European Commission

Strategic Mid-term Evaluation

of the

Facility for Refugees in Turkey

2016-2019/2020

Final Report

Volume II: Sector Report on Health

June 2021

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FRAMEWORK CONTRACT COM 2015
Europe Aid/137211/DH/SER/Multi/2018/401148/1
Specific Contract: N° 2018/401 148

Strategic Mid-term Evaluation of the Facility for Refugees in Turkey, 2016-2019/2020

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Contents

Figures

Tables

Acronyms

AFD	Agence Française de Développement
ANC	Antenatal care
BPGs	Bilingual patient guides
CEFM	Child, early and forced marriage
CMHCs	Community Mental Health Centres
CVME	Comprehensive Vulnerability Monitoring Exercise
DG ECHO	Directorate-General for European Civil Protection and Humanitarian Aid Operations
DGMM	Directorate-General for Migration Management (Turkey)
DG NEAR	Directorate-General for Neighbourhood and Enlargement Negotiation
EC	European Commission
EMHC	Extended Migrant Health Centre
EQ	Evaluation question
ESSN	Emergency Social Safety Net
EUD	European Union Delegation
EUTF	European Union Emergency Trust Fund
FGD	Focus group discussion
FMC	Family Medical Centre (also known as Family Health Centre)
FRIT	Facility for Refugees in Turkey
GoTR	Government of Turkey
GP	General practitioner
HLC	Healthy Living Centre
HI	Handicap International/Humanity and Inclusion
IFI	International financial institution
IMC	International Medical Corps
INGO	International non-governmental organisation
IP	Implementing Partner
JC	Judgement criteria
KfW	Kreditanstalt für Wiederaufbau
KII	Key informant interview
LEAP	Lifesaving Emergency Assistance for Protracted Conflict in Syria
LGBTI	Lesbian, gay, bisexual, transgender, intersex
MdM	Médecins du Monde
mhGAP	Mental Health Gap Action Programme
MHC	Migrant Health Centre
MHPSS	Mental health and psychosocial support
MHU	Migrant Health Unit
MoH	Ministry of Health (Turkey)
LGBTI+	Lesbian, gay, bisexual, transgender, intersex, plus
NCD	Non-communicable disease
NGO	Non-governmental organisation
PAB	Pre-Assistance Baseline
PDM	Post-distribution monitoring
PPE	Personal protective equipment
PRAG	Practical guide on contract procedures for European Union external action
PTSD	Post-traumatic stress disorder
RI	Relief International
SASH	Specialised Health Services in Turkey for Conflict-Affected Syrians
SGBV	Sexual and gender-based violence

SIHHAT	Improving the Health Status of the Syrian Population under Temporary Protection and Related Services Provided by Turkish Authorities (Direct Grant with MoH)
SRH	Sexual and reproductive health
SSCs	Social Service Centres
SUMAF	Technical Assistance to Support the Monitoring of Actions financed under the Facility for Refugees in Turkey
SuTP	Syrians under Temporary Protection
TRC	Turkish Red Crescent
TRY	Turkish Lira
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WGSS	Women and girl safe spaces
WHO	World Health Organization

1. Introduction

1.1. Purpose of the Health Sector Report

This report forms part of the Strategic Mid-term Evaluation of the Facility for Refugees in Turkey. It presents the evaluation team's in-depth assessment of health in relation to the main evaluation question posed in this focal area (EQ9), namely:

Evaluation question 9: *To what extent has the Facility contributed in an inclusive and equitable way to the availability, accessibility and demand for health care services – and as a consequence contributed to an improved health status of the refugee population?*

The report has been prepared on the basis of the health-related findings that were presented at the end of the evaluation's desk phase, in a desk report finalised in February 2020. These findings were further developed and preliminary hypotheses tested during a field visit which took place in Turkey in March 2020. Since then, further primary data collection has taken place to enrich the quality of the evidence by capturing the beneficiary perspective on health. This report presents the final synthesis of the evidence collected by the evaluation team, in direct response to the evaluation question posed. It constitutes one of four sector-specific studies which are annexed in Volume II of the evaluation's Final Report (Volume I)[1]. The Final Report also provides a summarised version of these findings.

1.2. Methodology

1.2.1. Evaluation design for the health sector analysis

The detailed design of the health sector analysis is provided in the evaluation matrix for the overall evaluation, which can be found in Volume III (Annex 3) of the Final Report (Volume I). The evaluation matrix details how the evaluation team has structured its assessment of the Facility's effectiveness in delivering improvements to the health of Syrian refugees in Turkey, specifying the judgement criteria, indicators, key data sources and modes of analysis.

As explained below, the evaluation's assessment of effectiveness focuses on the Facility's 'contribution' to health-related outcomes – as defined in its intervention logic. This already presents a challenge, as there is a lack of clear data on health-related outcomes for refugees in Turkey, and the evaluation can only present what can be 'observed' in relation to those outcomes, based on a variety of sources. Further to this, such 'observed' outcomes are influenced by many other factors outside of the European Union's (EU) support, because the Facility has been designed to complement and strengthen the host community's support for refugees, not deliver long-term outcomes through just its own resources. This is why the evaluation focuses on the 'contribution' of the Facility rather than suggesting 'causality' or seeking to 'attribute' outcome-level results to EU support alone.

Conducting this type of analysis in practice is challenging in such a complex environment, and the evaluation has been designed to generate as much evidence as possible on the basis of both Facility-specific data on its health interventions *and* national data on the Turkish health system in terms of its capacity, services available to refugees and policy environment. In addition to examining the whole portfolio of Facility interventions and results in relation to health, a sample of interventions were identified and examined further, to understand all aspects of their progress and explore key issues in-depth. This and other data, from a wide range of external secondary and primary sources, has been used to build the evidence over the course of the evaluation, as part of an iterative process of 'contribution analysis' as described below.

[1] The official use of the term 'Sector' has evolved throughout the lifespan of the Facility and continues to vary somewhat between stakeholders; for example, the Facility's Updated Strategic Concept Note adopts the term 'Priority Area' instead of 'Sector' for Health, Education, Socioeconomic Support and Protection. In line with this evaluation's original Terms of Reference and also for consistency across all evaluation products, the team chose to apply the term 'Sector' throughout all final reports. This choice of wording does not imply a judgement on or a preference for one term over the other.

1.2.2. Contribution analysis

As explained, it is methodologically challenging to isolate the contribution of the Facility in meeting its multi-faceted objectives in terms of health, given the broader context in which the Turkish government was already providing health care to Syrian refugees before the Facility started, and in which it continues to provide support through its own resources. There are also other external factors that may have influenced achievements on the availability, accessibility and demand for health care services. Therefore, as requested in the evaluation Terms of Reference, the evaluation team has used a theory-based approach, analysing the data and evidence according to a 'contribution analysis', which has been adapted from the original method developed by John Mayne and tailored specifically to the context of the Facility.

Box 1: Adaptation of contribution analysis methodology for the evaluation

The evaluation team has developed a 'contribution story' on the basis of the following logic with regard to health:

1) *What outcomes did the Facility support seek to achieve in relation to the sector of health, and what kind of support did it provide to realise these outcomes* – otherwise referred to as the 'intervention logic'*?*

2) *What evidence is there that the expected outcomes have been realised?*

3) *What have the achievements of the Facility been in relation to these outcomes and, to what extent have other contextual factors played an influential role?*

With an absence of data on concrete health outcomes among refugees, the evaluation has used quantitative and qualitative data to determine whether, at the mid-term of the Facility, there is evidence that the expected outcomes defined in the intervention logic can be observed in practice. The evaluators then analysed in-depth the results achieved by the Facility using both quantitative, output-level data (from Facility results monitoring) and qualitative aspects which were mainly explored through stakeholder interviews and beneficiary surveys. By examining the national context in terms of key policies, legislation, socio-economic and cultural factors, the evaluators were able to make a judgement on what the role and the contribution of the Facility has been, relative to those other factors.

In such a complex context, this approach has allowed the evaluators to present a balanced assessment of the EU's contribution, based on all the evidence available, also highlighting key aspects for future learning.

1.2.3. Data collection methodology

During the desk phase, mainly secondary sources were used to develop the preliminary findings of the evaluation, although stakeholder interviews were held with the European Commission (EC) to inform the evaluation team's general understanding of the Facility in terms of its establishment, structure and key actors involved. During the desk phase, preliminary interviews were held with the Delegation of the European Union (EUD), the Directorate-General for European Civil Protection and Humanitarian Aid Operations (DG ECHO), the Facility Secretariat based within the Directorate-General for Neighbourhood and Enlargement Negotiation (DG NEAR), and staff from the Facility's monitoring support contract (SUMAF)[2]. As preparation for the field phase, interview guides were developed and translated into Turkish, based on the evaluation matrix and addressing specific data gaps which emerged from the desk review.

A field mission then took place from 2nd to 14th March 2020 by the health sector evaluation team (ET) which was led by Dr Elizabeth Dyke (International Health Sector Expert) with support from a team of field researchers and specialists from Development Analytics, including: Safir Sumer, Dr Meltem Aran and Hazal Colak (Field Coordinator). The interviews with Syrian health staff and beneficiaries were conducted by Arabic-speaking field staff member, Yali Haj Hassan.

[2] Technical Assistance to Support the Monitoring of Actions Financed Under the Facility for Refugees in Turkey.

Fieldwork included collecting primary data through key informant interviews (KIIs) and focus group discussions (FGDs) with various stakeholders, including government staff, implementing partners (IP), EUD staff, and visits to various health facilities. The interviewees were selected in consultation with the ET, the EUD and the Facility Secretariat. Full details of the field mission, and a list of all stakeholders interviewed, are contained in Volume III of the Final Report. A very brief summary follows, and Table 1 describes the distribution of interviews carried out for this sector during both desk and field phases.

During the first week of the in-country mission in Turkey, central-level KIIs were carried out with a range of stakeholders. These consisted of seven interviews with twelve different government officials from seven directorate-generals and departments at the Ministry of Health (MoH); interviews with eight different IPs including two international financial institutions (IFIs), two UN organisations and four international non-governmental organisations (INGOs); one interview with the EUD; and one interview with SUMAF staff.

During the second week, the health ET carried out KIIs with province-level directorates of key ministries in Şanliurfa, Gaziantep, Osmaniye, Adana and Istanbul. These consisted of four KIIs with provincial directorates of health with the attendance of 25 province-level government officials, including provincial directors of health, district heads of health, heads and vice heads of public health departments under these provincial directorates.

Table 1: Distribution of health sector interviewees – desk and field phases

	Central	Provincial	Total
European Commission (EUD/NEAR/ECHO) and SUMAF	12	0	12
Government of Turkey institutions	14	25	39
IPs – INGOs/IFIs/UN agencies	12	6	18
Other NGOs/think tanks/academics	20	3	23
Service providing staff	0	24	24
Beneficiaries (patients and health care workers)	0	23	23
Total	**58**	**81**	**139**

In addition to the province-level KIIs, the health sector ET visited and carried out in-depth interviews at four Extended Migrant Health Centres (EMHCs); two Migrant Health Centres (MHCs); four Family Medicine Centres (FMCs) – *also known as Family Health Centres*; one Healthy Living Centre (HLC); one Community Mental Health Centre (CMHC); one cancer screening truck; one Women and Girls' Safe Space Centre (WGSS); one refugee camp; and two hospital construction sites. The health team also interviewed a chief physician and an administrative and finance manager of a public hospital in Hatay.

While visiting the respective centres, the health sector ET carried out beneficiary interviews in Arabic (or English) with: general practitioners; gynaecologists; paediatricians; internal medicine specialists; nurses; and bilingual patient guides (BPGs) working at these centres. Patients visiting medical centres or WGSS were also interviewed, and BPGs working in public hospitals were reached by phone. Interviews with other NGOs, think-tanks and academics provided an external, independent perspective on the Facility's health sector interventions.

