall's tau-b	p value
Emotional Exhaustion	0.039	0.578	0.025	0.618
Depersonalization	0.040	0.566	0.029	0.567
Personal Achievement	0.087	0.216	0.057	0.254

4.5.15 Maslach Burnout Inventory Score and Respondents' Self-reported Knowledge About Legal Status

The analyses of each sub-scale with Wilcoxon Rank-Sum Test showed that there was a statistically significant difference between the respondents' self-reported knowledge of legal status and Emotional Exhaustion (p=0.000) (Table 4.56, Figure 4.23). No statistically significant difference was observed in the Personal Achievement (p= 0.107) and Depersonalization (p=0.053) subscale scores.

Table 4.56. Maslach Burnout Inventory Scale Scores according to respondents' self-reported knowledge of the legal status of migrant, refugee and asylum seekers (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Group 1	Group 2	n1	n2	statistic	p value
Emotional Exhaustion	Yes	No	91	128	7732	0.000
Depersonalization	Yes	No	91	128	9118.5	0.053
Personal Achievement	Yes	No	91	128	9267	0.107

Wilcoxon Rank-Sum Test
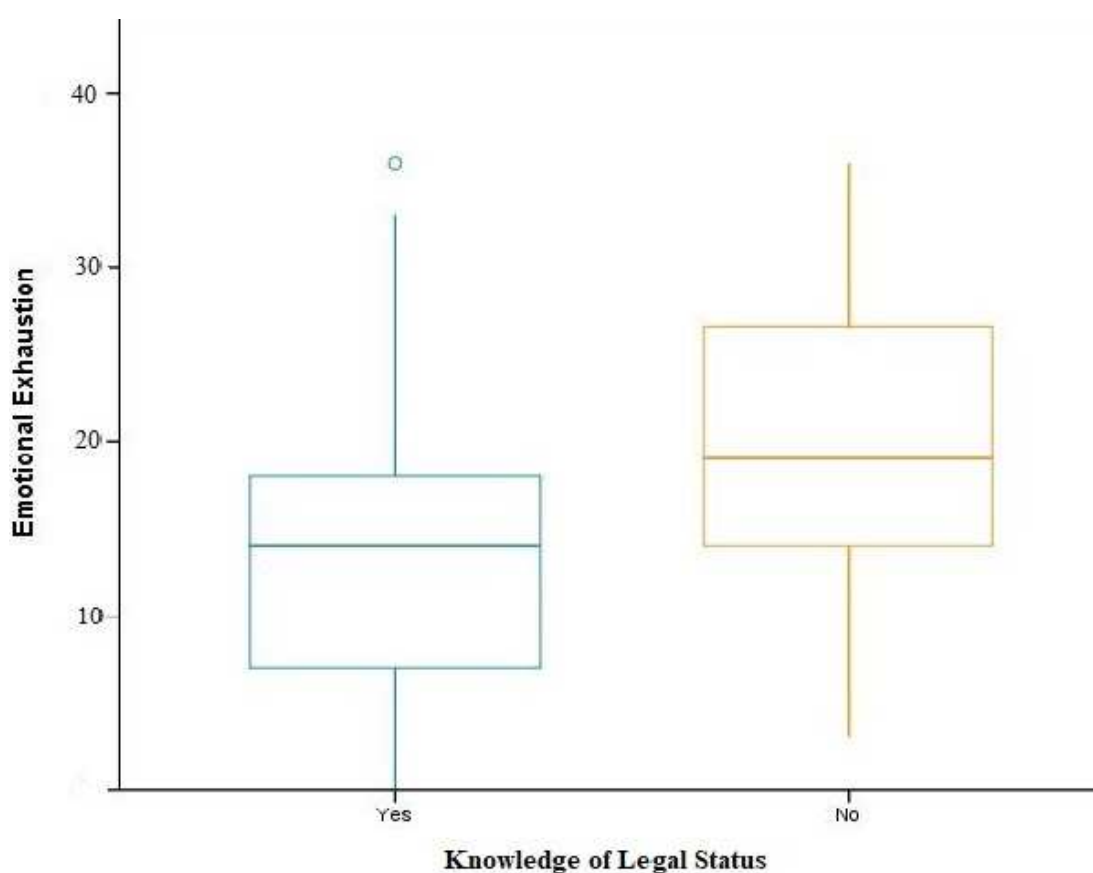
Figure 4.23. Emotional Exhaustion scores of Maslach Burnout Inventory and self-reported knowledge of legal status (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

4.5.16 Maslach Burnout Inventory Score and the Respondents' Self-Reported Knowledge About Culture of Migrant, Refugee and Asylum Seeker Patients

Kruskal-Wallis test was executed to analyse the relationship between the MBI scores and the responses about the knowledge of culture in Likert scales "Agree",

"Neutral" and "Disagree". The results showed that there was a statistically significant difference in the MBI Emotional Exhaustion (p=0.000) and Depersonalization (p=0.016) subscale scores of the respondents based on their self-reported level of knowledge about the culture of migrant, refugee and asylum seeker patients (Table 4.57).

Table 4.57. Maslach Burnout Inventory Scale Scores according to respondents' self-reported knowledge about the culture of migrant, refugee and asylum seekers (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Variable	Self-reported knowledge about culture			
	n	statistic	df	p
Emotional Exhaustion	183	30.069	2	0.000
Depersonalization	183	8.285	2	0.016
Personal Achievement	183	4.732	2	0.094

Kruskal-Wallis Test

For Emotional Exhaustion subscore, to understand between which categories there was a statistically significant difference, Pairwise-Wilcox Test was utilized. Accordingly, there was a difference between the respondent group who reported that they were knowledgeable about the culture of migrant, refugee and asylum seekers, and those who are not knowledgeable and who responded "neutrally" (Table 4.58).

Table 4.58. Pairwise Wilcox Test for Emotional Exhaustion scores of Maslach Burnout Inventory according to self-reported knowledge about the culture of migrants, refugees and asylum seekers (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

				Emotional Exhaustion			
Group 1	Group 2	n1	n2	statistic	p	p.adj	p.adj.signif
Not knowledgeable	Neutral	48	53	-0.37932	0.995	2.985	ns
Not knowledgeable	Knowledgeable	48	83	6.91893	0.000	0.000	*
Neutral	Knowledgeable	53	83	7.29825	0.000	0.000	*

Pairwise Wilcox Test
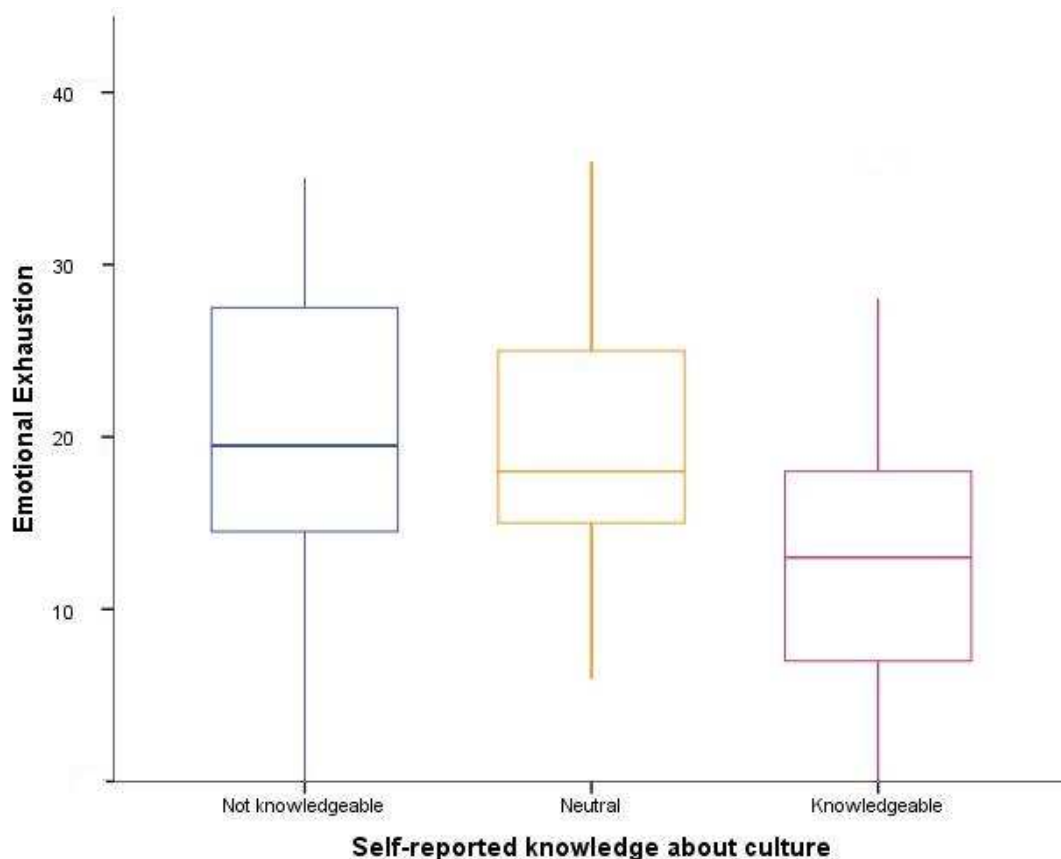
Figure 4.24. Emotional Exhaustion scores of Maslach Burnout Inventory and the self-reported knowledge about the culture of Migrant, Refugee and Asylum Seeker Patients (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Table 4.59. Pairwise Wilcox Test for Depersonalization scores of Maslach Burnout Inventory according to self-reported knowledge about the culture of migrants, refugees and asylum seekers (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

				Depersonalization			
Group 1	Group 2	n1	n2	Statistic	p	p.adj	p.adj.signif
Not knowledgeable	Neutral	48	53	-1.87618	0.148	0.444	ns
Not knowledgeable	Knowledgeable	48	83	6.91893	0.809	2.427	ns
Neutral	Knowledgeable	53	83	7.29825	0.012	0.036	*

Pairwise Wilcox Test

For the Depersonalization subscore, the pairwise comparisons showed that there was a difference between the respondent group who reported that they were

knowledgeable about the culture of migrant, refugee and asylum seekers, and those who responded "neutrally" (Table 4.59).
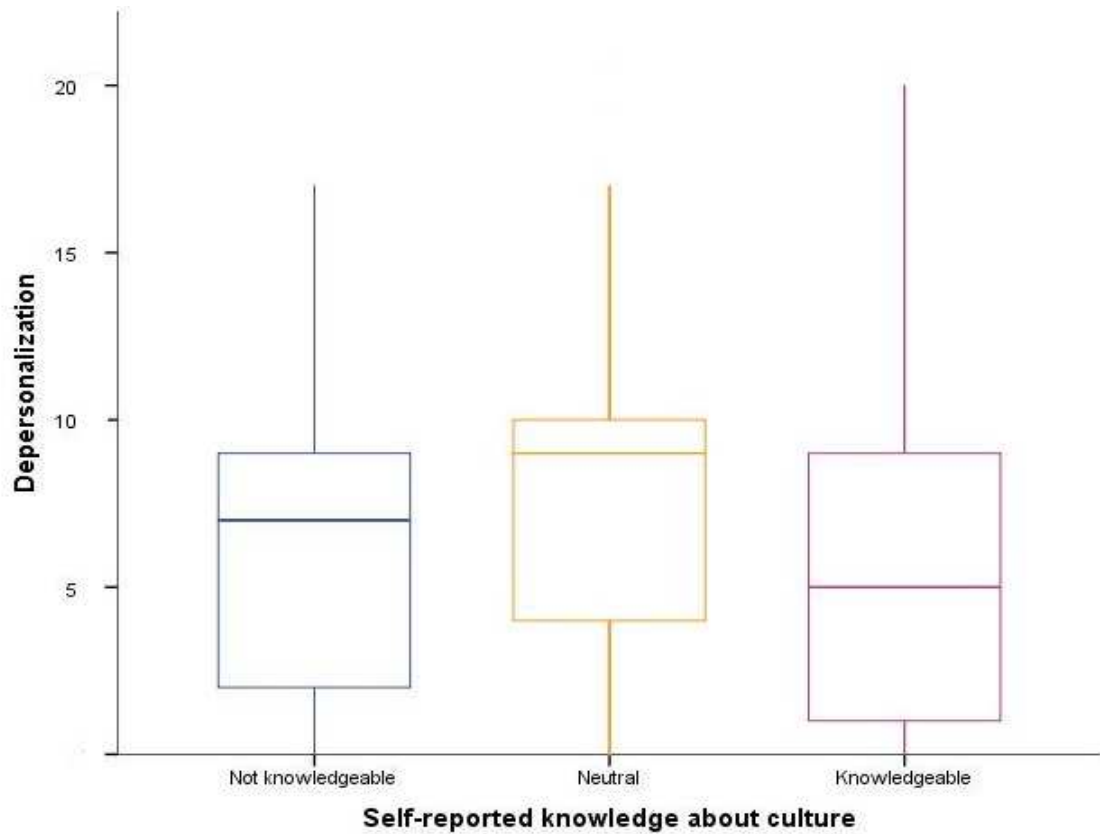
Figure 4.25. Depersonalization scores of Maslach Burnout Inventory and the self-reported knowledge about culture of Migrant, Refugee and Asylum Seeker Patients (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

4.6 Regression Analyses of the Maslach Burnout Inventory Subscale Scores

Multilinear Regression analyses were conducted to examine the relationships between the three MBI subscales and some of the predictor variables used in the study. These variables were selected based on three criteria: those which were found statistically significant in this study ($p<0.05$), those which had a significance value of 0.20 and below, and those that were found statistically significant in the literature.

Table 4.60. Multilinear Regression Analysis for the three subscales of Maslach Burnout Inventory (Health personnel, Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Model	Emotional Exhaustion		Depersonalization		Personal Achievement	
	β	t	β	t	β	t
Gender[1]	0.806	0.537	0.217	0.248	2.536	2.008*
Age	-0.203	-2.173*	-0.057	-1.052	0.002	0.027
Number of children	-0.087	-0.174	0.072	0.245	-0.194	-0.461
Duration of work in current workplace	0.034	1.490	-0.011	-0.800	0.022	1.134
Daily working hours	-0.303	-1.294	0.031	0.225	0.165	0.839
Profession[2]						
Nurse	-0.003	-0.002	1.237	1.230	-2.729	-1.883
Other	0.274	0.121	0.893	0.675	-2.636	-1.381
Training status[3]	-3.928	-2.035*	-1.964	-1.743	-1.975	-1.216
Institution of longest service duration[4]						
Primary Health Care	-1.044	-0.740	-0.111	-0.135	-1.399	-1.178
Other	4.785	1.670	1.270	0.760	1.192	0.494
Previous experience with migrant patients[5]	-0.833	-0.638	-0.534	-0.700	-0.978	-0.890
Current workplace[6]						
Migrant Health Center	-9.665	-3.567***	-4.370	-2.764**	0.432	0.189
Other	-2.961	-0.916	-0.195	-0.103	-0.920	-0.338
Ability to speak a common language[7]	-1.250	-0.707	-1.101	-1.067	-1.538	-1.034
Knowledge about legal status[8]	0.484	0.261	0.296	0.273	-4.064	-2.601*
Knowledge about culture[9]						
Agree	-0.776	-0.438	0.962	0.929	3.931	2.634**
Neutral	3.701	2.162*	3.418	3.421***	0.446	0.309
Adj. R²	0.331		0.093		0.080	
F value	6.152		2.063		1.904	
Significance	0.000		0.011		0.021	

*p<0.05, **p<0.01, ***p≤0.001, dummy variable: [1]male as reference group, [2]doctor as reference group, [3]a lack of prior training as reference group, [4]hospital as reference group, [5]a lack of previous experience as reference group, [6]family health center as reference group, [7]a lack of ability to speak a common language as reference group, [8]self-reported lack of knowledge about legal status as reference group, [9]self-reported lack of knowledge about culture as reference group

Based on the selection criteria, a total of 15 predictor variables were identified and analyzed in SPSS. Due to the multicollinearity problem and unmet assumptions, two predictor variables, namely the "duration of service to migrant, refugee and asylum seekers" and the "year of graduation" were excluded from the analyses. One analysis was conducted for each of the MBI subscales and the results were presented in Table 4.60.

The regression model for the Emotional Exhaustion subscale, $F(17, 160)=6.152$, $p=0.000$, explained 33.1% of the scores ($R^2_{adjusted} =.331$) in relation to four predictors; *age, training status, current workplace* and *knowledge about culture* which showed statistically significant relationships. Accordingly, the independent variables *age, training status* and *working in Migrant Health Center* predict the level of Emotional Exhaustion in a statistically significant and negative direction (Table 4.60). On the other hand, *having a neutral stance on the knowledge about the culture of migrant, refugee and asylum seekers* predicts the level of Emotional Exhaustion in a statistically significant and positive direction. This suggests that the respondents indicated lower levels of Emotional Exhaustion score when they are older, if they have received training on migration health before, and if they work in Migrant Health Centers as opposed to Family Health Centers and other healthcare facilities (i.e. Emergency Healthcare Centers, Cancer Screening and Early Diagnosis Centers and Temporary Shelters). Their Emotional Exhaustion scores were indicated higher if they provided a neutral response to the item "*I have sufficient knowledge of the health rights of migrants, refugees or asylum seekers*" (Table 4.60).

The regression model for the Depersonalization subscale, $F(17, 160)=2.063$, $p=0.011$, explained 9.3% of the scores ($R^2_{adjusted} =.093$) in relation to two predictors; *current workplace* and *knowledge about culture* which showed statistically significant relationships. According to the model, the independent variable *working in Migrant Health Center* contributes to the level of Depersonalization in a statistically significant and negative direction (Table 4.60). However, *having a neutral stance on the knowledge about the culture of migrant, refugee and asylum seekers* predicts the level of Depersonalization in a statistically significant and positive direction, as it is the case for Emotional Exhaustion. This means that the respondents indicated lower levels of Depersonalization score when they work in Migrant Health Centers as opposed to Family Health Centers and other healthcare facilities. Their Depersonalization scores were higher if they responded neutrally to the statement "*I have sufficient knowledge of the health rights of migrants, refugees or asylum seekers*" (Table 4.60).

Finally, the regression analysis of the Personal Achievement subscale, $F(17, 160)=1.904$, $p=0.021$, explained 8% of the scores ($R^2_{adjusted} =.080$) in relation to three predictors; *gender, knowledge about legal status and knowledge about culture* which

showed statistically significant relationships. The independent variables *gender* and *presence of self-reported knowledge about culture* contribute to the level of Personal Achievement in a statistically significant and positive direction (Table 4.60). On the other hand, *having knowledge about the legal status of migrant, refugee and asylum seekers* predicts the level of Personal Achievement score in a statistically significant and negative direction. This suggests that the respondents reported higher levels of Personal Achievement when they are female and feel that they have sufficient level of knowledge of the culture of migrants, refugees or asylum seekers they serve. However, their scores get lower when they are knowledgeable about the legal status of migrant, refugee and asylum seekers (Table 4.60).

5. DISCUSSION

There is a dearth of research on health professionals working with migrant groups in literature even though the issue has been explored quite extensively from the beneficiary perspective. This study investigated the presence of safety risks, burnout and challenges that health professionals serving migrants, refugees and asylum seekers might experience in four provinces of Turkey with high population of migrant groups, particularly Syrians under temporary protection.

The data collected from each province unfortunately did not represent all the health professionals working in the four different provinces as workplaces were disproportionately clustered. To exemplify, all the responses were collected from Family Health Centers in Şanlıurfa and from Migrant Health Centers in Hatay, both of which have essential differences in the organization of services and human resources. Since the experiences of the healthcare professionals would vary extensively depending on these factors, interpretation of data and drawing conclusions based on province were impossible. Therefore, the frequency analysis by province showed only how the data was distributed across the provinces, not to make province-related interpretations.