Following the field visit, a preliminary debriefing presentation was provided to the EC on 27 March 2020 via a videoconference, attended by EC staff from DG NEAR (the Facility Secretariat and EUD), DG ECHO (HQ and Field) and SUMAF. The draft version of this report was also presented to the evaluation's Inter-service Steering Group, which includes representatives of EU Member States, at a further videoconference on 1 July 2020.

i. Impact of COVID-19 pandemic on fieldwork

As a result of the worsening situation in relation to the COVID-19 pandemic and the imminent restrictions on international travel, the International Health Sector Expert exited Turkey a few days before the finalisation of the field mission (14 March 2020). From this point, the national team were able to complete the remaining interviews and visits where applicable, and additional, remote Skype

interviews were undertaken by the International Health Sector Expert during the week 16–20 March 2020. Following the fieldwork, additional interviews were held with EUD staff to gather further information, documentation and further clarify their perspectives.

ii. Qualitative data from refugee households (FGD alternatives)

In order to reach out to beneficiaries during the remote-based field phase, other sources of data were used in the absence of collecting primary data through FGDs. These are summarised in Table 2.

Table 2: Data collection methods to obtain beneficiary perspective

ESSN FGD Data 2017	• Re-coding and analysis of FGD raw data (transcripts) collected between November and December 2017 (by Development Analytics) for the mid-term evaluation of the Emergency Social Safety Net (ESSN)[3] in Turkey, for which 23 FGDs were held in 5 provinces: Istanbul, Hatay, Şanliurfa, Izmir and Afyon. The data includes responses from 177 participants (106 women and 71 men: 2/3 of respondents ESSN beneficiaries, 1/3 non-beneficiaries). The FGD data included information on the ESSN as well as other services provided to refugees. • The data provides insights on the daily problems that ESSN participants face, their coping mechanisms, ESSN application process challenges and problem-solving strategies, and their perception of coverage and social integration/cohesion.
Web-scraped social media data	• ***'TRC-SUY' Facebook page*** – comments posted on the page between February 2017 and April 2020 were selected based on random sampling. 2,171 comments were collected and analysed in total. The collected data was then analysed to understand basic needs, application barriers, perceptions of fairness, suggestions to strengthen programme targeting and problem-solving strategies raised by comment owners. • ***UNHCR Information Board Facebook page*** – the team randomly selected comments written between December 2018 and May 2020 on the UNHCR page – 399 comments were collected and analysed in total. The data collected from the UNHCR page has provided the team with an important source to understand protection risks as defined by comment owners as well as their concerns about resettlement and their problem-solving strategies.
Online survey and follow-up phone survey	• The survey includes a **demographic questions** section in the introduction and then four main sections (**education, health, socio-economic support, and protection**). It received 365 responses, 110 of which were directed to answer the health section questions. • Those that shared their phone numbers and gave their consent to be contacted were contacted in August 2020 with a follow-up phone call/discussion. This phone survey reached a sample of 38, 10 of whom responded to questions on health.

iii. Quantitative data from refugee households

The quantitative data analysis examined a number of data sets collected by the World Food Programme (WFP) and Turkish Red Crescent (TRC) from 2017 to 2020. These are pre-assistance baseline survey (PAB), post-distribution monitoring surveys (PDMs) and comprehensive vulnerability monitoring exercises (CVMEs). PAB and PDM surveys are representative of the ESSN applicant population and allowed the ET to look at the trends for applicant population over time using cross-sectional data. PAB is a baseline survey of the applicant population pre-assistance and includes beneficiaries and non-beneficiaries of the ESSN, though it does not include any of the ESSN non-applicant population. These surveys were collected by phone interviews and were thus shorter and

[3] ESSN (Emergency Social Safety Net) is an EU-funded cash assistance programme designed to support the most vulnerable registered refugees in Turkey and help them cover their basic needs such as food, shelter and transport. The cash transfers amount to approximately TRY 120 per household member per month.

more concise. Surveys CVME3, CVME4 and CVME5 are representative of the whole refugee population in Turkey; hence they have provided the ET with valuable insights about the overall refugee population. These were face-to-face surveys and provide more detailed information about the refugee population compared to PAB and PDMs. Details of surveys analysed for this evaluation are contained in Annex 3 of the evaluation's main report (contained in Volume III).

1.2.4. Data coding and analysis

Notes from all interviews were transcribed in English by the health sector ET and pre-coded into a template based on the indicators in the evaluation framework, as detailed in the evaluation matrix. Detailed coding using specialist qualitative data analysis software (NVivo) was then completed under the instruction of the International Health Sector Expert. Following review of the coded data, common themes were then identified from data collected across different stakeholder groups and the ET triangulated the analysis with findings from the desk report, and further documents analysed during and after the country visit. The synthesised findings are detailed in this report, and fully recorded in a separate evidence matrix.

1.2.5. Potential limitations and remaining gaps

Stakeholders in the field were generally positive to the evaluation, and there were minimal political discussions between the EU and the Turkish government at the time of the field visit.

The team had no cancellations during the first two weeks, and cancellations after this were because of the COVID-19 pandemic (interview with Istanbul Provincial Directorate of Health and visit to the CMHC in Istanbul). The team continued to carry out Skype calls following the cancellation of meetings due to COVID-19, to ensure that as many people were interviewed as possible. However, no site visits were conducted in Istanbul, and only one CMHC was visited. The health sector ET was unable to speak with a midwife at any of the centres. The team was unable to visit any hospitals (due to COVID-19) but the team was able to interview patient guides and hospital staff by telephone or off-site. An interview was also conducted with a hospital head off-site. Additional documentation is also included in the report to triangulate this data and to help with addressing any gaps. Given that the Facility funding focused on equipment in hospitals and BPGs (versus other funding of secondary health care), the interviews conducted were suitable to provide additional context to the documentation provided.

While the Ministry selected the clinics that the health sector ET visited, this represented a good range of facilities, including both very busy and less busy clinics, modern facilities and those in disrepair. To help ensure a lack of bias (and to fill gaps in data), the ET asked to visit a CMHC, a refugee camp and a mobile truck for cancer screening for Syrian refugees. The ET also held interviews with other stakeholders (e.g. NGOs, academics, other contacts working in the health system) that were not arranged by the Ministry.

A few people did not respond to interview invitations after repeated requests. All NGOs involved in the health sector were contacted for interviews (although the original plan was to only take a sample of NGOs). Another challenge was that some projects have been finished for a while and, along with staff turnover, this sometimes made it difficult to gather data. A further challenge has been in accessing some data from the Turkish government, including disaggregated data by host versus refugee population, and thus some data gaps remain.

1.3. Structure of the report

This report has been structured according to the evaluation questions (EQs) and judgement criteria (JCs) of the evaluation matrix. Section 2 describes the rationale for the evaluation and the theory of change (also referred to as the intervention logic) for the Facility's investments in the health sector. Section 3 presents the evaluation's main findings in response to the EQ on health. In Section 4, we present a brief analysis of Facility support in light of the COVID-19 outbreak; and in Section 5 we present conclusions for the health sector.

2. Rationale

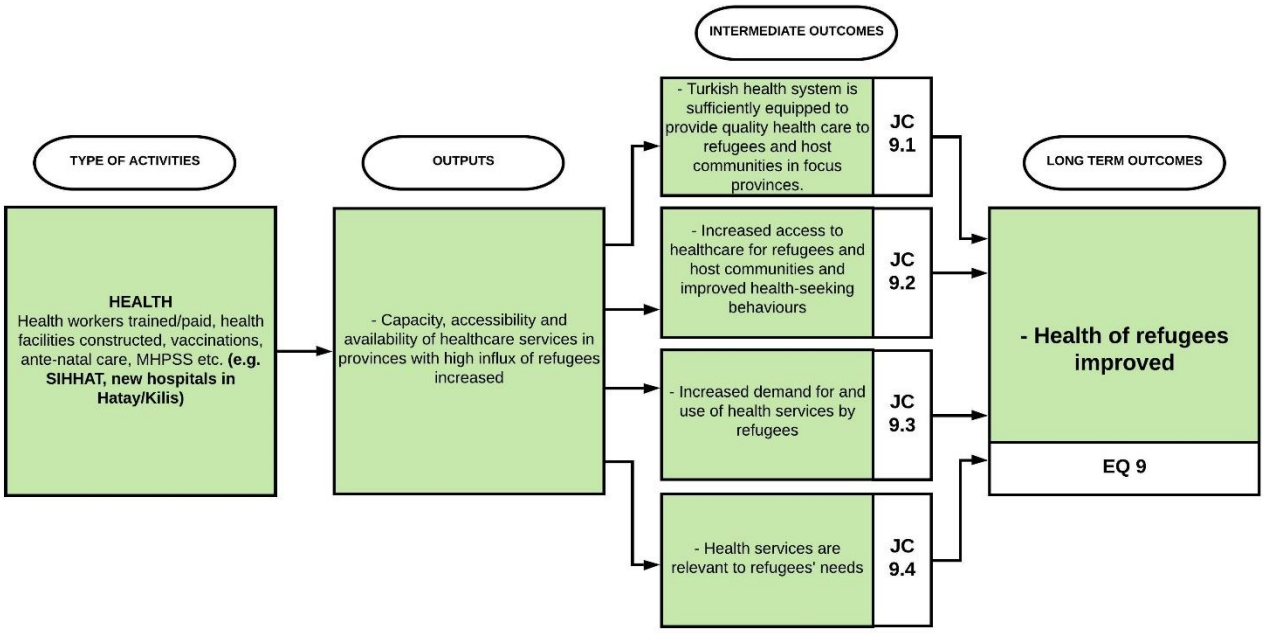
Evaluation question 9: *To what extent has the Facility contributed in an inclusive and equitable way to the availability, accessibility and demand for health care services – and as a consequence contributed to an improved health status of the refugee population?*

This report evaluates the overall effectiveness of the Facility's support in health. It explores EQ9 through an in-depth examination of the extent to which Facility interventions have contributed to the intermediate outcomes defined in the Facility theory of change, and which were further developed in the intervention logic for Facility Tranche I which was reconstructed in the inception phase for this evaluation. The contribution analysis approach encourages evaluators to revisit and revise the intervention logic throughout the data collection and analysis process. The health sector strand of the reconstructed intervention logic has been revised by the evaluators since the submission of the Inception Report. The intermediate outcomes, also depicted in Figure 1, are now defined as:

- Turkish health system is sufficiently equipped to provide quality health care to refugees and host communities in focus provinces;
- increased access to health care for refugees and host communities including improved health seeking behaviours;
- increased demand for and use of health services by refugees;
- health services are relevant to refugees' needs.

As shown in the diagram below, these intermediate outcomes are considered to be pre-requisites to the achievement of the long-term outcome 'health of refugees improved'. As a mid-term evaluation, it is appropriate to examine progress towards achieving the intermediate outcomes, and reflect on learning to improve the possibility of achieving the Facility's long-term health outcome.

Figure 1: Health sector reconstructed intervention logic



For the purpose of this evaluation, these **intermediate outcomes** in the reconstructed intervention logic have been developed into a series of JCs around which evidence has been gathered in order: (a) to identify the extent to which the intermediate outcomes have been achieved; and (b) to assess the extent to which the Facility has contributed to the achievement of these outcomes. In the evaluation, these aspects have been translated into a series of indicators which have guided the collection of data, and which provide the basis of the evidence presented in this report.

For example, the outcome of the 'Turkish health system being sufficiently equipped to provide quality health care to refugees and host communities in focus provinces' looks in detail at availability of health care services (JC 9.1). The indicators chosen to assess availability include the availability of equipment, trained health workers including physicians, health care facilities and mobile clinics.

The JCs for the evaluation's overall response to EQ9 are worded as follows:

- **JC 9.1:** The Facility has contributed to an increased **availability** of health care services
- **JC 9.2:** The Facility has contributed to an increased **accessibility** of health care services
- **JC 9.3:** The Facility has contributed to an increased **demand** for health care services
- **JC 9.4:** The Facility health response is **relevant** to the target population's identified health needs.

In this report, we present the data and evidence (findings) for our assessment of contribution against the first three judgement criteria using a contribution analysis, as described above in Section 1.2.2. In addition, and throughout the analysis, the report identifies where unintended consequences, both positive and negative, have occurred.

Based on this systematic assessment, this report then presents its main conclusions, which constitute a synthesised interpretation of the evidence, in response to the main evaluation question. Following further consultation with EC stakeholders, recommendations with respect to the Facility's support to health were developed and are contained in this report. In addition, one strategic recommendation for the health sector is reflected in the main report of the evaluation (Volume I). These recommendations will inform the remainder of the Facility, with the objective of ensuring the longer-term outcome of improved health for refugees.

2.1. Brief overview of health system in Turkey

The Turkish health system, like those of many other countries, includes primary, secondary and tertiary health care. Turkey started its Health Transition Programme in 2003 and in 2008 it was renamed Primary Healthcare Services: Family Medicine Model. There were a number of changes aimed at easing the burden of secondary health care and improving the primary health care system. This included the institution of contracted, family physicians who can serve between 1,000 and 4,000 patients and who are required to work with at least one other medical staff member; and the requirement for all citizens to contribute to the public health insurance fund[4]. This requires monthly payments which are paid by (or on behalf of) all officially employed citizens. The Turkish primary public health care structure is composed of Family Medicine Centres[5] (FMCs), Community Health Centres which also contain mother and child health and family planning centres and Healthy Living Centres (HLCs). There are also Foreigners' Health Centres.

Health services first started for Syrian refugees in April 2011[6]. In October 2014, the 'Regulation on Temporary Protection' granted free access to health services for Syrians under Temporary Protection (SuTPs[7]) under the General Health Insurance Scheme (*Genel Sağlık Sigortası* or GSS)[8]. This continues for Syrians, who are exempt from paying SGK *(Sosyal Güvenlik Kurumu)* premiums when they visit the health services in their province of registry, and follow the proper chain of referral. This continues until they are officially employed.

As of 25 December 2019, however, health care services for international protection applicants are no longer free of charge and a 'contribution fee' (set by the Ministry of Interior Affairs) must be paid to

[4] Yıldırım, C.A., Komsuoğlu, A. and Özekmekçi, İ. (2019). The transformation of the primary health care system for Syrian refugees in Turkey. *Asian and Pacific Migration Journal, 28*(1):75–96. doi:10.1177/0117196819832721.
[5] Also referred to in this report as Family Health Centres.
[6] Contracting Authority: Delegation of the EU to Turkey Anne I of the Specific Conditions of the grant contract. CRIS IPA 2016/378-641. (Signed 3 September 2019).
[7] Turkey's Temporary Protection Regulation establishes that 'Syrian nationals, stateless people and refugees who have arrived in Turkey, whether individually or as part of a mass movement of people, due to events unfolding in Syria, are eligible for temporary protection in Turkey' (Article 1). As such, the term Syrians under Temporary Protection, and the acronym SuTPs, is commonly used by the Government of Turkey, certain EC services, and Facility implementing partners to refer to any Syrian person who has arrived in Turkey after a cut-off date in 2011. This report prefers to simply use the term 'Syrians' or 'Syrian refugees' and does not use the SuTP acronym except when directly quoting an external sources.
[8] Yıldırım et al. op. cit.

access primary and emergency health care and medicines, although there are exceptions for vulnerable groups, including vulnerable non-Syrian international protection applicants[9].

Persons under temporary protection and international protection applicants can access **primary health care** through Migrant Health Centres (MHCs) and Extended Migrant Health Centres (EMHCs) which they can attend in the province where they are registered. Through these facilities, they can have an appointment with a general practitioner (GP), access immunisations, receive antenatal and reproductive health care and participate in group trainings on a variety of topics. For planning, monitoring and statistical purposes, both MHCs and EMHCs are considered to be collections of a number of Migrant Health Units (MHUs), which are defined as one doctor and one nurse aiming to serve a population of up to 4,000 people. MHCs were modelled on the existing Family Medicine Centres and were established in September 2015[10] in 29 provinces with high concentrations of refugees[11]. EMHCs provide access to some specialised health care services which are normally not seen in primary care levels (e.g. gynaecologists, paediatricians, internal medicine specialists, dentists). There are Syrian health care workers who speak Arabic in MHCs and EMHCs. Seven Migrant Health Training Centres provide training for all E/MHCs. All EMHCs have the necessary equipment, such as ultrasound and X-ray machines, but not all EMHCs have appropriate staffing to conduct tests for these specialist services. EMHCs also have the capacity to take samples, which are sent out to laboratories for analysis. The MHCs and EMHCs are open during the daytime on weekdays, and services are provided on a first come, first served basis, which is different from the secondary care system, where patients are usually able to make an appointment in advance.

Registered refugees are also able to access FMCs if they so choose (with services largely in Turkish), as well as Tuberculosis Dispensaries. If unregistered, only emergency care and vaccination services can be accessed.

For secondary health care services (e.g. hospitals), registered refugees can access public hospitals in their own province (in Turkish – but with potential assistance from a translator or bilingual patient guide – in selected hospitals in 65 provinces). They can also call the 112 emergency phone line for emergency care, which is also available to refugees out of province and unregistered refugees. In theory, the proper/formal chain of referral starts from primary level, and one needs a general practitioner to refer a patient to a specialist. However, in practice, patients can access hospitals directly without referrals in Turkey. Similar to a Turkish citizen, if a Syrian wishes to book an appointment with a specialist, they can go online and book a hospital appointment or call 182. The online appointment system is in Turkish.

Mental health care services are provided through in-patient health care services for severe, acute mental illness (e.g. bipolar disorder and schizophrenia) and are provided to hospital in-patients. When these patients are discharged, care is provided by community mental health centres (CMHCs) for rehabilitation for outpatients (for both Turkish citizens and Syrians). There is supplementary access to patient guides and translators at 10 CMHCs established with support from the Facility. Other mental health and psychosocial services (MHPSS) services (e.g. psychological counselling, group sessions) are provided through MHCs, EMHCs and HLCs. In addition, a number of MHPSS services have been provided under the Facility by NGOs.

Healthy Living Centres were developed for all people in Turkey to receive upstream preventive care (e.g. services from social workers, psychologists, childhood development specialists, physiotherapists, dieticians, as well as cancer screening and smoking cessation services). HLCs are technically accessible by both Turkish citizens and Syrians (with services in Turkish). Syrians can also access five **mobile screening trucks** for cancer screening services conducted in Arabic (provided through the Facility). While Syrians previously received prescription medications for free (at a contracted pharmacy), they now pay the same small co-payment as the host population (TRY 15–20 Health Contribution Fee per prescription, equivalent to EUR 1.61–2.14[12]).

[9] Regulation no.30989 amending Article 27 of the Temporary Protection Regulation
[10] Yıldırım et al. op. cit.
[11] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of December 2019). Brussels: EU.
[12] Exchange rate based on InfoEuro (December 2020) https://ec.europa.eu/info/funding-tenders/how-eu-funding-works/information-contractors-and-beneficiaries/exchange-rate-inforeuro_en

2.2. Facility Tranche I health sector actions

The Facility project that provides the most significant and wide-ranging support to the Turkish health care system is ***Improving the Health Status of The Syrian Population Under Temporary Protection and Related Services Provided by Turkish Authorities (also referred to as SIHHAT)*** which is delivered via a direct grant to the Ministry of Health (MoH). The SIHHAT project aims to improve availability, accessibility, demand for health care and health care relevance, and constitutes around 65% of spending within the Facility's health portfolio. As important background for the whole of this report, a summary of SIHHAT is provided in Box 2.

Box 2: Summary description of SIHHAT

SIHHAT (Contract no. IPA/2016/378-641) – is a Facility Tranche I, IPA-funded, EUR 300m grant to the Turkish MoH, under direct management by the EUD, which started in December 2016 and will now close in January 2021 (following a 2-month extension in response to COVID-19). It will be followed by a similar direct grant under Facility Tranche II).

The action targets Syrians in Turkey and has an overall objective of improving the health status of this group (measured by self-reported health status and access status, prevalence/risk of communicable and non-communicable diseases).

The intended outcomes of SIHHAT are to:

1. **Increase the availability and accessibility of health care services in 29 targeted provinces with high concentrations of Syrian refugees (**Adana, Adıyaman, Ankara, Batman, Burdur, Bursa, Denizli, Diyarbakır, Elazığ, Gaziantep, Hatay, İstanbul, Isparta, İzmir, Kahramanmaraş, Kayseri, Kilis, Kocaeli, Konya, Malatya, Manisa, Mardin, Mersin, Muğla, Nevşehir, Osmaniye, Sakarya, Samsun and Şanlıurfa). This is measured by, for example: population per health care professional; numbers of consultations/treatments delivered; vitamin/mineral deficiency rates; vaccination coverage; geographic coverage of services).

2. **Increase demand for health care services within the Syrian refugee population –** measured by, for example, total visits by Syrians to health care facilities and patient satisfaction with services.

The SIHHAT intervention includes a number of components. It provides:

- **support to MHCs, EMHCs and CMHCs** by paying salaries, providing equipment and meeting running costs, including rent;
- **mobile primary health care services** targeting rural and hard-to-reach Syrians (including agricultural workers) and mobile cancer screening;
- **training and employment of BPGs** in both primary and secondary facilities;
- **vaccination and vitamin D/iron supplements** for children and women of childbearing age;
- **reproductive health equipment;**
- **medical equipment for secondary health care facilities** in focus provinces;
- **training of health care staff** delivering services to Syrian patients;
- **a visibility campaign**, aiming to improve health literacy in the Syrian population;
- **ambulances for emergency services.**

Table 3 below provides a summary of SIHHAT's targets within these broad components. The first column describes the original intended results and targets according to the contract signed in 2016, the middle column details the most significant adaptations/updates to the project's targets (non-exhaustively), and the final column shows the progress achieved to date (based on the most recent data from September 2020).

Table 3: Summary of SIHHAT's programmes and results

Area	Original intended outputs[13]	Updated target[14]	Progress to date (Sept. 2020)[15]
MHUs	Establish and support 500 Migrant Health Units (1 doctor + 1 nurse) in target provinces to provide primary health care services for up to 2m people by 2019.	Increased to 790 MHUs (target of 7.5m consultations by end of 2019 and 11m by end of 2020).	• By the end of 2020, there were 792 MHUs in operation. • 13.5m primary health care consultations have been provided to Syrian refugees at MHCs where SIHHAT personnel work.
CMHCs	10 CMHCs will be available in provinces with the highest proportion of Syrian refugees to provide curative and rehabilitative mental health services for up to 1m persons.	Target unchanged but extended to 2020.	• 10 CMHCs are now complete and 'available' to a very large number of refugees. • 2,315 people (including host communities) have been reached at these centres, although MHPSS has been provided with Facility funding to around 35,000 people per year (2017–2019) through other facilities.
Supplements	150,000 infants and women will be nutritionally supported by Vitamin D and iron supplements.	Support 270,000 infants and women (no specific target) with Vitamin D and iron supplements.	• 317,189 Syrian infants/ children received Vitamin D and 235,267 infants/children received iron supplements. • 188,206 Syrian women received Vitamin D and 187,796 Syrian women received iron supplements.
Reproductive health	a) 14,400,000 condoms per year are made available in primary health care centres. b) 5,000 intra-uterine devices per year. c) 444,000 contraceptive pills and 600,000 injectable contraceptives per year. d) Number of deliveries attended by health care professionals in the targeted 29 provinces (annual targets of 90,000 (2017), 102,000 (2018), 105,000 (2019) and 108,000 (2020).	2m antenatal care (ANC) consultations at MHCs target added.	• Contraceptive pills and condoms over-delivered but other methods experienced procurement delays and have been dropped. • 2,664,552 ANC consultations delivered. • 20,187,500 condoms delivered. • Deliveries attended by health care professionals exceeded targets in 2017 (95,649) and 2018 (103,533); and were below target in 2019 (100,868) and 2020 (71,724).
Vaccination	Deliver 5.5m vaccine doses for children and women of reproductive age (Tetanus and Diphtheria – Td).	86% coverage of child MMR vaccine by January 2021.	• 5.5m vaccines delivered; and 3.75m doses administered by September 2020.