As one of the recurring themes in the migration and health literature, communication problems due to language barrier and the importance of health interpreters were emphasized in this study (17, 23, 26, 52). The statements about the importance of working with interpreters were stressed by most of the respondents. There were some neutral responses to the statements about interpreters, which could be attributed to the health professionals working in centers without interpreters such as in Family Health Centers and Emergency Units. Their lack of experience in service provision with the support of interpreters prevented them from responding to certain statements exploring detailed aspects of translation in medical settings. Factors such as interpreters' professional competence and their knowledge about medical terminology and culture were found to be important elements of service provision, along with reservation about patient privacy and confidentiality in the presence of an interpreter (27, 28, 29, 30). The need for training for the interpreters was highlighted to ensure professional, linguistic and cultural competence. The training of healthcare

professionals specifically on interpreter-facilitated healthcare was also found necessary.

It was clear that most respondents appreciated the significance of training targeting different groups like healthcare professionals, interpreters, and even patients. However, half of them expressed their reluctance to receive training in migration and health. This may be explained by the heavy workload as reported by some respondents in the open-ended items in the survey and supported by the literature of migration health, and dissatisfaction about previously attended training programmes (9, 13).

Service provision to migrant groups was found to be difficult and mentally exhausting by over half of the respondents. This result is in line with previous research findings about the challenges of diagnosis and noncollaborative patient behavior (10,11,12,13,14). The most common challenges reported in the study were related to the difficulty of diagnosing mental health problems, convincing patients for a certain type of treatment method, language barrier and lack of communication, and patients' noncollaborative behaviour like not following application routines, appointment times and queue taking rules. In addition to the aspects of service provision that cause difficulties, certain patient groups, namely infants, women and older persons, were also considered more challenging to serve. Data for the reasons why these groups were particularly more challenging was limited, and therefore, this topic needs to be further investigated in a future study.

In terms of the challenges associated with the physical environment, the responses were quite distributed, which makes it hard to reach a common conclusion. Hence, the sufficiency of resources like reproductive health counseling materials and overall physical conditions in the facilities require further and more in-depth inquiry. On the other hand, the issue of inadequate human resources was reported to be a challenge by almost half of the respondents. The rationale behind the requirement for more human resources in healthcare for migrant groups may be justified by the findings of previous studies in the literature that emphasize the additional time and effort required for service provision to migrant groups due to linguistic and cultural barriers and a lack of knowledge about the health system (9, 13, 14, 17, 24, 27).

The data was collected right before the beginning of the COVID-19 pandemic when the service provision was not affected by the implications of the pandemic.

However, it would not be unreasonable to assume that some of the challenges reported in this study were exacerbated due to increased workload. It is, therefore, recommended that new studies be conducted to explore the challenges faced by the healthcare professionals working with migrant groups in the face of the pandemic.

Safety risks and threat of violence turned out to be a concern for one third of the respondents. This result is in line with the similar concerns raised in the reports by the International Committee of the Red Cross (ICRC) and cases reported by different healthcare facilities in different countries the UK and Sweden (46, 48). There are some crucial implications of this finding for the overall healthcare system in Turkey where violence against health workforce is becoming a serious issue these days.

In regard to the respondents' level of burnout, the results suggest that there is definitely room for the improvement of conditions for healthcare professionals to prevent burnout (*MBI Emotional Exhaustion (EE): 17.189±9.202, Depersonalization (DP): 6.274±4.767, and Personal Achievement (PA): 21.783±6.431*). Since the MBI does not offer any cut-off points, it was not possible to suggest a single descriptive finding regarding the status of burnout, however, factors that might be affecting the scores were analyzed separately.

Accordingly, factors such as *age*, *workplace* and *training status* were found important predictors for EE. It was observed that an increase in age suggested a decrease in the EE scores, which is consistent with the previous research on the burnout among primary and secondary healthcare service providers in non-migrant settings (85, 86, 87). However, unlike these studies where age was also a predictor for DP and PA scores, this study did not find a significant relationship between age and the MBI scores other than EE.

The difference in the EE scores was evident between the healthcare professionals working in Family Health Centers and Migrant Health Centers. The respondents working in Migrant Health Centers had significantly lower levels of EE and DP than those working in Family Health Centers. This finding could be attributed to the clear distinctions between these two types of facilities. In Migrant Health Centers, services and human resources are designed in a way that caters for the specific needs of migrant populations, through the employment of interpreters, social workers and psychologists who have received training in migration health. On the other hand,

Family Health Centers across the country operate based on a system which is predominantly shaped by the healthcare needs of the host community without the additional human resources for translation, cultural mediation and social work. It is, therefore, not surprising to see that the professionals working in these settings are more vulnerable to burnout due to a lack of institutional and structural support. Considering that approximately 970,000 Syrian refugees are already registered to family physicians in 29 provinces[3], it is of utmost importance that necessary interventions are put into action to strengthen the Family Health Centers in providing healthcare services to migrant populations through additional human resources and capacity building programmes.

Another finding of the study is that training is an important predictor for EE. Having received a training in migration and health seemed to lower the level of EE for the health professionals in the study. Although not entirely specific to the migration health settings, the importance of training has been also emphasized extensively in the literature with findings supporting the positive impact of it on the prevention of burnout (59, 88, 89, 90, 91).

Other factors such as *gender*, *profession* and *number of children* showed some relationship with the MBI subscores. Although gender was found to be a predictor for EE and DP in some studies in the literature, no profound impact was observed in this study (92, 93, 94, 95). It just slightly explained some increase in the PA scores of the female respondents. In addition to gender, profession and number of children showed some relationship with EE. The findings suggest that doctors have higher EE scores than nurses, and those with three or more children have lower levels of EE compared to those with 2 or fewer. In the literature, the types of MBI subscales and the direction of relationship with these factors vary and the differences might be explained by contextual diversities related to both parenthood and professions (89, 96, 97, 98, 99, 101). Besides, the data collected for these variables in the study is lacking depth and detailed inquiry. That's why it is difficult to analyse the reasons for these findings and draw solid conclusions.

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[3] Information shared by the head of the Department of Migration Health of the Ministry of Health, Turkey

Knowledge about culture was found to be a predictor for EE, DP and PA. The respondents with sufficient level of knowledge about culture had higher PA scores. On the other hand, those who reported that they neither have nor don't have sufficient knowledge about the culture of their patients (i.e. those who responded to the item neutrally) scored higher in DP and EE in the multivariate analysis. Interestingly, the scores of those who reported that they were **not** knowledgeable were lower than this group. This could be attributed to the wording of the option for a neutral response to this Likert item in Turkish, which could be translated as "no idea" (in Turkish: Fikrim yok). Some respondents might have misinterpreted it as they have no idea about the culture of their patients, and hence, selected this option. Although it would be misleading to make strong conclusions about this factor in the presence of current data, the bivariate analysis of the responses suggested that having knowledge about culture could be consistent with lower levels of EE and DP. In terms of knowledge about the legal status of patients, the results were not conclusive. It could still be suggested that knowing about legal status may decrease EE, but also interestingly, PA. Therefore, more data is needed to further analyse the relationship of it to burnout.

Speaking a common language with patients seemed to diminish EE and DP. Due to the limited number of studies conducted specifically on burnout among the healthcare professionals serving in refugee and migrant settings, it is not possible to compare the effect of the knowledge of language and culture found in this study to other research findings. However, there is, indeed, great emphasis in the literature on how much linguistic and cultural barriers hinder services and how important it is to plan and implement interventions to overcome these problems in healthcare services, and eventually, ease the burden of healthcare professionals (10, 11, 12, 13, 14, 15, 16, 23, 28, 30).

In general, the duration of work with migrant populations seemed to be associated with PA since PA scores were higher in the group that served migrants, refugees and asylum seekers for more than 41 months than those that served them for less than 20 months. This may suggest that the more experienced healthcare professionals are in providing healthcare to migrant and refugee patients, the greater their sense of achievement becomes. On the other hand, duration of work in their

position seemed to have a relationship with EE scores increasing in time, meaning EE was higher in groups who served for 37 months and longer. This could be explained by the additional effort that serving migrant populations usually requires, which may be associated with high levels of exhaustion. The relationship between burnout and the duration of work has also been investigated widely in previous studies which found inconsistent results with both significant and insignificant relationships (59, 87, 89, 97, 100, 101, 102).

Finally, the findings about the relationship between burnout and daily working hours surprisingly showed a negative correlation for EE. That is, increased working hours was associated with decreased EE scores. This could be attributed to some unreported problems that the respondents might have experienced during data collection. As some of them responded to the survey electronically, instead of pen and paper format, they might have miscoded the number of hours on the interface. Therefore, the impact of daily working hours requires to be explored again in a future study.

Overall, the study has certain limitations to be considered for better interpretation of findings. First of all, this study involved participation of public officials whose personal data, i.e. contact details, are protected by the Ministry of Health. Therefore, data collection was only possible through the responsible officers at Provincial Health Directorates who distributed the survey to the healthcare professionals based on the selection criteria communicated to them both in writing and verbally. This caused the data collection procedures to be selective based on the judgment of the officers, with certain health facilities overly represented in some provinces, as in Hatay and Şanlıurfa. It might also have resulted in bias and less objectivity in the responses to the items due to power differentials. Some participants may have felt insecure while responding to certain items and avoided showing a critical attitude, using bold statements or expressing discontent in a form which was sent by their superior officers. Besides, the mixed approach that had to be used in data collection might have affected the reliability of data in an adverse way. Not all healthcare professionals are good at using technology and the interface used for the survey might not have been found user-friendly and simple. This may explain some of the inconsistencies observed in certain findings.

Secondly, the study only included quantitative research methods whereas the hypotheses would be better tested in combination of qualitative and quantitative approaches. Unfortunately, employing both types of methods was not possible due to time constraints and heavy workload of the healthcare professionals.

Finally, due to the lack of previous research on the interplay between burnout and different aspects of healthcare services provided specifically in migration contexts, it was impossible to interpret findings in relation to previous studies. This may have led to limited depth in the analysis and interpretation of the outcomes of the study.