[13] Contracting Authority: Delegation of the EU to Turkey Annex I of the Specific Conditions of the grant contract. CRIS IPA 2016/378-641. (Signed 3 September 2019).
[14] SIHHAT Logframe – September 2020 (shared with ET by EUD PM in February 2021) – includes updated targets as per a 2020 contract addendum.
[15] Ibid.

Area	Original intended outputs[13]	Updated target[14]	Progress to date (Sept. 2020)[15]
		23% coverage of pregnant women vaccinated against Td by January 2021.	• 83% MMR vaccine coverage achieved (used as an indicator because it is the last in the series of infant vaccinations). • 20% Td vaccine coverage among pregnant women achieved.
Mobile health care	26 mobile primary health care vehicles and 5 mobile cancer screening vehicles are procured and in use.	Provide 102 mobile (smaller) primary health care vehicles and 5 mobile cancer screening vehicles to reach rurally based refugee populations.	• Procurement of the mobile primary health care vehicles was underway but vehicles were not in place by September 2020. EUD reported procurement as complete in November 2020. • The 5 cancer screening vehicles had been delivered, and were operational.
Secondary health care equipment	Provide medical equipment, inventory stock and furnishing for 115 secondary health care facilities in focus provinces.	113 facilities equipped by end-2019. 113+24 facilities equipped by January 2021.	• Wide range of equipment procured and delivered to 113+24 secondary health care facilities.
Training	Deliver 3-day training to 1350 primary and secondary health care workers who provide services to refugees.	Increased to 3530 primary and secondary level health care professionals and patient guides.	• 3,536 MoH staff trained by SIHHAT. • 3,407 SIHHAT-employed health workers also trained by WHO and MoH (outside of SIHHAT).
Visibility and health literacy	Produce and distribute 0.5m posters, 20m brochures and 5 short videos to increase health literacy among Syrian refugees.	No change.	• 500,000 posters developed. • 20m brochures developed.
Interpretation	960 health mediators (bilingual patient guides) in primary and secondary health care services are employed and on active duty.	Increased to 1,100 BPGs.	• 1,128 BPGs hired and working at both primary and secondary facilities.
Emergency health care	Not included.	Provide 380 ambulances and 50 neo-natal ambulances.	EUD reported that this procurement was completed by November 2020.

Analysis of the breakdown of SIHHAT's EUR 300 million budget provides an illustration of the action's priorities. As illustrated in Table 4 below, a significant proportion (44.65%) of the action budget is used to support MHCs and CMHCs. Within this EUR 134 million, around 70% (EUR 93 million) covers health centre staff costs (general practitioners, specialist doctors, nurses, midwives, technicians, auxiliary staff, social workers and psychologists, plus BPGs and translators in hospitals); 18% covers unit running costs (e.g. rent, medical consumables, laboratory tests); and 9% has provided the required furniture, medical equipment and electronic/IT equipment to establish the centres. As shown, more than EUR 68 million (23% of the total budget) has funded new medical equipment at secondary health care facilities, EUR 48.5 million has supported the vaccination programme, EUR 6.5 million has funded

emergency health services and the remainder of the budget is used to support mobile health services, reproductive health services, supplements, research and studies, training and visibility/health literacy activities.

Table 4: Breakdown of the SIHHAT budget[16]

Type of service/activity	Budget (EUR)	% of total
MHCs/CMHCs comprising	**133,958,997**	**44.65**
Staff salaries	*93,253,000*	31.08
Furniture and therapy/medical equipment	*12,477,385*	4.16
Rent and utilities	*5,185,780*	1.73
Laboratory tests	*5,634,869*	1.88
Consumables	*12,659,013*	4.22
Contingency reserves (utilised for COVID-19 response)	*4,748,950*	1.58
Medical equipment for secondary facilities	**68,523,953**	**22.84**
Vaccination programme	**48,562,514**	**16.19**
Emergency health services	**27,443,625**	**9.15**
Mobile health services	**6,514,727**	**2.17**
Project support team (including salaries and expenses)	**3,604,696**	**1.20**
Supplement programme	**2,723,600**	**0.91**
Reproductive health services	**2,560,963**	**0.85**
Training	**2,429,993**	**0.81**
Visibility	**423,219**	**0.14**
Research, studies and surveys	**259,888**	**0.09**
Indirect costs	**132,083**	**0.04**
Unused budget	**2,861,742**	**0.95**
TOTAL	**300,000,000**	**100.00**

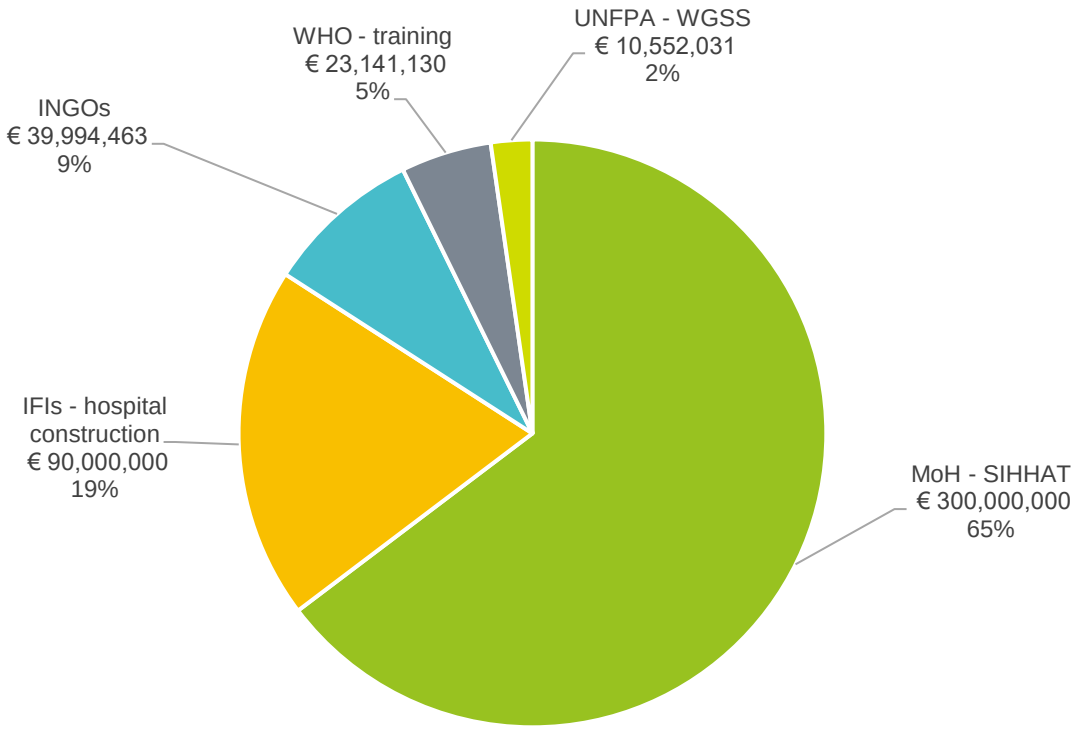
Source: SIHHAT

In addition to SIHHAT, the Facility's Tranche I health portfolio includes a further EUR 164 million of support for interventions that are delivered by a range of other Facility partners, including IFIs, UNFPA, the World Health Organization (WHO) and various INGOs. This is shown by IP type in Figure 2, with a further breakdown of emergency and humanitarian support shown in Table 5. While this report focuses mainly on SIHHAT, as the largest Facility intervention, these other Facility-supported actions also constitute part of the overall support that has been provided through the Facility in this sector and are described and included within the analysis.

Facility targets mentioned in this report sometimes refer to SIHHAT targets, while others may be targets that are set at the level of the Facility (i.e. in the Facility Results Framework), thus encompassing all Facility interventions. Similarly, results data is sometimes specific to the SIHHAT programme (as reported in the SIHHAT logframe) and, at other times, is Facility-wide, as reported in the facility monitoring reports which are produced by SUMAF.

[16] Updated in February 2021, data provided to evaluation team by EUD by email.

Figure 2: Facility Tranche I health sector expenditure by IP type



Source: Analysis of EC data by evaluation team

Table 5: Facility-funded projects providing services of particular relevance to refugee needs and not covered by the Turkish health system

NGO partner	Title	Services provided	Value	Time frame
Médecins du Monde (MdM)	Strengthen the longer-term resilience of refugees and migrants by improving the level of their emotional, mental and physical well-being	Support was narrowed to MHPSS in three locations only 2017/18, but the most recent grant (EUR 9m – 2018/19) provides **MHPSS, physiotherapy and rehabilitation and mobile primary health care units** in Istanbul, Hatay, Gaziantep, Kilis, Izmir, Reyhanli and Manisa	9,000,000	2015–2019
	Provision of medical relief to refugees and migrants in Turkey through direct support to health facilities and implementing partners		6,975,996	
	Contribute to sustainable integration of refugees into host population		3,000,000	
International Medical Corps (IMC)	Provision of lifesaving health care and GBV protection to the most vulnerable refugees in southern Turkey	IMC supported **11 mobile and 6 static rehabilitation units** in south-eastern Turkey between 2015 and 2017	3,397,256	2015–2018
	Improving the well-being of Syrian refugees through physical rehabilitation, protection mechanisms and primary health care services in southern Turkey		3,453,723	

NGO partner	Title	Services provided	Value	Time frame
	Provision of lifesaving health, physical rehabilitation, mental health, GBV and protection services in Turkey		2,284,993	
Relief International (RI)	Strengthening Access to Specialised Health Services in Turkey for Conflict-Affected Syrians (SASH)	LEAP, primarily a project operating within Syria, also supported **mental health centres and teams in Gaziantep and prosthetics and rehabilitation centre**. This support was continued by SASH I and II and expanded to Ankara, Istanbul, Hatay, Kilis, Izmir and Manisa by 2019	4,000,000	2015–2019
	Strengthening Access to Specialised Health Services for Refugees in Turkey – Tranche III (SASH II)		3,000,000	
	Lifesaving Emergency Assistance for Protracted Conflict in Syria (LEAP)		2,129,525	
Handicap International/ Humanity and Inclusion	Emergency intervention for the most vulnerable Syrian-crisis affected people in Turkey	Support to two **rehabilitation centres in in Hatay and MHPSS activities in Gaziantep** and mainstreaming /inclusion activities	1,409,033	2016–2018
	A multi-stakeholder and multi-sectoral response mechanism improves the access to inclusive and quality services for the most vulnerable Syrian and non-Syrian refugees including people with disabilities in west Turkey (Izmir and Istanbul city)		931,676	
Total			**39,582,202**	

3. Key findings

3.1. **Judgement criterion 9.1:** The Facility has contributed to an increased availability of health care services

As explained in the methodology section, this report comprises a series of findings which respond to the judgement criteria defined for the assessment. JC 9.1 looks at the availability of quality health care services to meet needs, as a determinant of whether the Turkish health system is sufficiently equipped to provide quality health care to both refugees and host communities in focus provinces.

Broadly following the WHO definition of 'availability' of health care as a 'sufficient quantity of functioning public health and health care facilities, goods and services, and programmes,' this JC breaks availability down into the measurable indicators of: (a) availability of equipment; (b) availability of trained health workers including physicians; (c) availability of health care facilities and mobile clinics.

3.1.1. 'Turkish health system is sufficiently equipped to provide quality health care' as an outcome

Before examining the Facility's contribution to this intermediate outcome, it is first necessary to know the extent to which this outcome has been achieved, or can be observed. In this case, the question is whether there are sufficient equipment, staff and facilities available to meet the needs of refugees and host communities in targeted provinces.

To determine the appropriate number of Migrant Health Units (MHUs) required to meet the needs; there are two different standards that could be applied. The Organisation for Economic Cooperation and Development (OECD) suggests that there should be an average of one physician per 3,333 people. However, as explained in the introduction to this report, the Turkish health reforms of 2008 permit one general practitioner (GP) to serve up to 4,000 people (alongside one nurse). The unit of planning used in Turkey and by the Facility is the MHU (i.e. a family doctor–nurse team) rather than a facility (i.e. a physical clinic). The size of each MHC varies according to the population in the specific areas in which they are located.

In 2020, the Turkish Directorate-General for Migration Management (DGMM) reports that there were 3.64m[17] Syrian refugees in Turkey, distributed across 81 provinces. However, taking into account the fact that the outcome focuses on the 29 provinces that are targeted by the Facility, a more accurate population figure for assessing progress towards this outcome would be 3.48m[18].

By the Turkish standard of one GP per 4,000, this evaluation estimates that the number of additional physicians – and thus the number of MHUs – needed to adequately serve a population of 3.48m Syrians would be 870. The SIHHAT intervention (Phase 1) laid down a target of 790 MHUs, which was based on the number required to serve a population figure of 3.16m Syrian refugees; this has been updated to a target of 900 MHUs under SIHHAT Phase 2. A similar estimate of 870 is reasonable for midwives and nurses, given that each physician is required to work alongside one nurse.

By the end of 2020, the Facility was employing 734[19] physicians (605 GPs and 129 specialists), representing 84% of the above-estimated need, using the Turkish standard described above (population of 3.48m) and coming very close (93%) to the target of 790 set for SIHHAT Phase 1. In addition, 996 midwives and nurses were employed through the Facility by the end of 2020 (out of a Facility planning target of 1,000) which is well in excess of the estimated target of 870 required to meet Turkish standards.

When considering the number of refugees who are now registered in the Turkish health care system, progress towards this outcome looks even more positive. This is because Syrians can also access health care through the Turkish system outside of MHCs, e.g. through Family Medicine (or Health)

[17] https://en.goc.gov.tr/temporary-protection27
[18] SIHHAT.QPR3.Brief Logframe.
[19] Data provided by EUD, Project Status Table for SIHHAT, January 2021.

Centres, although only in Turkish. There are indications that as many as 800,000 Syrians and non-Syrian refugees in Turkey have registered with Family Medicine/Health Centres[20].

While this data is based on estimates, it would suggest that the population requiring additional Facility-supported physicians may be around 800,000 lower than the total population of Syrian refugees in Turkey, and closer to 2.68m. Using Turkish standards, the number of MHUs (and thus physicians) required to serve this size of population would be approximately 670. This suggests that, based on progress reported at the end of 2020, there is now a sufficient quantity of both physicians (734) and MHUs (792) to meet the needs of the Syrian refugee population in the target provinces[21].

As expressed in Table 6, one can conclude that this outcome has been achieved in terms of the numbers of qualified human resources delivering primary health care across all MHCs and EMHCs. However, the situation is more complex than these figures suggest, because the quality, type and distribution of resources are also critical factors in determining the availability of quality health care. In addition, increases in capacity within secondary health care have been slower to materialise. In these areas, there remain challenges which are discussed further in this report.

In the following, we examine the extent to which the Facility has contributed to the achievement of this outcome by increasing the availability of health care resources (as defined in this JC 9.1) through its various activities; and to what extent this has influenced the quality of health care, and ensured its equitable provision.

The analysis below utilises the most recently available results from the SIHHAT programme (January 2021), and Facility results monitoring data presented to the Facility Steering Committee in the form of the biannual facility monitoring reports. Relevant results data for this JC are summarised below.

Table 6: Summary of extent to which intermediate outcome achieved

Expected outcome	**The Turkish health system is sufficiently equipped** to provide quality health care to refugees and host communities **in focus provinces**. This entails ensuring availability of equipment, availability of health workers with sufficient training, and availability of health facilities and mobile clinics
Observed outcome	The Turkish health system is sufficiently equipped to provide quality health care to refugees and host communities in focus provinces in terms of absolute numbers of qualified medical staff, although staffing across all categories of health workers is uneven, with a need for more physicians, especially general practitioners and bilingual patient guides. There are some shortages in medical equipment and delays in provision of hospitals and mobile health services, and gaps in provision of Migrant Health Units
Facility results contributing to the outcome[22]	Increased availability of equipment • There has been an increase in medical equipment, including 3,805 medical devices and 163 microscopes supplied[23] although some challenges remain in procurement of some devices, e.g. for E/MHCs[24]. Increased availability of trained health workers including physicians • 3,421[25] health care workers received salaries via Facility funding, exceeding the initial Facility target of 3,034[26] but not reaching the revised target of 3,710. Data shows that most of these work for MHCs or emergency EMHCs, with 1,128 bilingual patient guides, 734 doctors/physicians, 996 midwives and nurses, 403

[20] Meeting of Minutes of Steering Committee, SIHHAT. 21 January 2020.
[21] Even this might be a low estimate, since the total number of refugees in Turkey might be less than the number reported by the Government (see Protection Sector report).
[22] Results and targets include both SIHHAT targets and Facility-level targets, incorporating activities outside of the SIHHAT programme, e.g. training by WHO and services delivered by NGOs.
[23] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of December 2019). Brussels: EU.
[24] Meeting of Minutes of 3rd Steering Committee, SIHHAT. 19 September 2019.
[25] Data provided by EUD, Project Status Table for SIHHAT, January 2021.
[26] European Commission. (2020). (November). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of June 2020). Brussels: EU.

auxiliary staff, 42 psychologists and 38 social workers receiving salaries as of December 2020.

- In June 2020, the majority (67%) of these health care workers receiving financial support from the Facility were male[27].
- 8,426 health care workers (all categories[28]) have been trained against a target of 7,830[29]. Target exceeded.
- By December 2020, 2,370 Syrian health care professionals (physicians, midwives and nurses) have been trained and certified under the Facility, and 1,730 of these were employed by this date[30].

Increased availability of health care facilities and mobile health care services

- By September 2020, there were 792 operational MHUs.
- 2 new hospitals are under construction (550 beds; however, one of the hospitals is a replacement for an older hospital that will be closed, which will result in less increase in overall capacity than intended). Implementation is delayed and construction is expected to be complete by mid-2021.
- 10 MoH-operated CMHCs operational out of 10 targeted for Tranche I (with an additional 9 clinics providing MHPSS services through NGOs). Facility target of 10 exceeded.
- 12 mobile primary health care clinics (from UNFPA and MdM) will be transferred to the Ministry of Health (SIHHAT) in the early part of 2021.
- 102 small cars that include basic equipment for health care were due to be procured (instead of an additional 26 mobile clinics that were originally planned) by November 2020[31]. This target has not yet been achieved, and services are not yet provided given that procurement is delayed[32].
- 5 mobile screening trucks through SIHHAT currently provide cancer screening for Syrian women including cervical, breast and colon cancers (target was 5)[33].

3.1.2. Description of Facility interventions aimed at increasing the availability of health care

The majority of activities delivered through the SIHHAT action, as described in Box 2 (Section 2.2) are aimed at increasing availability of health care services, including funding to MHCs and CMHCs; vaccination, vitamin supplement and reproductive health programmes; mobile primary health care and cancer screening vehicles; medical equipment provided to secondary health care facilities; and emergency health care services (ambulances). Several other Facility actions also support availability of health care, including services delivered by NGOs, and the hospital construction projects.

i. Availability of equipment

The activity outlined in the contract with SIHHAT was 'Supplying 15 public hospitals with medical equipment and devices and increasing their intensive health care capacity in the provinces with high proportion of Syrian refugees'[34]. This target was revised to 113 facilities at the end of 2019 and 113+24 at the end of 2020 in the most recent addendum[35]. Equipment was provided for hospitals in the 28 provinces with the highest populations of Syrians based on a needs analysis, at a total cost of around

[27] Ibid.
[28] Includes health care professionals and other non-medically qualified staff, such as bilingual patient guides, translators, auxiliary workers, technicians.
[29] European Commission. (2020). (November). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of June 2020). Brussels: EU.
[30] Data provided by EUD, Project Status Table for SIHHAT, January 2021 and analysed by evaluation team.
[31] KII H01; SIHHAT Project 13th Monthly Management Meeting, 14/07/2020.
[32] SIHHAT. (2020). State of Play – SIHHAT, July 2020.
[33] Contracting Authority: Delegation of the EU to Turkey Annex I of the Specific Conditions of the grant contract. CRIS IPA 2016/378-641. (Signed 3 September 2019); KII H33.
[34] Contracting Authority: Delegation of the EU to Turkey Annex I of the Specific Conditions of the grant contract. CRIS IPA 2016/378-641. (Signed 3 September 2019).
[35] Contracting Authority: Delegation of the EU to Turkey Annex I of the Specific Conditions of the grant contract. CRIS IPA 2016/378-641. (Signed 3 September 2019). SIHHAT Logframe with results to 30 June 2020 – shared with ET by EUD, October 2020

EUR 68.5 million. Equipment provided includes incubators and ventilators, patient monitors for neo-natal, paediatric, and adult intensive care units, anaesthesia and eco-cardiography devices, X-ray and mammography devices, haemodialysis devices and microscopes[36].

Equipment provided to MHCs totalled EUR 25.1 million and included furniture, medical furniture, medical equipment, oxygen generators, digital X-rays, ECGs, centrifuges and medical consumables. This budget line also included non-medical IT and electronic equipment[37].

ii. Availability of health care workers

The vast majority of health care workers receiving salaries under the Facility do so through SIHHAT, and most of these workers are employed in MHCs or EMHCs. As shown in Table 7 below, as of December 2020, SIHHAT's overall recruitment rate exceeds the initial recruitment target (3,034) and is close to the revised target of 3,710.

Table 7: SIHHAT recruitment by role

Personnel type	Recruitment target[38]	Recruitment number (December 2020)
Dentists	**42** (1 for each of the 42 EMHCs)	**0**
Physicians	**790**	**734**
General practitioners	*664*	*605*
Specialists – gynaecologists, internal diseases specialists and paediatricians	*126 (1 for each specialism in each of the 42 EMHCs)*	*129*
X-ray technicians and laboratory technicians	**168** (2 for each role at 42 EMHCs)	**76**
Midwives/nurses	**1000**	**996**
Bilingual patient guides	**1100**	**1128**
Auxiliary staff	**400**	**403**
Psychologists/social workers (Psychosocial services staff)	**84**	**80**[39] (42 psychologists and 38 social workers)
Translators	-	**4**
Total number of personnel	**3,710**	**3,421**

In addition to SIHHAT training activities, other Facility-supported projects (approximately EUR 23 million across three actions) are providing training to Syrian health workers so that they are eligible to work in the Turkish health care system, and providing training to both Turkish and Syrian health workers/

[36] SUMAF (2020), Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities (SIHHAT) (IPA/2016/378-641) Monitoring Report, Mission No: 2, Date: 11 July 2019; SIHHAT Project Quarterly Brief and Logframe Q3 2019
[37] SIHHAT Project Quarterly Brief and Logframe Q3 2019.
[38] The original recruitment target was 3,034. The revised targets were set out in the SIHHAT Interim Report II (2019); Contracting Authority: Delegation of the EU to Turkey Annex I of the Specific Conditions of the grant contract. CRIS IPA 2016/378-641 (Signed 3 September 2019).
[39] Figure provided to ET by EUD in February 2021.

interpreters to better serve Syrian patients. These are delivered by WHO in close partnership with the MoH.

iii. Availability of health care services/facilities

As explained in (Section 2.2) above, SIHHAT covers the costs required to establish MHCs and keeps them open and operational.

The Facility is also supporting the Government of Turkey to construct two new hospitals, with pillar-assessed IFIs acting as grant managing intermediaries, allowing the EUD to manage the actions indirectly. The Council of Europe Development Bank action is responsible for the construction of a EUR 50 million 300-bed hospital in the south-eastern border province of Kilis (the only Turkish province with more registered Syrian refugees than Turkish citizens). The Agence Française de Développement (AFD) action is constructing and equipping a new EUR 40 million state hospital in Dörtyol, Hatay province (which also borders Syria). These construction projects directly aim to increase the availability of health care for Syrian refugees and host communities, and to alleviate pressure on existing health infrastructure and services in the provinces which host the highest concentration of refugees (and potentially a particular cohort of refugees with increased health care needs). As explained above, however, both of these construction projects remain underway, and are yet to be completed[40].