6. CONCLUSION

The aim of this study was to examine the challenges, burnout and potential of safety risks experienced by the healthcare professionals who provide health services to migrants, refugees and asylum seekers in four provinces of Turkey, namely Gaziantep, Hatay, Şanlıurfa and İzmir, where the migrant population is high. The study is one of the very few attempts globally and nationally to generate scientific knowledge about migration and health topic from a provider perspective. It is geographically relevant to the context of migration in that it was conducted in a country with the highest number of refugees in the world. In this regard, the findings of this study could contribute to future research and knowledge generation in the area greatly.

The results of the study suggest that there are some factors that may not only represent challenges to healthcare providers' professional practices but also put them at risk of burnout and violence. These factors should be further explored in future studies, and effective measures need to be taken in order to overcome the difficulties hindering both staff welfare, and accessibility, acceptability and quality of healthcare services for migrant populations.

Based on the findings of this study, it could be recommended that there should be a holistic approach to staff safety and security, involving the healthcare systems both for migrant and host communities to protect the safety of health workforce in the country. The human resources and capacities of the staff, particularly working in the Family Health Centers, should be strengthened through the employment of multilingual healthcare professionals and/or interpreters, and training programmes covering a variety of topics from effective communication, social inclusion, legal entitlements and cultural sensitivity and competency, to the clinical management of mental and reproductive health of refugees, infant and pregnancy follow up, and health systems. Besides, the linguistic competence of interpreters must be ensured through competitive recruitment, and their professional competence should be supported through in-service training that focuses on the principles of intercultural communication.

All healthcare professionals and interpreters should follow a common protocol that defines the standard operating procedures for translation that takes place in clinics to increase cultural acceptance, monitor the accuracy of translation, and protect patient

confidentiality and privacy. Finally, the human resource plans for the facilities where migrant populations regularly receive services should prioritize the recruitment of more experienced healthcare professionals, preferably with professional or personal background in vulnerable groups. The appointment of novice healthcare professionals to these centers should be avoided.

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8. ANNEXES

ANNEX-1: Ethical Committee Approval

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

Sayı : 16969557 -216

Konu : ARAŞTIRMA PROJESİ DEĞERLENDİRME RAPORU

Toplantı Tarihi	: 07 OCAK 2020 SALI
Toplantı No	: 2020/01
Proje No	: GO 19/211(Onay Tarihi: 28.02.2019)
Karar No	: 2020/01-01

Kurulumuzun 28.02.2019 tarihli toplantısında GO 19/211 kayıt numarası ile onaylanmış olan Üniversitemiz Tıp Fakültesi Halk Sağlığı Anabilim Dalı öğretim üyelerinden Prof. Dr. Kerim Hakan ALTINTAŞ' ın sorumlu araştırmacı olduğu, Nurtaç KAVUKCU'nun yüksek lisans tezi olan, GO 19/211 kayıt numaralı, *"Türkiye'de Geçici Barınma Merkezleri ve Yabancı Uyruklular Polikliniklerinde Sağlık Hizmeti Sunan Sağlık Çalışanlarının Hizmet Sunumuna Yönelik Görüşleri ve Tükenmişlik Durumlarının Değerlendirilmesi"* başlıklı proje için verilen süre uzatma, başlık değişikliği dilekçesi ve protokol revizyon talebi Kurulumuzun 07.01.2020 tarihli toplantısında görüşülmüş ve **uygun bulunmuştur.** Çalışmanın başlığı *"Hatay, Şanlıurfa, Gaziantep ve İzmir İllerinde Göçmen, Mülteci ve Sığınmacılara Birinci Basamak Sağlık Hizmeti Sunan Sağlık Çalışanlarının Hizmet Sunumuna Yönelik Görüşleri ve Tükenmişlik Durumlarının Değerlendirilmesi"* olarak değiştirilmiş ve kayıtlarımıza eklenmiştir. Projenin yeni sonlanım tarihi 05 Mayıs 2020 olarak belirlenmiştir. Çalışma tamamlandığında sonuçlarını içeren bir rapor örneğinin Etik Kurulumuza gönderilmesi gerekmektedir.

1.Prof. Dr. Ayşe Lale DOĞAN	(Başkan)	9. Doç. Dr. Fatma Visal OKUR	(Üye)
2. Prof. Dr. Sevda F. MÜFTÜOĞLU	(Üye)	10. Doç. Dr. Can Ebru KURT	(Üye)
3. Prof. Dr. M. Yıldırım SARA	(Üye)	11. Doç. Dr. H. Hüsrev TURNAGÖl	(Üye)
4. Prof. Dr. Neeter SKGiNAAM	(Üye)	12. Dr. Öğr. Üyesi Özay GÖKÖZ	(Üye)
İZİNLİ			
5. Prof. Dr. Mintaze Kerem GÜNEL	(Üye)	13. Dr. Öğr. Üyesi Müge DEMİR	(Uye)
6. Prof. Dr. Oya Nuran EMİROĞLU	(Üye)	14. Öğr. Gör. Dr. Meltem ŞENGELEN	(Üye)
7. Prof. Dr. M. Özgür UYANIK	(Üye)	15. Av. Meltem ONURLU	(Üye)
8. Doç. Dr. Gözde GİRGİN	(Üye)		

ANNEX-2: Digital Receipt

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Digital Receipt

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Page count:	173
Word count:	42,152
Character count:	234,509
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Submission ID:	1659759710

THE PERCEPTIONS OF HEALTHCARE PROFESSIONALS SERVING
MIGRANT, REFUGEE AND ASYLUM SEEKERS IN THE PRIMARY
HEALTHCARE CENTERS OF HATAY, ŞANLIURFA, GAZİANTEP
AND İZMİR ABOUT HEALTHCARE PROVISION, AND THEIR

ANNEX-3

Table 4.15. Distribution of health professionals according to province and ethnicity of patients (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Ethnicity		Gaziantep		Hatay		İzmir		Şanlıurfa		Total*	
		n	%	n	%	n	%	n	%	n	%
Syrian	Very often	22	84.6	51	100.0	50	96,2	47	74.6	170	88.5
	Often	4	15.4	-	-	2	3,8	16	25.4	22	11.5
	Total**	26	13.5	51	26.6	52	27.1	63	32.8	192	100.0
Afghan	Often	-	-	-	-	6	40.0	-	-	6	40.0
	Sometimes	-	-	-	-	8	53.3	-	-	8	53.3
	Rarely	-	-	-	-	1	6.7	-	-	1	6.7
	Total**	-	-	-	-	15	10.0	-	-	15	100.0
Iraqi	Often	-	-	-	-	11	84.6	7	63.6	18	75.0
	Sometimes	-	-	-	-	2	15.4	3	27.3	5	20.8
	Rarely	-	-	-	-	-	-	1	9.1	1	4.2
	Total**	-	-	-	-	13	54.2	11	45.8	24	100.0
Turkish	Very often	4	66.7	-	-	3	100.0	21	95.5	28	90.3
	Often	2	33.3	-	-	-	-	1	4.5	3	9.7
	Total**	6	19.4	-	-	3	9.7	22	71.0	31	100.0
Bulgarian	Very often	-	-	-	-	1	50.0	-	-	1	50.0
	Often	-	-	-	-	1	50.0	-	-	1	50.0
	Total**	-	-	-	-	2	100.0	-	-	2	100.0
Libyan	Very often	-	-	-	-	-	-	2	50.0	2	33.3
	Often	-	-	-	-	1	50.0	-	-	1	16.7
	Sometimes	-	-	-	-	-	-	2	50.0	2	33.3
	Rarely	-	-	-	-	1	50.0	-	-	1	16.7
	Total**	-	-	-	-	2	33.3	4	66.7	6	100.0
Uzbekistani	Sometimes	1	100.0	-	-	-	-	-	-	1	100.0
	Total**	1	100.0	-	-	-	-	-	-	1	100.0
Omani	Often	-	-	-	-	1	100.0	-	-	1	100.0
	Total**	-	-	-	-	1	100.0	-	-	1	100.0
Dutch	Sometimes	-	-	-	-	-	-	1	100.0	1	100.0
	Total**	-	-	-	-	-	-	1	100.0	1	100.0
Palestinian	Sometimes	-	-	-	-	2	100.0	-	-	2	100.0
	Total**	-	-	-	-	2	100.0	-	-	2	100.0
Lebanese	Often	-	-	-	-	1	100.0	-	-	1	100.0
	Total**	-	-	-	-	1	100.0	-	-	1	100.0
African	Sometimes	-	-	-	-	2	100.0	-	-	2	100.0
	Total**	-	-	-	-	2	100.0	-	-	2	100.0
Russian	Sometimes	-	-	-	-	1	100.0	-	-	1	100.0
	Total**	-	-	-	-	1	100.0	-	-	1	100.0
Iranian	Often	-	-	-	-	1	100.0	-	-	1	100.0
	Total**	-	-	-	-	1	100.0	-	-	1	100.0
Yemeni	Rarely	-	-	-	-	1	100.0	-	-	1	100.0
	Total**	-	-	-	-	1	100.0	-	-	1	100.0

ANNEX-4

Table 4.18. Distribution of health professionals according to province and the most frequent and significant challenges to care (Gaziantep, Hatay, İzmir, Şanlıurfa, January-March 2020)