Many humanitarian projects were implemented in the earlier years of the response, and were designed to deliver a range of activities to support availability, access, demand/use and relevance of health care services in specific locations, in contrast to the wider system strengthening that has been supported by the development programmes of the Facility. These humanitarian actions included:

- **Provision of Women and Girls' Safe Spaces (WGSS),** sexual and reproductive health (SRH) and sexual and gender-based violence (SGBV) services at Migrant Health Centres across Turkey (approximately EUR 10.5 million) – delivered by UNFPA.
- **Around EUR 40m granted to five INGOS** – Médecins du Monde, Relief International (RI), International Medical Corps (IMC), Handicap International/Humanity and Inclusion (HI) and GOAL) – see Table 5. These were mostly in the early years of the response before the full roll-out of SIHHAT[41]. Of these funds, around EUR 33 million covers a wide range of primary health care services to refugees between 2016 and 2017, before narrowing their focus to areas in which refugees have specific needs and where the Turkish system left gaps, such as in MHPSS. Such projects may also provide for unregistered or out of province refugees who are not legally entitled to mainstream public health care.

  Many of these services have already transitioned from NGOs to the Ministry of Health, for example primary health clinics (in June 2018) and services to support in SRH and SGBV (in September 2019). The only remaining programmes to be transitioned to SIHHAT are mobile primary health services (due in early 2021), MHPSS services (due at the end of the first phase of SIHHAT) and post-operative care (physiotherapy) and rehabilitation services[42] (in 2022).

In addition to the services delivered by NGOs**, mental health care services** are provided through in-patient health care services for severe, acute mental illness (e.g. bipolar disorder and schizophrenia) and are provided in hospital. When these patients are discharged, care is provided by CMHCs for rehabilitation for outpatients (for both Turkish citizens and Syrians). Facility support also provides supplementary access to patient guides and translators at these CMHCs, of which there are currently 10 in operation. Other MHPSS services (e.g. psychological counselling, group sessions) are provided through MHCs, EMHCs and HLCs.

Two further actions (delivered by the Danish Red Cross/TRC and Association for Solidarity with Asylum Seekers (ASAM)) have some health care components; health education programmes, referrals and psychosocial support, which are referred to in this report. However, these actions are not counted in the

[40] Delegation of the European Union of Turkey. Construction of a State Hospital in Hatay. https://www.avrupa.info.tr/en/project/construction-state-hospital-hatay-7507 Delegation of the European Union of Turkey. Health Infrastructure in Kilis. https://www.avrupa.info.tr/en/project/health-infrastructure-kilis-7379.
[41] Universalia, Landell Mills International Consortium. (2019). *Evaluation of the European Union's Humanitarian Response to the refugee crisis in Turkey.* Brussels: European Commission.
[42] Ibid.

quantification of the Facility health portfolio (see Figure 2) and, in this evaluation, they are covered in the sector report on protection (see Volume II of the Final Report).

3.1.3. Contextual analysis of Facility interventions

In the following, we present a contextualised analysis of the Facility's support in increasing the availability of health care and how, in doing so, it has delivered quality and has been inclusive in its approach. The strengths of the Facility's approach, as well as areas where targets have not yet been reached, and where further progress is required are discussed within the wider context of the Facility's support.

i. Availability of equipment

As explained above, Facility interventions have increased the supply of equipment. The equipment procured was based on identified needs, and the evaluation found no concerns on quality during fieldwork. At the time of the field visit for this evaluation (March 2020), equipment for some EMHCs was still lacking, although by the time of writing this report, MHC equipment that was formerly missing (e.g. computers, cabinets)[43] had been delivered.

As mentioned, availability relates not only to quantity and quality supplied: the extent to which it can be effectively used is also important. During this evaluation's fieldwork and, as indicated by figures on recruitment levels[44], some EMHCs reported a lack of technicians, meaning that some ultrasound and X-ray equipment[45] could not be fully used.

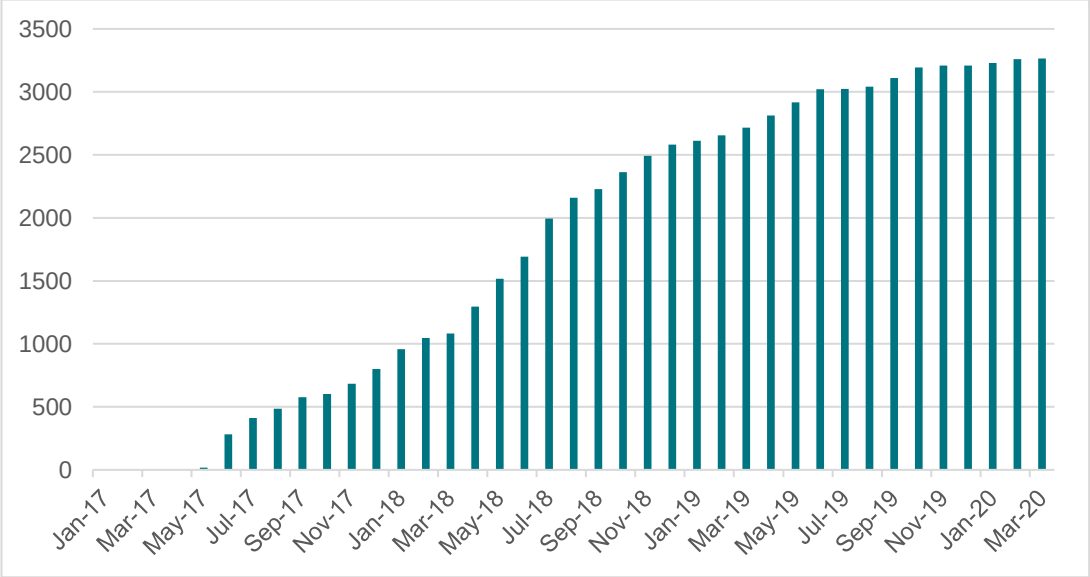
The evaluation team was unable to quantify the full extent of these gaps in equipment availability. However, they are significant enough to warrant attention as they have an impact on the availability of health services.

ii. Availability of trained health care workers including physicians

While there were some delays in staff recruitment and thus in the opening of MHCs, interviewees explained that this has improved in recent months[46], this can also be seen in SIHHAT recruitment data, which rose rapidly between 2018 and 2019 (see Figure 3) has now reached 3,421 (see Table 7).

[43] Meeting of Minutes of 3rd Steering Committee, SIHHAT, 19 September 2019; SUMAF. (2019). Monitoring Report: WHO Action – Improved Access to Health Services for Syrian Refugees in Turkey. Qualitative Results Based Monitoring Report for Ongoing Missions. 18 March 2019; KII 40.1.
[44] SUMAF (2020), Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities (SIHHAT) (IPA/2016/378-641), Monitoring Report, Mission No: 2, Date: 11 July 2019; SIHHAT Logframe Q3 2019; SIHHAT, Project Status Table 30 April 2020.
[45] KIIs H26, H27.1, H36.1.
[46] Interview, 25 November 2019.

Figure 3: Number of staff receiving salaries from SIHHAT by month (Jan 2017 to Mar 2020)



The Facility has made significant efforts to facilitate Syrian health workforce adaptation to the Turkish system through training, as described above. The results show that 2,370 Syrian health care professionals were trained/certified under the Facility, as well as 1,128 BPGs[47]. Syrian health care workers interviewed for this evaluation were generally satisfied and grateful that they are able to work, and apply their skills at MHCs, as confirmed in documentation[48].

Facility Tranche I is regarded by some as having provided the impetus for the changes in legislation which enabled Syrian health care workers to be employed, i.e. the 'legal instrument for employment of Syrian health care staff'[49]. However, the contracting document notes that these legislative changes happened before the Facility Tranche I funding began[50]. On 1 April 2017, an amendment was issued to the regulation (Official Gazette Numbered 28212, from 22 February 2012 and provisions of International Workforce Law No. 6735) stating that Syrian health care workers did not require 'equivalency of diploma and/or certificate of expertise' when providing care for refugees[51]. Instead, a certification through a specially designed orientation training with theory and practice is needed for Syrian health care staff to work under contracts provided by SIHHAT.

As one government official noted:

> *SIHHAT provided the first strong legal environment for their [Syrian health workers'] employment. We know NGOs employed some of them before, when there was a sudden influx of refugees in 2012 and 2013. Many NGOs employed staff but because of legislative constraints in Turkey, to best of my knowledge, they could not have brought a doctor as a doctor, but they were allowed to help with medical services. This was a bit understandable under emergency conditions, but some regularisation was needed later and the SIHHAT project provided some very formal, safe, legal basis[52].*

[47] Data on the number of Syrians trained is not available in latest Facility Monitoring Reports, to December 2019 and June 2020. SIHHAT reports a number of MoH and SIHHAT staff trained and certified (which includes Syrians and Turkish nationals and Syrians who have also acquired Turkish citizenship. These figures are based on the SIHHAT Project Status Table of December 2020 (shared with the ET in January 2021).
[48] World Health Organization. (n.d.). Factors Affecting Employability of Trained Syrian Health Care Professionals in Turkey. Ankara: WHO.
[49] KII H01.
[50] Contracting Authority: Delegation of the EU to Turkey Anne I of the Specific Conditions of the grant contract. CRIS IPA 2016/378-641. (Signed 3 September 2019).
[51] Turkish Laburlaw. (2020). Exemption for Syrian Medial Personnel. https://turkishlaborlaw.com/news/business-in-turkey/exemption-for-syrian-medical-personnel/; Turkish documentation (2017): https://www.resmigazete.gov.tr/eskiler/2017/04/20170401-5.htm
[52] KII H01.

Nevertheless, it is the combination of Facility support for hiring and training of Syrian health care workers, and the change in national legislation, that together have led to the significant increase in the availability of health workers and physicians[53].

Despite this increase in availability, however, Facility data (see Table 7), documentary evidence and some interviewees note that there continues to be a need for more Syrian health care professionals working in MHCs, including physicians, psychologists and dentists[54], and particularly in the areas where refugees are concentrated[55].

Table 7 also shows that recruitment of X-ray and laboratory technicians (which aimed at Syrian refugees who had already been trained in Syria) are below target. Several challenges were explained to the ET in this regard, including delays in the delivery and installation of equipment (completed by December 2018); delays in the installation of safety measures in X-ray rooms, waiting to receive the necessary operational permits from the relevant authorities; and delays in securing permission to work for technicians who were trained in Syria, but did not yet have the certificate of equivalence, or a valid Turkish diploma. This situation applied to both X-ray and laboratory technicians, but the process has since been accelerated as the relevant ministries within the MoH (DG Public Health and DG Health Services) have allowed technicians to be employed following completion of 6-week adaptation training. By December 2020, 36 X-ray and 40 laboratory technicians had been recruited, out of a target of 168.

Shortages of physicians (GPs) are also evidenced by data on average patient waiting times in MHCs. While waiting times have decreased, with physicians seeing fewer patients per day compared to six months ago, the number of patients being seen each day is still very high (50–80 per day) compared to other countries[56]. According to the Turkish Medical Association (TTB), 'the ideal is for a physician to look at 20 patients a day'[57]. A 2018 study in the US found that the average physician saw 20 patients a day[58]. A survey by KfW and WHO presented in 2019 showed that 71% of physicians report seeing over 40 patients a day, with 36% seeing over 60 patients a day[59]. In addition to this being an indicator of insufficient numbers of physicians, it also reflects on the quality of care, as physicians cannot spend sufficient time with each patient [60].

Tt is currently more difficult for Syrians to be employed in certain professions such as dentists, psychologists and social workers. This is because the legislative restrictions do not allow Syrian dentists or psychologists equivalency to work in Turkey. However, social workers are necessarily all Turkish since social work is not a profession in Syria in the same way as in Turkey[61].

While recruitment of psychologists and social workers has risen from 38 in March 2020 to 80 by January 2021[62], these are all Turkish and thus the employment of Syrians in these professions continues to be a challenge. Although language barriers present a major challenge in accessing these services (see Section 3.2.3), SUMAF has reported that Turkish dentists are being employed in some MHCs, despite the language barrier, and more dentists are needed[63].

One way to address this barrier is through an increase in translators and BPGs, which has been expressed as a need across many interviewee groups together with more Syrian physicians[64]. Facility support in this area has been good, with recruitment targets for BPGs already exceeded. The EU has

[53] KII H20; see also KII H25.
[54] KIIs H22, H42; Republic of Turkey, Ministry of Health and SIHHAT. (2019). Pre-Survey Study Information Sharing Meeting: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection, MOH SIHHAT/2018/SER/NEG/04.
[55] Strategic Interview with EC staff, November 2019; SIHHAT. (2019-2020). Field Observers' Monthly Reports. 8 August 2019; 5 September 2019; 5 October 2019; 5 November 2019; 5 December 2019; 5 January 2020; 5 February 2020; 5 March 2020; 5 April 2020.
[56] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of December 2019). Brussels: EU.
[57] https://www.haber3.com/guncel/doktorlara-gunde-72-hasta-bakma-zorunlulugu-getirildi-haberi-5053338#:~:text=TTB'ye%20g%C3%B6re%20ideal%20olan,hekimin%20g%C3%BCnde%2020%20hasta%20bakmas%C4%B1.
[58]The Physicians Foundation. (2018). America's Physicians: Practice Patterns & Perspectives. Https://Physiciansfoundation.Org/Wp-Content/Uploads/2018/09/Physicians-Survey-Results-Final-2018.Pdf
[59] KfW, WHO. Presentation to the 3rd Joint Steering Committee Meeting. Ankara, 13 November 2019.
[60] KIIs H21, H22,3, H24.2, H26, H32.
[61] KII H01.
[62] Data provided by EUD, February 2021.
[63] SUMAF. (2019). Monitoring Report: WHO Action – Improved Access to Health Services for Syrian Refugees in Turkey. Qualitative Results Based Monitoring Report for Ongoing Missions. 18 March 2019; KII H47; Meeting of Minutes of 3rd Steering Committee, SIHHAT. September 19, 2019.
[64] Akyol-Faria, Özge. (2019). *SIHHAT Mission Report.* Mardin, 11/02/2019 to 12/02/2019. Ref. Ares(2019)924032 – 15 February 2019; KIIs H12, H22.1, H26, H41.1, H44.

identified the requirement for additional BPGs, and has encouraged the Ministry to recruit more, but the Ministry has expressed concerns over sustainability of funding for these positions from the Ministry budget once Facility funding is finished[65]. There is a difference of opinion between partners (EC and the Government of the Turkish Republic (GoTR)) on whether these staff should be hired on an interim basis with EU funding at least temporarily to fill a gap, even if it is not sustainable in the long term. As more Syrians learn Turkish, fewer patient guides may be needed. However, if further integration of primary care services is undertaken (e.g. in accordance with the Family Medicine/Health Centre model), then more patient guides will be needed.

These examples illustrate the complexity of addressing gaps in availability of health care, and the influence of factors such as language and regulations on health care employment.

Other circumstances can also influence the availability of trained health care workers. For example, of the 2,370 Syrian health care workers who have been trained/certified, only 1,730 of these are employed (latest data reported). Based on a WHO report and corroborated by interviews in Turkey, one of the reasons for this is that health care workers do not wish to relocate to the location they have been asked to work in, as this would take them away from their family, and also result in a higher cost of living, particularly if they are asked to work in bigger cities[66].

A further issue impacting on quality is that the majority (67%) of refugee health care workers are male. Females attending clinics tend to be more comfortable with female health care workers for certain conditions (e.g. gynaecology), and so there should be an increase the proportion of female health care workers in the system.

In addition, interviews suggest that the supply side of the Syrian health workforce, and particularly in terms of physicians willing to take part in the system, is mostly saturated – and it is difficult now to find additional Syrian physicians to train for deployment at MHCs[67].

To address this supply shortage, there are a number of key constraints that require attention at a national level to improve the conditions for the recruitment of Syrian workers, as highlighted below. These are based on the views of a range of stakeholders interviewed during this evaluation[68] which are recognised in a recent journal article. This states that the equivalency 'introduced as a remedy to the short-term problems may produce a problem in the long term with respect to the employment policies of Turkey'[69].

- **Language:** One issue affecting availability of employable human resources relates to language skills, with a lack of Arabic-speaking psychiatrists, dentists, psychologists and pharmacists.

- **Legislation:** A regulatory obstacle[70] is that current laws only provide exemptions for equivalency for nurses and physicians working as family practitioners in MHCs (and not for other professions such as pharmacists, psychologists and dentists). In some cases, implementing partners (IPs) have been able to hire Syrian psychiatrists (although there are few as will be explained later in the report). In addition, IPs explained that they also faced challenges later, when trying to transition staff from the IP to the Ministry[71].

- **Lack of performance-based pay:** While Turkish physicians get paid performance pay against set targets[72], Syrian physicians do not. Performance pay is seen by some as being a key motivator, and can result in increased pay. If applied to Syrian physicians, this would better align remuneration for Syrian physicians with Turkish physicians, and would increase Syrian physicians'

[65] EU Correspondence, July 2020.
[66] World Health Organization. (n.d.). Factors Affecting Employability of Trained Syrian Health Care Professionals in Turkey. Ankara: WHO.
[67] KII H03.
[68] KIIs H21, H22,3, H24.2, H26, H30, H32, H42.
[69] Yıldırım et al. op. cit.
[70] Turkish Labour Law. (2020). Exemption for Syrian Medial Personnel. https://turkishlaborlaw.com/news/business-in-turkey/exemption-for-syrian-medical-personnel/; Turkish documentation (2017): https://www.resmigazete.gov.tr/eskiler/2017/04/20170401-5.htm
[71] KIIs H01, H09, H17, H19, H19.1, H36.1, H44.
[72] Menon, R., Nguyen, S.N., Arur, A., Yener, A.L. and Postolovska, I. (2014). *Turkey: family medicine performance contracting scheme. In Paying for Performance: Implications for health system performance and accountability.* Edited by C. Cashin, Y-L. Chi., P.C. Smith, M. Borowitz and S. Thomson. New York, New York, Open University Press.

accountability vis-à-vis the pre-determined primary care targets (as well as potentially increase their pay, based on their performance)[73].

- **Inability of Syrian physicians to practise their specialty:** As explained in the WHO report *Factors Affecting Employability of Trained Syrian Health Care Professionals in Turkey*, the certification programme for Syrian physicians only allows them to practice as general physicians in MHCs, regardless of the specialty they trained in[74].

- **Lack of awareness amongst Syrian physicians and nurses on next steps to be able to practise outside of MHCs and in their own profession**, including diploma equivalency expectations for physicians and nurses[75].

iii. Additional training needs

The Facility provided training in a number of areas, including funding the WHO training for Syrian health care workers and specifically in the area of MHPSS (e.g. the Mental Health Gap Action Programme – mhGap). While the statistics show that training has been appropriate and sufficient to ensure certification for employment by SIHHAT, interviewees suggested that Syrian physicians need additional training on software (computer use, database use), MHPSS services, SRH, non-communicable diseases (NCD), and Turkish language training[76]. Other training needs identified, for both Syrian and Turkish health care workers, included intercultural communications and stress management[77].

During the evaluation fieldwork, BPGs, in particular, expressed a desire for more regular and ongoing training, including more training on medical terminology (in Turkish and Arabic) as it is felt that the 'WHO training is not enough'[78]. Softer skills training on dealing with people under pressure, self-control and discipline were all identified by BPGs as areas in which additional training would be welcome, as well as for using software[79]. Translators at hospitals expressed a desire for more training on reproductive health and family planning[80] and, for those translating in CMHCs, on mental illness[81].

iv. Availability of health care services

a. Primary health care through Migrant Health Centres and other Facility-supported facilities

As noted above, one Migrant Health Unit consists of one nurse and one physician (there are a number of units within an MHC). Each MHU aims to serve 4,000 people, in line with the standard for the Turkish population at FMCs[82]. Before the start of the Facility, there were 86 in-camp/out-camp MHCs in 17 provinces, with 175 MHUs already established and brought into service by the Turkish government[83]. Through the SIHHAT programme, Tranche I of the Facility enabled an increase in primary health care facilities so that, by September 2020, there were 792 MHUs in operation, distributed across 177 MHCs[84]. While this number indicates good progress towards there being a sufficient number of MHUs (870) to serve the Syrian population in the 29 focus provinces (3.48m), evidence from waiting times in MHCs and from interviews suggest that more facilities are still needed[85].

While the SIHHAT programme works mainly through government health systems, other Facility-supported interventions, such as those delivered by NGOs, have provided health services directly to refugees, particularly in the initial stages of the response[86], as shown in Table 5.

[73] KIIs H22, H28.1.
[74] World Health Organization. (n.d.). Factors Affecting Employability of Trained Syrian Health Care Professionals in Turkey. Ankara: WHO.
[75] SUMAF. (2019). Key Findings and Some Lessons Learned from Recent Action Monitoring Mission. Ankara: SUMAF. (November 21).
[76] KfW, WHO. Presentation to the 3rd Joint Steering Committee Meeting. Ankara, 13 November 2019; KIIs H01, H05, H12, H24.2.
[77] KII H01.
[78] KIIs H32; also H41.1.
[79] KIIs H36.2, H41.1.
[80] KII H46.
[81] KII H43.1.
[82] SIHHAT (2018). *Improving the Health Status of the Syrian Population under Temporary Protection and Related Services.* IPA 2016/378-641. Ankara.
[83] Data provided by SIHHAT, email correspondence, 11/08/20.
[84] Data provided by SIHHAT, email correspondence, 12/02/21.
[85] KIIs H25, H27.1.
[86] Universalia, Landell Mills International Consortium. (2019). Op. cit..

Physical therapy and rehabilitation (PTR) – by June 2020, the number of refugees who had received specialised treatment for post-operative and rehabilitative care was 25,487 (target 33,180), and the majority (67%) of these services were taken up by those with disabilities. While the target had not been met by the date of reporting this data[87], the evaluation team concludes that it is likely that the target will have been reached by the end of 2020. Furthermore, progress in this area will continue as the Facility strengthens physiotherapy in hospitals under the 'infrastructure' programme in Facility Tranche II[88].

Mental health and psychosocial support (MHPSS) – here it is more difficult to assess whether there are adequate services to meet the needs. Services delivered across the MHPSS spectrum (Levels 1 to 4) are supported by the Facility in a variety of ways (e.g. through SIHHAT-supported CMHCs and interventions delivered by NGOs).

Due to the trauma of the conflict in Syria and the challenges of the refugee experience, needs were already high at the beginning of the Facility and the key message of a 2018 study was that 'mental health problems and unmet need for mental health care among refugees are high[89]'. These are known to have been further exacerbated by the circumstances and economic impact of the COVID-19 pandemic, as well as increases in social tensions.

Framework for MHPSS intervention

MHPSS is a key area of focus for refugees, especially those escaping war. The intervention pyramid suggested for MHPSS by UNHCR is to ensure services across four levels:

Level 1. Basic services and security (including basic health care services).

Level 2. Community and family support (including ensuring community structures are in place, as well as addressing social cohesion, which is discussed in Section 3.3.3).

Level 3. Focused psychosocial support (including individual, family and group programs for people who need support, offered by trained workers who are not specialised per se).

Level 4. Clinical services for those with more severe mental illnesses (typically offered by mental health professionals).

However, the evaluation team was unable to obtain strong data on the extent to which the available services were sufficient to meet needs, partly because of limited service availability data, but also because of some of the barriers which limit the extent to which mental health needs can be fully understood and quantified. For example, some MHPSS needs (especially for anxiety and stress-related disorders) are not always recognised as needs by refugees themselves; and there is also a 'treatment gap' where a high proportion of people suffering do not seek care, for reasons including not knowing how or where to access services; cultural, language or cost obstacles to accessing services; and stigma. This has been recognised in various academic studies, including a study published in 2020 which concluded that 'Syrian refugees hardly access MHPSS services despite high mental health needs, and despite formally having access to the public mental health system in Turkey'[90].

Interviewees consulted in this evaluation also reported that there were significant unmet needs, and refugees themselves, when asked about suggestions to improve quality of health care services, identified in the surveys for this evaluation need for more MHPSS services (alongside interpreters and reduced dental care costs)[91].