Challenges		Gaziantep		Hatay		İzmir		Şanlıurfa		Total	
		n	%	n	%	n	%	n	%	n	%
Negative/ nonadaptive behavior	Very often	3	50.0	1	33.3	3	75.0	-	-	7	50.0
	Often	3	50.0	2	66.7	1	25.0	-	-	6	42.9
	Sometimes	-	-	-	-	-	-	1	100.0	1	7.1
	Total	6	42.9	3	21.4	4	28.6	1	7.1	4	100.0
Lack of communication/ language barrier	Very often	19	90.5	1	100.0	11	78.6	62	98.4	93	93.9
	Often	1	4.8	-	-	2	14.3	1	1.6	4	4.0
	Sometimes	1	4.8	-	-	-	-	-	-	1	1.0
	Rarely	-	-	-	-	1	7.1	-	-	1	1.0
	Total	21	21.2	1	1.0	14	14.1	63	63.6	99	100.0
Difficulty in reaching patients	Often	1	33.3	-	-	-	-	10	62.5	11	57.9
	Sometimes	2	66.7	-	-	-	-	5	31.2	7	36.8
	Very often	-	-	-	-	-	-	1	6.3	1	5.3
	Total	3	15.8	-	-	-	-	16	84.2	19	100.0
Unnecessary application	Very often	3	42.9	-	-	-	-	-	-	3	42.9
	Often	3	42.9	-	-	-	-	-	-	3	42.9
	Sometimes	1	14.3	-	-	-	-	-	-	1	14.3
	Total	7	100.0	-	-	-	-	-	-	7	100.0
Poor hygiene	Often	1	33.3	-	-	1	25.0	3	100.0	5	50.0
	Very often	-	-	-	-	2	50.0	-	-	2	20.0
	Sometimes	1	33.3	-	-	-	-	-	-	1	10.0
	Rarely	1	33.3	-	-	-	-	-	-	1	10.0
	Very rarely	-	-	-	-	1	25.0	-	-	1	10.0
	Total	3	30.0	-	-	4	40.0	3	30.0	10	100.0
Heavy workload	Very often	-	-	6	100.0	9	100.0	-	-	15	78.9
	Sometimes	-	-	-	-	-	-	3	75.0	3	15.8
	often	-	-	-	-	-	-	1	25.0	1	5.3
	Total	-	-	6	31.6	9	47.4	4	21.0	19	100.0
Low level of education	Very often	-	-	-	-	2	50.0	-	-	2	33.3
	Often	-	-	-	-	1	25.0	1	50.0	2	33.3
	Sometimes	-	-	-	-	1	25.0	1	50.0	2	33.3
	Total	-	-	-	-	4	66.7	2	33.3	6	100.0
Cultural difference	Often	3	100.0	-	-	3	75.0	3	100	9	90.0
	Very often	-	-	-	-	1	25.0	-	-	1	10.0
	Total	3	30.0	-	-	4	40.0	3	30.0	10	100.0

Table 4.18. (continued)

Challenges		Gaziantep		Hatay		İzmir		Şanlıurfa		Total	
		n	%	n	%	n	%	n	%	n	%
Registration and ID problems	Very often	-	-	3	100.0	2	66.7	-	-	5	62.5
	Often	-	-	-	-	1	33.3	2	100,0	3	37.5
	Total	-	-	3	37.5	3	37.5	2	25.0	8	100.0
Lack of trust	Very often	-	-	-	-	-	-	1	50.0	1	33.3
	Often	-	-	-	-	1	100.0	-	-	1	33.3
	Sometimes	-	-	-	-	-	-	1	50.0	1	33.3
	Total	-	-	-	-	1	33.3	2	66.7	3	100.0
Lack of information	Very often	-	-	1	50.0	2	100.0	1	33.3	4	50.0
	Often	1	100.0	-	-	-	-	2	66.7	3	37.5
	Sometimes	-	-	1	50.0	-	-	-	-	1	12.5
	Total	1	12.5	2	25.0	2	25.0	3	37.5	8	100.0
Vaccine noncompliance	Often	-	-	-	-	-	-	7	77.8	7	77.8
	Very often	-	-	-	-	-	-	2	22.2	2	22.2
	Total	-	-	-	-	-	-	9	100.0	9	100.0
Ambiguity of legal entitlements	Very often	-	-	-	-	-	-	1	100.0	1	100.0
	Total	-	-	-	-	-	-	1	100.0	1	100.0
Insufficient number of personnel and equipment	Very often	-	-	2	100.0	2	66.7	-	-	4	80.0
	Often	-	-	-	-	1	33.3	-	-	1	20.0
	Total	-	-	2	40.0	3	60.0	-	-	5	100.0
Mental health problems (patients)	Very often	-	-	1	50.0	1	100	-	-	2	66.7
	Often	-	-	1	50.0	-	-	-	-	1	33.3
	Total	-	-	2	66.7	1	33.3	-	-	3	100.0
Low socio-economic status	Very often	-	-	1	100	-	-	-	-	1	50.0
	Often	-	-	-	-	1	100.0	-	-	1	50.0
	Total	-	-	1	50.0	1	50.0	-	-	2	100.0
Lack of drug compliance	Very often	-	-	1	100.0	-	-	-	-	1	50.0
	Often	-	-	-	-	-	-	1	100.0	1	50.0
	Total	-	-	1	50.0	-	-	1	50.0	2	100.0

Table 4.18. (continued)

Challenges	Gaziantep		Hatay		İzmir		Şanlıurfa		Total	
	n	%	n	%	n	%	n	%	n	%
Most significant challenge										
Lack of communication/ language barrier	17	68.0	-	-	9	21.4	47	79.7	73	47.7
Heavy workload	-	-	6	22.2	6	14.3	1	1,7	13	8.5
Negative/nonad aptive behavior	3	12.0	4	14.8	2	4.8	1	1.7	10	6.5
Registration and ID problems	-	-	1	3.7	5	11.9	-	-	6	3.9
Poor hygiene	1	4.0	-	-	2	4.8	2	3.4	5	3.3
Vaccine noncompliance	-	-	-	-	2	4.8	3	5.1	5	3.3
Difficulty of reaching patients	2	8.0	-	-	-	-	2	3.4	4	2.6
Insufficient number of personnel and equipment	-	-	2	7.4	2	4.8	-	-	4	2.6
Adolescent pregnancy	2	8.0	-	-	-	-	-	-	2	1.3
Low salary	-	-	2	7.4	-	-	-	-	2	1.3
Ambiguity of legal entitlements	-	-	-	-	-	-	2	3.4	2	1.3
Low level of education	-	-	1	3.7	-	-	-	-	1	0.7
Cultural differences	-	-	-	-	1	2.4	-	-	1	0.7
No sense of security (health workers)	-	-	-	-	1	2.4	-	-	1	0.7
Mental health problems (patients)	-	-	-	-	1	2.4	-	-	1	0.7
Low socio-economic status	-	-	-	-	1	2.4	-	-	1	0.7
Lack of experience and trust (patient)	-	-	-	-	-	-	1	1.7	1	0.7
None	-	-	11	40.7	10	23.8	-	-	21	13.7
Total	25	16.3	27	17.6	42	27.5	59	38.6	153	100.0

ANNEX-5

Emotional Exhaustion

Personal Achievement

Depersonalization
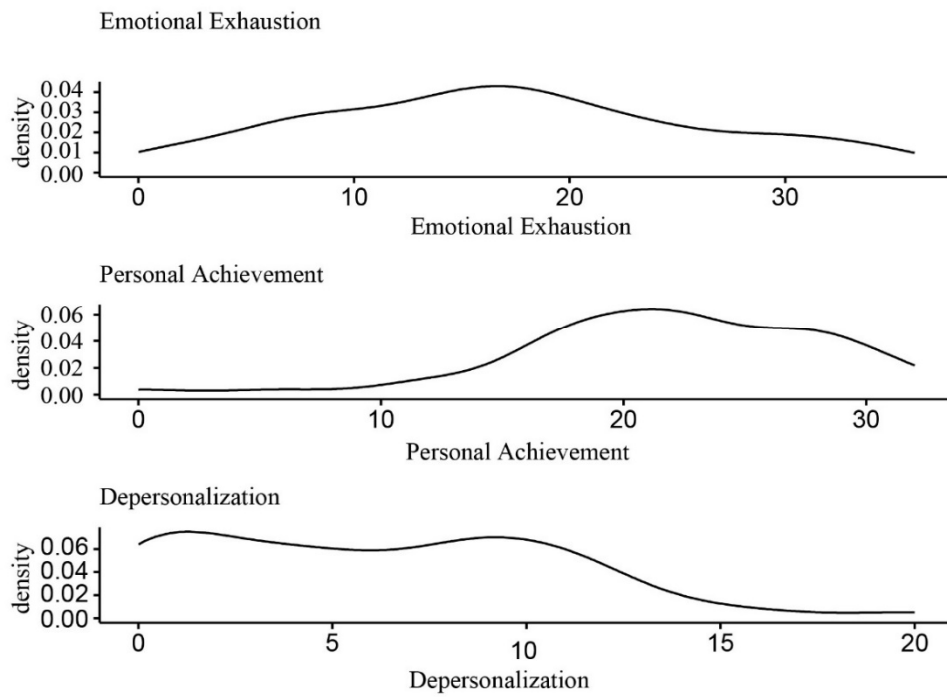
Figure 4.1. Normality Tests for MBI scores

ANNEX-6

Stresli Anlarda Ne Yapmalı?:
Resimli Rehber

DÜNYAYLA BAĞLANTI KURMA
DEĞERLERİNE UYGUN HAREKET ETME
BULUNDUĞU ORTAMA KATILMA

SIKINTI VEREN DÜŞÜNCE VE HİSLERDEN UZAKLAŞMA
SIKINTI VEREN DÜŞÜNCE VE HİSLERE YER AÇMA
NAZİK OLMA

World Health Organization
REGIONAL OFFICE FOR **Europe**

ANNEX-7

ANKET ARAŞTIRMASI İÇİN AYDINLATILMIŞ ONAM FORMU

Hatay, Şanlıurfa, Gaziantep ve İzmir illerinde göçmen, mülteci ve sığınmacılara birinci basamak sağlık hizmeti sunan sağlık çalışanlarının hizmet sunumuna yönelik görüşleri ve tükenmişlik durumlarının değerlendirilmesi

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Sayın katılımcı,

"Hatay, Şanlıurfa, Gaziantep ve İzmir illerinde göçmen, mülteci ve sığınmacılara birinci basamak sağlık hizmeti sunan sağlık çalışanlarının hizmet sunumuna yönelik görüşleri ve tükenmişlik durumlarının değerlendirilmesi" başlıklı bu araştırma, Hacettepe Üniversitesi Halk Sağlığı Anabilim Dalı Halk Sağlığı Yüksek Lisans Programı öğrencisi tarafından yapılmaktadır. Yanıtlarınızdan elde edilecek sonuçlarla çok araştırılmamış bir grup olarak göçmen, sığınmacı ve mültecilere sağlık hizmeti sunan sağlık çalışanlarının mesleki koşullarından doğan ihtiyaçlarına yönelik potansiyel düzenlemeler ve eğitimlerine altyapı oluşturulması beklenmektedir. Bu nedenle soruların tümüne ve içtenlikle cevap vermeniz büyük önem taşımaktadır.

Araştırmaya katılmanız gönüllülük esasına dayalıdır. Bu form aracılığı ile elde edilecek bilgiler gizli kalacaktır ve sadece araştırma amacıyla kullanılacaktır. Çalışmaya katılmamayı tercih edebilirsiniz veya soruları yanıtlarken son verebilirsiniz.

Sıra no: ....

Araştırmaya katılma konusundaki kararınızı aşağıda uygun kutucuğu işaretleyerek belirtiniz.

Araştırmaya katılmayı kabul ediyorum. ☐

Araştırmaya katılmayı kabul etmiyorum. ☐

Katılım ve katkılarınız için teşekkür ederiz.

Araştırmacılar:
Prof. Dr. Kerim Hakan Altıntaş[1]
Nurtaç Kavukcu[2]
[1]Hacettepe Üniversitesi Tıp Fakültesi Halk Sağlığı Anabilim Dalı

İletişim Bilgileri:

BÖLÜM 1

1. Cinsiyetiniz nedir?   1. Erkek2. Kadın

2. Doğum tarihiniz nedir? …………..…….….. (*Yıl olarak belirtiniz*)

3. Şu andaki medeni durumunuz nedir?

   1) Evli   2) Bekar   3) Eşinden ayrılmış   4) Eşi ölmüş   5) Diğer,

   belirtiniz......................

4. Kaç çocuğunuz var?

   0) Çocuğum yok

   ....çocuğum var.

5. Mesleğiniz ve mesleki eğitiminizi belirtiniz:

	Mesleğiniz	Mesleki eğitiminizi tamamladığınız mezuniyet yılınızı yazınız
a.	Doktor, uzmanlık alanı:	....
b.	Hemşire	....
c.	Ebe	…………………………………..

6. <u>En uzun süre</u> çalıştığınız sağlık kuruluşunu belirtiniz.

   1) Birinci Basamak Sağlık Kuruluşu /ayaktan tedavi kuruluşu (devlet)

   2) Hastane – yataklı tedavi kuruluşu (devlet)

   3) Özel hastane

   4) Özel Muayenehane

   5) Üniversite

   6) Diğer, belirtiniz ....

7. Şu anki hizmet yerinizden önce <u>en son</u> nerede çalışıyordunuz?

   1) Birinci Basamak Sağlık Kuruluşu /ayaktan tedavi kuruluşu (devlet)

   2) Hastane – yataklı tedavi kuruluşu (devlet)

   3) Özel hastane

   4) Özel Muayenehane

   5) Üniversite

   6) Diğer, belirtiniz ....

8. Şu anki görevinizden daha önce göçmen, mülteci veya sığınmacılara hizmet verdiniz mi?

   1) Evet (9. soruya geçiniz)   2) Hayır (10. soruya atlayınız)

9. Göçmen, mülteci veya sığınmacılara ne kadar süre/süredir hizmet verdiniz/veriyorsunuz?

   ....ay.......yıl

10. Göçmen, mülteci veya sığınmacılara sağlık hizmeti verme konusunda herhangi bir eğitim aldınız mı?

   1) Evet   2) Hayır

Cevabınız evet ise eğitimi veren kuruluşun adını ve eğitim süresini belirtiniz:

   Kuruluş adı:……………………….

   Eğitim süresi:…………..gün

11. Göçmen, mülteci veya sığınmacılarla ilgili bilgiye nereden ulaştınız? (Birden fazla seçenek işaretleyebilirsiniz)

   1) Radyo

   2) Televizyon

   3) Gazete

   4) Internet

   5) Arkadaşlar

   6) Akrabalar

   7) Kitaplar

   8) Makaleler

   9) Hastalar

   10) İş arkadaşları

   11) Eğitimler

   12) Yurtdışı seyahatleri

   13) Diğer, belirtiniz…………………………………………………………………

12. Şu an hangi ilde çalışıyorsunuz?

   …………………………

13. Şu anki çalışma yeriniz neresidir?

   1) Geçici barınma merkezi

   2) Yabancı uyruklular polikliniği

   3) Göçmen sağlığı merkezi

   4) Aile sağlığı merkezi

   5) Diğer, belirtiniz…………………………….

14. Şu anki hizmet yerinizde çalıştığınız toplam süreyi belirtiniz: .... yıl .... ay

15. Çalıştığınız yerde hizmet verdiğiniz göçmen, mülteci veya sığınmacılarla ortak bir dil konuşuyor musunuz/konuşuyor muydunuz?

   1) Evet (16. soruya geçiniz)   2) Hayır (17. soruya atlayınız)

16. Çalıştığınız yerde göçmen, mülteci veya sığınmacılarla iletişim kurduğunuz yabancı dili/dilleri ve seviyesini/seviyelerini belirtiniz.

DİL	SEVİYE (yuvarlak içine alınız)		
1-	İLERİ	ORTA	DÜŞÜK
2-	İLERİ	ORTA	DÜŞÜK
3-	İLERİ	ORTA	DÜŞÜK
4-	İLERİ	ORTA	DÜŞÜK

17. Çalıştığınız yerde göçmen, mülteci veya sığınmacılara günde ortalama kaç saat hizmet veriyorsunuz/veriyordunuz? ....saat

18. Çalıştığınız yerde günlük baktığınız ortalama hasta/başvuran sayınız nedir/neydi? Tek bir rakam yazınız: …………hasta/başvuran

19. Çalıştığınız yerde ağırlıklı olarak hangi ülkelerden hastalara bakıyorsunuz /bakıyordunuz? En sık başvurandan başlayarak en aza doğru aşağıdaki boşluğa yazınız.

   1) ....

   2) ....

   3) ....

   4) ....

   5) ....

20. Çalıştığınız yerde baktığınız hastalar/başvuranlar ağırlıklı olarak hangi gruplardan/ gruplardandı? *Birden çok işaretleyebilirsiniz.*

   1) Bebek

   2) Çocuk

   3) Kadın

   4) Yetişkin

   5) Yaşlı

   6) Diğer, belirtiniz. ....

21.Çalıştığınız yerde hangi gruba hizmet sunarken <u>en fazla</u>

zorlanıyorsunuz/zorlanıyordunuz?

   1) Bebek

   2) Çocuk

   3) Kadın

   4) Yetişkin

   5) Yaşlı

   6) Diğer, belirtiniz. ....

Lütfen, nedenini açıklayınız:

....

....

....

22. Kendinizi hizmet verdiğiniz göçmen, mülteci veya sığınmacıların hukuki statüleri ve

hakları ile ilgili yeterli bilgiye sahip hissediyor musunuz/muydunuz?

   1) Evet   2) Hayır

23. Çalıştığınız yerde göçmen, mülteci veya sığınmacılara sağlık hizmeti sunarken <u>en sık</u>

yaşadığınız sorunları, en sık yaşadıklarınızdan başlayarak en aza doğru yazar mısınız?

   1) ....

   2) ....

   3) ....

   4) ....

   5) ....

24. Çalıştığınız yerde göçmen, mülteci veya sığınmacılara sağlık hizmeti sunarken yaşadığınız

<u>en önemli</u> sorun nedir/neydi?

....

....

BÖLÜM 2

Aşağıdaki her bir ifadeyi okuduktan sonra buna ne derece katıldığınızı ya da katılmadığınızı işaretleyiniz. (1. Kesinlikle katılmıyorum 2. Katılmıyorum 3. Fikrim yok 4. Katılıyorum 5. Kesinlikle katılıyorum)

İfade	Kesinlikle katılmıyorum	Katılmıyorum	Fikrim Yok	Katılıyorum	Kesinlikle katılıyorum
25. Göçmen, mülteci veya sığınmacılara sağlık hizmeti sunmaktan memnunum/memnundum.	1	2	3	4	5
26. Göçmen, mülteci veya sığınmacılara sağlık hizmeti verirken farklı dilleri konuşuyor olmak işimi zorlaştırır/zorlaştırırdı.	1	2	3	4	5
27. Göçmen, mülteci veya sığınmacıların dilini konuşuyor olmak sunulan hizmetin kalitesini artırır.	1	2	3	4	5
28. Göçmen, mülteci veya sığınmacı hastalarla farklı dili konuşuyor olmam sık sık sağlık durumlarını tam olarak anlayamama neden olur/olurdu.	1	2	3	4	5
29. Göçmen, mülteci veya sığınmacılara uygun hizmet sunmak için tercümanların desteği çok önemlidir.	1	2	3	4	5
30. Birlikte çalıştığım tercümanların çoğu hizmet için gereken yetkinliğe sahiptir/sahipti.	1	2	3	4	5
31. Tercümanlarla çalışmak hasta ile görüşme ve muayenelerin uzun sürmesine sebep olur/olurdu.	1	2	3	4	5

İfade	Kesinlikle katılmıyorum	Katılmıyorum	Fikrim Yok	Katılıyorum	Kesinlikle katılıyorum
32. Birlikte çalıştığım tercümanlar hastalar ile iletişimimi büyük ölçüde kolaylaştırır/kolaylaştırırdı.	1	2	3	4	5
33. Daha iyi bir hizmet sunumu için tercümanların tıp terminolojisine hakim olması gerekmektedir.	1	2	3	4	5
34. Tercümanların hizmet sunulan topluluğun kültürü ile	1	2	3	4	5

ilgili detaylı bilgiye sahip olması gerekir.					
35. Tercümanlarla yaptığım hasta görüşmelerim genellikle sorunsuz geçer/geçerdi.	1	2	3	4	5
36. Hizmet sunumunda tercümanın varlığı hasta mahremiyeti açısından olumsuz bir etki yaratır.	1	2	3	4	5
37. Tercümanlar göçmen, mülteci veya sığınmacılarla ilgili konularda eğitim almalıdır.	1	2	3	4	5
38. Sağlık çalışanları göçmen, mülteci veya sığınmacı hastalarla iletişimde tercüman ile çalışma yöntemleri konusunda eğitim almalıdır.	1	2	3	4	5
39. Hizmet sunduğum göçmen, mülteci veya sığınmacıların kültürü hakkında yeterli bilgiye sahibim/sahiptim.	1	2	3	4	5
40. Göçmen, mülteci veya sığınmacı hastalarla aramdaki kültür farkı günlük çalışma hayatımda stres düzeyimi yükselten önemli faktörlerdendir/faktörlerdendi.	1	2	3	4	5

İfade	Kesinlikle katılmıyorum	Katılmıyorum	Fikrim Yok	Katılıyorum	Kesinlikle katılıyorum
41. Göçmen, mülteci veya sığınmacı hastalar hastalıklarını sağlık çalışanları ile rahatça konuşurlar/konuşurlardı.	1	2	3	4	5
42. Göçmen, mülteci veya sığınmacıların hukuki durumları hakkında yeterli bilgiye sahibim.	1	2	3	4	5
43. Göçmen, mülteci veya sığınmacıların sağlık hakları ile ilgili yeterli bilgiye sahibim.	1	2	3	4	5
44. Göçmen, mülteci veya sığınmacı hastalar Türkiye'deki sağlık hizmetleri konusunda yetersiz bilgiye sahiptir.	1	2	3	4	5
45. Göçmen, mülteci veya sığınmacı hastaların hastalık algısı Türkiye vatandaşı hastalardan oldukça farklıdır.	1	2	3	4	5
46. Sağlık çalışanları hizmet sundukları göçmen, mülteci veya sığınmacıların gelenek ve görenekleri ile ilgili bilgi sahibi olmalıdır.	1	2	3	4	5
47. Göçmen, mülteci veya sığınmacılara sağlık hizmeti sunmak kolaydır.	1	2	3	4	5
48. Göçmen, mülteci veya sığınmacı hastalarda ruh sağlığı problemlerinin teşhisi Türkiye vatandaşı hastalara göre daha zordur.	1	2	3	4	5
49. Göçmen, mülteci veya sığınmacı hastalarda laboratuvar tetkikleri yapmak Türkiye vatandaşı hastalara göre daha zordur.	1	2	3	4	5

İfade	Kesinlikle katılmıyorum	Katılmıyorum	Fikrim Yok	Katılıyorum	Kesinlikle katılıyorum
50. Göçmen, mülteci veya sığınmacıları belli bir tedavi yöntemine ikna etmek Türkiye vatandaşı hastalara göre daha zordur.	1	2	3	4	5
51. Göçmen, mülteci veya sığınmacı hastalar başvuru, randevu saatleri, sıra alma gibi kurallara uygun hareket ederler.	1	2	3	4	5
52. Göçmen, mülteci veya sığınmacı hastaların sağlık personeline olan güveni oldukça yüksektir.	1	2	3	4	5
53. Göçmen, mülteci veya sığınmacılara hizmet verdiğim çalışma ortamında personel sayısı yeterlidir/yeterliydi.	1	2	3	4	5
54. Göçmen, mülteci veya sığınmacılara hizmet verdiğim çalışma ortamında üreme sağlığı danışmanlığı malzemesi yeterlidir/yeterliydi.	1	2	3	4	5
55. Göçmen, mülteci veya sığınmacılara hizmet verdiğim çalışma ortamının fiziki şartları yeterlidir/yeterliydi.	1	2	3	4	5
56. Göçmen, mülteci veya sığınmacılara hizmet sunmak hizmet sunanın ruh sağlığı açısından yıpratıcıdır.	1	2	3	4	5
57. Göçmen, mülteci veya sığınmacılara hizmet sunarken kendimi tehdit (örneğin fiziksel şiddet tehdidi) altında hissettiğim olur/olmuştur.	1	2	3	4	5
58. Elimde başka imkan olsa da yine de göçmen, mülteci veya sığınmacılara hizmet vermek isterim.	1	2	3	4	5
59. Göçmen, mülteci veya sığınmacılara hizmet sunarken mesleki tatmin hissediyorum/hissediyordum.	1	2	3	4	5

BÖLÜM 3

Aşağıda, kişilerin ruh durumlarını ifade ederken kullandıkları bazı cümleler verilmiştir. Lütfen her bir cümleyi dikkatle okuyarak hangi sıklıkla hissettiğinizi size uyan seçeneğe işaret koyarak belirtiniz.

İfade	Hiçbir zaman	Yılda birkaç kez	Ayda birkaç kez	Haftada birkaç kez	Hergün
60. Kendimi işimden duygusal olarak uzaklaşmış hissediyorum.	1	2	3	4	5
61. İşgününün sonunda kendimi bitkin hissediyorum.	1	2	3	4	5
62. Sabah kalkıp yeni bir işgünü ile karşılaşmak zorunda kaldığımda kendimi yorgun hissediyorum.	1	2	3	4	5
63. Hastalarımın pek çok şey hakkında neler hissettiklerini anlayabilirim.	1	2	3	4	5
64. Bazı hastalarıma onlar sanki kişilikten yoksun bir objeymiş gibi davrandığımı hissediyorum.	1	2	3	4	5
65. Bütün gün insanlarla çalışmak benim için gerçekten bir gerginliktir.	1	2	3	4	5
66. Hastalarımın sorunlarını etkili bir şekilde hallederim.	1	2	3	4	5
67. İşimin beni tükettiğini hissediyorum.	1	2	3	4	5
68. İşimle diğer insanların yaşamlarını olumlu yönde etkilediğimi hissediyorum.	1	2	3	4	5
69. Bu mesleğe başladığımdan beri insanlara karşı katılaştığımı hissediyorum.	1	2	3	4	5
70. Bu iş beni duygusal olarak katılaştırdığı için sıkıntı duyuyorum.	1	2	3	4	5

İfade	Hiçbir zaman	Yılda birkaç kez	Ayda birkaç kez	Haftada birkaç kez	Hergün
71. Kendimi çok enerjik hissediyorum.	1	2	3	4	5
72. İşimin beni hayalkırıklığına uğrattığını düşünüyorum.	1	2	3	4	5
73. İşimde gücümün üstünde çalıştığımı hissediyorum.	1	2	3	4	5
74. Bazı hastaların başına gelenler gerçekten umrumda değil.	1	2	3	4	5
75. Doğrudan insanlarla çalışmak bende çok fazla strese neden oluyor.	1	2	3	4	5
76. Hastalarıma rahat bir atmosferi kolayca sağlayabilirim.	1	2	3	4	5
77. Hastalarımla yakın ilişki içinde çalıştıktan sonra kendimi ferahlamış hissediyorum.	1	2	3	4	5
78. Bu meslekte pek çok değerli işler başardım.	1	2	3	4	5
79. Kendimi çok çaresiz hissediyorum.	1	2	3	4	5
80. İşimde duygusal sorunları bir hayli soğukkanlılıkla hallederim.	1	2	3	4	5
81. Hastaların bazı problemleri için beni suçladıklarını hissediyorum.	1	2	3	4	5

BÖLÜM 4

82. Şu anda, göçmen, mülteci ve sığınmacılara sağlık hizmeti sunumu ile ilgili eğitim almak istiyor musunuz?
  1) Evet   2) Hayır

Yanıtınız <u>Evet</u> ise, lütfen eğitim konularını açıklayınız.
1) …………………………………………………………………………………………
2) …………………………………………………………………………………………
3) …………………………………………………………………………………………
4) …………………………………………………………………………………………
5) …………………………………………………………………………………………

83. Eğitimin nasıl verilmesini önerirsiniz? *Birden çok işaretleyebilirsiniz.*
1) Pratik/uygulamalı eğitim (işbaşında)
2) Teorik eğitim
3) Uzaktan eğitim
4) Konferans, sempozyum
5) Basılı ve/veya elektronik ortamda eğitim materyalleri desteği sağlanması
6) Diğer, lütfen belirtiniz. ………………………………………………………..

84. Göçmen, mülteci, sığınmacılara sağlık hizmetini daha iyi sunabilmek önerilerinizi yazınız.
………
………
………………………………………………………………
………………………………………………………………………………………..
85. Göçmen, mülteci, sığınmacılara sağlık hizmeti sunumu ile ilgili olarak belirtmek istediğiniz diğer görüş / öneri vb varsa yazınız:
………
………
………………………………………………………………
………………………………………………………………………………………..

Çalışmamıza katkınız için teşekkür ederiz.

INFORMED CONSENT FORM ON SURVEY RESEARCH

The evaluation of perceptions of health workers providing primary care services to migrants, refugees and asylum seekers in Hatay, Şanlıurfa, Gaziantep and Izmir provinces and their level of burnout

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Dear Participant,

This research, entitled "The evaluation of perceptions of health workers providing primary care services to migrants, refugees and asylum seekers in Hatay, Şanlıurfa, Gaziantep and Izmir provinces and their level of burnout" is carried out by a student of Hacettepe University Public Health Department Public Health Master's Program. With the results of your answers, it is expected that, as a highly under-researched group, health workers providing health care services to migrants, asylum seekers and refugees will be given an infrastructure for potential arrangements and training for their needs arising from their professional conditions. It is therefore of great importance that you answer all questions with sincerity.

Your participation in the research is on a volunteer basis. The information obtained through this form will remain confidential and will only be used for research purposes. You may choose not to participate in the study, or you may end up the survey while answering questions.

In this survey, which contains eighty-five questions and will take 20 minutes of your time, indicate your answers by selecting the appropriate one from the options below the questions or by typing in the space left under the question in open-ended questions. For questions where you can mark more than one option, mark all options that you find suitable. If the option "other" is present among the answers to the question and your answer is not included in the options given, then write your answer in the space in the option "other".

Do not write your first and last name on the survey form.

Row no: ………..

Please indicate your decision whether to participate in the research by checking the appropriate box below.

I agree to participate in the research

I do not agree to participate in the research

We thank you for your participation and contributions.

Researchers:

Prof. Dr. Kerim Hakan Altıntaş[1]
Nurtaç Kavukçu[2]
[1]Hacettepe University Faculty of Medicine Department of Public Health
[2]Hacettepe University Institute of Health Sciences
Contact details:

Section 1

1. What's your gender?   1. Male   2. Female
2. What's your date of birth? …………………. *(Specify in years)*
3. What's your current marital status?
    1) married 2) single 3) separated 4) widowed 5) other, please specify................?
4. How many children do you have?
    0) I have no children
    I have …….. children.
5. State your profession and vocational training:

	Your profession	Write down your graduation year when you have completed your vocational training
a.	Doctor, area of expertise:	....
b.	Nurse	....
c.	Midwife	…………………………………………………

6. Specify the health care provider where you have worked for the longest period of time.
    1) Primary care institution/outpatient institution (State)
    2) Hospital - inpatient facility (State)
    3) Private hospital
    4) Private clinic
    5) University
    6) Other, please specify ……………………………
7. Where did you last work before your current place of service?

    1) Primary care institution/outpatient institution (State)
    2) Hospital - inpatient facility (State)
    3) Private hospital
    4) Private clinic
    5) University
    6) Other, please specify ……………………………
8. Have you served migrants, refugees or asylum seekers before your current assignment?

    1) Yes (Proceed to 9th question)   2) No (Skip to 10th question)
9. How long have you/have been serving/providing for migrants, refugees or asylum seekers?

    ……. months …… years

10. Have you received any training in providing health care to migrants, refugees or asylum seekers?

1) Yes 2) No

If yes, please state the name of the institution providing the training and the duration of the training:

Name of the institution ……………

Duration of the training ……… days

11. Where did you get information about migrants, refugees or asylum seekers? (You can mark multiple options)

    1) Radio
    2) Television
    3) Newspaper
    4) Internet
    5) Friends
    6) Relatives
    7) Books
    8) Articles
    9) Patients
    10) Co-workers
    11) Trainings
    12) Overseas travels
    13) Oher, please specify …………………………………………………………

12. What province do you work currently?

………………..

13. Where is your current place of work?

1) Temporary refuge center

2) Polyclinic for foreign nationals

3) Migrant health center

4) Family health Center

5) Other, please specify.....................................

14. Specify the total time you have worked at your current service location:

…. years …months

15. Did you/do you speak a common language with the migrants, refugees or asylum seekers you serve where you work?

1) Yes (Proceed to 16th Question)   2 No (Skip to 17th Question)

16. Specify the foreign language (s) and level (s) in which you communicate with migrants, refugees or asylum seekers where you work.

LANGUAGE	LEVEL (Please circle accordingly)		
5-	ADVANCED	INTERMEDIATE	BEGINNER
6-	ADVANCED	INTERMEDIATE	BEGINNER
7-	ADVANCED	INTERMEDIATE	BEGINNER
8-	ADVANCED	INTERMEDIATE	BEGINNER

17. How many hours per day did you/do you serve migrants, refugees or asylum seekers in your place of work? …….. hours

18. What is the average number of patients/applicants you care for daily at your workplace? Write a single number: …………. Patients/applicants

19. From which countries did you/do you mostly look after patients at your workplace?
Write in the space below, starting with the most frequent applicant to the less frequent.
1) ....
2) ....
3) ....
4) ....
5) ....

20. Which group/groups did the patients/applicants you looked mainly belong to at your workplace? *You can mark multiple*

1) Baby

2) Child

3) Woman

4) Adult

5) Elderly

6) Other, please specify. ....

21. Which group did you have the most difficulty when you provided/provide services at your workplace?

1) Baby

2) Child

3) Woman

4) Adult

5) Elderly

6) Other, please specify. ....

Please, specify why:

....

....

....

22. Did you/do you feel to have sufficient knowledge of the legal status and rights of the migrants, refugees or asylum seekers you serve?
1) Yes 2) No

23. Please write down the problems you experience most often when providing health care to migrants, refugees or asylum seekers where you work, starting with what you experience most often?

1) ....

2) ....

3) ....

4) ....

5) ....

24. What was/is the most important problem you faced when providing health care to migrants, refugees or asylum seekers where you worked?

....

....

Section 2

After reading each statement below, mark the degree to what extent you agree or disagree. (1. Strongly disagree, 2. Disagree, 3. Undecided, 4. Agree, 5. Strongly Agree)

Statement	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
25. I was/am pleased to offer health care to migrants, refugees or asylum seekers.	1	2	3	4	5
26. Speaking different languages when providing health care to migrants, refugees or asylum seekers made/makes make my job difficult.	1	2	3	4	5
27. Being able to speak the language of migrants, refugees or asylum seekers improves the quality of the service provided.	1	2	3	4	5
28. The fact that I speak different languages with migrant, refugee or asylum-seeker patients often caused/causes me to not fully understand their health status.	1	2	3	4	5
29. The support of interpreters is crucial in terms of providing appropriate services to migrants, refugees or asylum seekers.	1	2	3	4	5
30. Most of the interpreters I worked with had/has the competence required for the service.	1	2	3	4	5
31. Working with interpreters led/leads to a prolonged period of interviewing and examinations with the patient.	1	2	3	4	5

Statement	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
32. The interpreters I worked with greatly facilitated/facilitate my communication with patients.	1	2	3	4	5
33. Interpreters need to be familiar with medical terminology in order to provide a better service.	1	2	3	4	5

34. Interpreters need to have detailed knowledge of the culture of the community they serve.	1	2	3	4	5
35. My patient interviews with interpreters usually went/go smoothly.	1	2	3	4	5
36. The presence of an interpreter in service delivery has a negative effect on patient privacy.	1	2	3	4	5
37. Interpreters should receive training on issues relating to migrants, refugees or asylum seekers.	1	2	3	4	5
38. Health workers should be trained in the methods of working with interpreters when communicating with migrant, refugee or asylum-seeking patients.	1	2	3	4	5
39. I had/have sufficient knowledge of the culture of migrants, refugees or asylum seekers with whom I provided services.	1	2	3	4	5
40. The difference in culture between me and migrant, refugee or asylum seeker patients was/is one of the important factors that raised my stress level in my daily work life.	1	2	3	4	5

Statement	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
41. Migrant, refugee or asylum seeker patients talked/talk their illnesses comfortably with health workers.	1	2	3	4	5
42. I have sufficient knowledge of the legal status of migrants, refugees or asylum seekers.	1	2	3	4	5
43. I have sufficient knowledge of the health rights of migrants, refugees or asylum seekers.	1	2	3	4	5
44. Migrant, refugee or asylum seeker patients have insufficient knowledge of health care in Turkey.	1	2	3	4	5

45. The perception of illness of migrant, refugee or asylum-seeking patients is quite different from that of Turkish citizen patients.	1	2	3	4	5
46. Health workers should be aware of the customs and traditions of the migrants, refugees or asylum seekers they provide services to.	1	2	3	4	5
47. Providing health care to migrants, refugees or asylum seekers is easy.	1	2	3	4	5
48. Diagnosis of mental health problems in migrant, refugee or asylum seeker patients is more difficult than in patients who are citizens of Turkey.	1	2	3	4	5
49. Conducting laboratory tests on migrant, refugee or asylum-seeking patients are more difficult than those of Turkish citizens.	1	2	3	4	5

Statement	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
50. Convincing migrants, refugees or asylum seekers to a certain treatment method is more difficult than for patients who are citizens of Turkey.	1	2	3	4	5
51. Migrant, refugee or asylum seeker patients act in accordance with the rules such as application, appointment times, queue-taking.	1	2	3	4	5
52. Migrant, refugee or asylum seeker patients have a high level of confidence in their medical staff.	1	2	3	4	5
53. The number of staff in the working environment where I served migrants, refugees or asylum seekers was/is sufficient.	1	2	3	4	5
54. Reproductive health counseling material was/is sufficient in the working	1	2	3	4	5

environment where I served migrants, refugees or asylum seekers					
55. The physical conditions of the working environment in which I served migrants, refugees or asylum seekers were/are sufficient.	1	2	3	4	5
56. Providing services to migrants, refugees or asylum seekers is exhausting in terms of the mental health of the service provider.	1	2	3	4	5
57. When providing services to migrants, refugees or asylum seekers, there were/are times I felt/feel under threat (e.g. threat of physical violence).	1	2	3	4	5
58. If I had other opportunities, I would still like to serve migrants, refugees or asylum seekers.	1	2	3	4	5
59. I feel professionally satisfied when serving migrants, refugees and asylum seekers.	1	2	3	4	5

SECTION 3

Statement	Never	A few times a year	A few times a month	A few times a week	Every day
I feel emotionally drained from my work.	0	1	2	3	4
I feel used up at the end of the workday.	0	1	2	3	4
I feel fatigued when I get up in the morning and have to face another day on the job.	0	1	2	3	4
Working with people all day is really a strain for me.	0	1	2	3	4

I feel burned out from my work.	0	1	2	3	4
I feel frustrated by my job.	0	1	2	3	4
I feel I'm working too hard on my job.	0	1	2	3	4
Working with people directly puts too much stress on me.	0	1	2	3	4
I feel like I'm at the end of my rope.	0	1	2	3	4

Chapter 4

82. Right now, would you like to receive training on health care provision for migrants, refugees and asylum seekers?

   1) Yes   2) No

If yes, please explain the training topics.

1) …..

2) …..

3) …..

4) …..

5) …..

83. How would you recommend the method of training? *You can mark multiple options.*

1) Practical/applied training (at work)

2) Theoretical education

3) Distance Education

4) Conference, symposium

5) Providing support for educational materials in printed and/or electronic media

6) Other, please specify. …………………………………………………………

84. Write down your suggestions for better health care for migrants, refugees and asylum seekers.

…………………………………………………………………………………………………
……..…………………………………………………………………………………………
……………..
...…………………………………………………..……………………………………………
….

85. If you have any other opinions/suggestions, etc. that you would like to express regarding the provision of health care to migrants, refugees, asylum seekers, please specify.

…………………………………………………………………………………………………
……..…………………………………………………….…………………………………
……………..
...…………………………………………………….………………………………………

We thank you very much for your contribution to our study.

9. RESUME