The ET's assessment is that, while provision of services has been good, with targets met in terms of numbers of CMHCs in operation, and numbers of consultations exceeding targets, the unmet MHPSS needs of the Syrian population of refugees, particularly for stress-related disorders, are a complex problem which have not yet been fully addressed through Facility support. This is confirmed by 2020 Facility monitoring data which found that 'gaps persist in the scope and reach of MHPSS services

[87] European Commission. (2020). (November). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of June 2020). Brussels: EU
[88] Correspondence with DG ECHO, July 2020.
[89] Migrants and mental health: Need for and barriers to accessing mental health care among refugees in Turkey: a mixed methods study by Ozge Karadag Caman published in 11th European Public Health Conference: Parallel Programme: p.15.
[90] Fuhr, D.C. et al. (2020). Treatment gap and mental health service use among Syrian refugees in Sultanbeyli, Istanbul: a cross-sectional survey. *Epidemiology and Psychiatric Sciences, 29*, e70, 1–11. https://doi.org/10.1017/S2045796019000660.
[91] Development Analytics. (2020). Online survey health section data set.

provision' and that 'coverage was far less than that required to reach the large number of people in need of mental health services'[92].

It is worth noting that the restricted operational and regulatory environment for NGOs working in Turkey on delivery of services (including health), combined with compliance issues on rules and regulations, has limited NGOs' abilities to address gaps in health services during the period of Tranche I, although the situation has improved more recently and, at the beginning of 2020, there was a positive development where 21 NGOs were granted registration in Turkey[93].

While current availability is important, there is also a concern regarding the sustainability of health care facilities, and a central question of whether MHCs should operate as a parallel system for the long term, or should be integrated into Family Medicine/Health Centres. This decision is contingent upon the future of the Syrian refugee population, and especially on whether they will mostly stay in Turkey or return to Syria if the conditions change significantly for the better. As the conflict in Syria continues, and as Syrians continue to adapt in Turkey and their children are integrated into Turkish schools, it seems increasingly likely that most Syrians will remain in Turkey. This raises questions about the future integration of Syrian health staff into the Turkish health system (also see Section 3.3.3 on social cohesion). A number of interviewees, particularly GoTR interviewees, believe that MHCs should be integrated into Family Medicine/Health Centres[94] stating: 'We are thinking that the MHCs could be transformed into FMCs, and integrated directly'[95]. This is also felt by many interviewees across categories to be an important way to ensure that refugees are not isolated from the rest of Turkish society, as illustrated by this quotation:

> *The efforts should support the Turkish system, not an additional/parallel system … In the long run, if MHCs continue operating, there will be more isolation for Syrian people as MHCs are separate structures. Therefore, they need to be integrated into the existing Turkish primary health care system[96].*

There are indications that this integration has already started and is happening at scale, with 800,000 Syrians registered at Family Medicine/Health Centres along with other non-Syrian migrants in Turkey[97].

b. Secondary health care

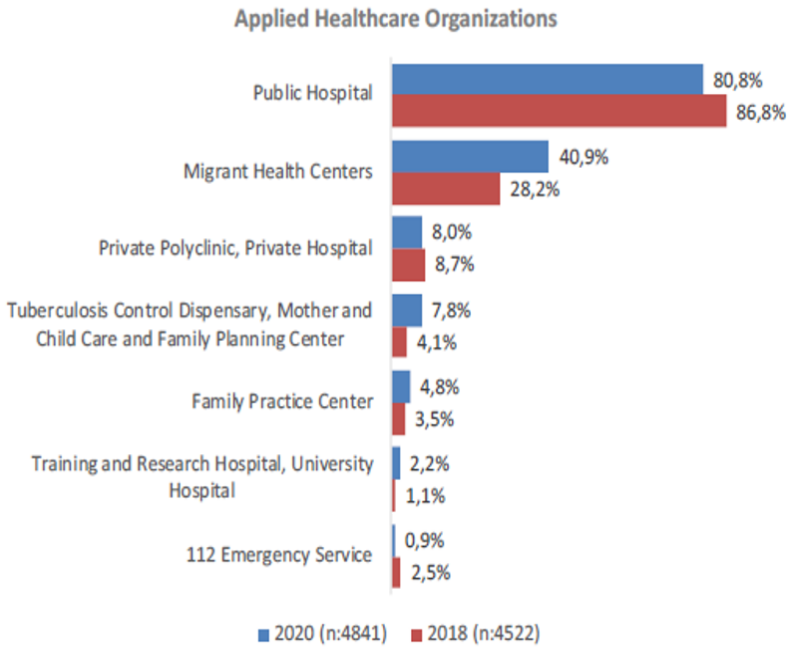
In the 2019 pre-survey conducted through SIHHAT: *Survey for Health Care Needs Analysis of Syrian People under Temporary Protection*, of those Syrians who indicated that they had applied for services at any health care organisation in the last year, 86.8% had applied mostly to public hospitals and 28.2% to Migrant Health Centres[98].

[92] European Commission. (2020). (November). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of June 2020). Brussels: EU: p25.
[93] EC (DG ECHO) clarifications, December 2020.
[94] KIIs H08, H09, H191, H32, H35.
[95] KII H04.
[96] KII H32.
[97] Meeting of Minutes of Steering Committee, SIHHAT, 21 January 2020.
[98] Republic of Turkey, Ministry of Health and SIHHAT. (2019). Pre Survey Study Information Sharing Meeting: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection, MOH SIHHAT/2018/SER/NEG/04, slide 37.

This is likely for a few reasons as identified by interviewees across categories, including the lack of a primary health system in Syria (and hence lack of knowledge and awareness of the Turkish system), the opening hours of service for primary care, and the lack of a formal referral system in Turkey (as a result of which people can access specialists in hospitals without first seeing a primary care physician). A number of interviewees working in MHCs felt that laboratory services should be within the MHC or closer (as laboratory results can sometimes take a few days), which is also a factor encouraging refugees to go to a hospital instead – where it is faster to get results for tests[99]. Those refugees who are not registered or who are out of province may also access hospitals, even if theirs is not a 'true emergency', since they do not have a primary care option.

Encouragingly, more recent survey data[100] indicates that, while applications to public hospitals remain high (80.8%), use of primary health care has risen from 28.2% to 40.9% since 2018, as shown in Figure 4.

Figure 4: Distribution of health care organisations applied in the recent year by Syrian refugees (2020 and 2018)



Source: SIHHAT Surveys for Health Care Needs Analysis of Syrian Population under Temporary Protection, Post Survey, 2020

Nevertheless, Syrians still tend to access secondary health care services for their ailments regardless of the level of seriousness, rather than the (often more appropriate) primary health service. This contributes to long wait times in hospitals, and the perceived inappropriate use of hospital services can increase tensions between the Turkish host community and Syrian refugees[101], as illustrated in a number of interviews with GoTR and MHC staff:

> *There are challenges at hospitals. Local population have difficulties in accessing care due to Syrians. We solved the primary care and now it is time to address secondary level. There are problems in hospitals. This causes the reaction of the people[102].*

> *The lack of a formal referral system in Turkey is also a challenge, as it increases the use of hospitals[103].*

As one solution, the EU has approached the MoH to discuss the possibility of extending MHC opening hours, but the MoH is not certain of the feasibility of this[104] as this would not be consistent with the practice in Family Medicine/Health Centres, which are only open during these limited daytime hours. This is an internal GoTR policy decision to be made.

While a few people believe that a separate secondary health care system for Syrians is needed[105], most interviewees felt that an integrated system would be more appropriate for both primary and secondary/tertiary care. Another option discussed in some interviews, as well as in the WHO report on

[99] KIIs H18, H22.2, H26, H27.1, H38, H40.1.
[100] Republic of Turkey, Ministry of Health and SIHHAT. (2020). *Final Report: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection,* MOH SIHHAT/2018/SER/NEG/04. SIHHAT post survey, p.88.
[101] KIIs H22.2, H22.3.
[102] KII H22.3.
[103] KII H19.1.
[104] Meeting of Minutes of 3rd Steering Committee, SIHHAT, 19 September 2019.
[105] KIIs H12, H24.2, H37.

health care workers[106], is for MHCs to provide increased emergency care (e.g. opening beyond daytime hours) to help fill the gaps in secondary care. This view is illustrated as follows:

> *I would like to see this centre offering even wider services, like emergency services and night shifts for instance … There are unvalued experiences being wasted as Syrian specialist doctors are working as GPs, considering hiring these specialists in their own fields could actually decrease the burden off the hospitals[107].*

Facility support to increase the availability of public hospitals is important in the context of refugees' tendency to access secondary health care as a first option, since it creates a burden on hospitals as explained above. New Facility-supported hospitals in Kilis and Hatay, where there is a high concentration of Syrians, are expected to help increase refugee access to secondary services (as they are being built in locations that have high numbers of refugees), although they will be available to both refugees and the host community. Given the concentration of refugees in these provinces, additional hospital capacity will be helpful to ensure availability of health care services for both the host and Syrian populations and. Once constructed, the two new hospitals will have a capacity for a total of 550 beds[108] although interviewees also explained that the old hospital in Hatay (which has 150 beds) will likely be closed, and so the net increase in capacity of 400 beds will be lower than the target of 550 beds[109].

Construction of both hospitals, even prior to the pandemic, however, has been delayed. Reasons identified by stakeholders interviewed during this evaluation include issues with land (where the building did not fit the land due to planning limitations), changed Turkish seismic codes for buildings, soil issues, differences in rules between the Turkish government and the IFIs[110], and administrative delays[111]. In the latest Facility Monitoring Report available to the evaluation, progress towards their construction was still estimated at 71.4% as of June 2020, showing no further progress since June 2019[112].

The Facility decision to make IFIs responsible for hospital construction has been suggested by some stakeholders as having contributed to the delays[113], and it has also been questioned by the GoTR, which already has extensive experience in infrastructure development. At the same time, however, the preferred modality for the EC for Facility-supported infrastructure projects has been to work in partnership with 'pillar-assessed' entities, such as IFIs, under the 'indirect management' modality, which requires that, when acting as implementing partners, these institutions are assessed according to their capacity to apply certain systems and procedures (such as due diligence, accounting, external audit, data protection) that are equivalent to those applied by the EC, in order to safeguard the financial interests of the EU, in accordance with the EU Financial Regulation (Article 154(4))[114]. Hence, this modality was used, given the large size of the funding for infrastructure and procurement projects.

c. Mobile health care services

Due to challenges with transportation, internal migration, waiting times, language barriers and health literacy, mobile health clinics play a critical role in the health of Syrians in Turkey, particularly for those in rural and remote areas. The Facility is currently providing support through two key programmes, one of which is implemented by UNFPA and providing mobile health and protection services in five provinces; and the other is implemented by Médicins du Monde (MdM) and is providing two mobile health units. The vehicles procured under this grant are to be donated to MoH (or directly to provincial directorates of health) at the end of the UNFPA intervention, with the understanding that the mobile units will continue to be operated by the provincial health authorities. SIHHAT will also provide 102 small cars that include basic equipment for health care, and which will strengthen mobile health services by enabling transportation of health care staff to the field to deliver services[115]. The provision

[106] World Health Organization. (n.d.). Factors Affecting Employability of Trained Syrian Health Care Professionals in Turkey. Ankara: WHO.
[107] KII H27.2.
[108] European Commission. (2019). (November). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of 30 June 2019). Brussels: EU.
[109] KIIs H46, H48.
[110] UK DFID. (2018). The UK's contribution to the Facility for Refugees in Turkey (FRIT): Annual Review (post April 2018). DFID.
[111] KIIs H01, H34, H45.
[112] European Commission. (2019). (November). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (as of 30 June 2019). Brussels: EU.
European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of December 2019). Brussels: EU.
[113] KIIs H05, H48.
[114] European Commission (2018). EU Financial Regulation applicable to the general budget of the Union.
[115] KII H01.

of these cars replaces the additional 26 mobile clinics that were originally planned. These should enable broader service (since there are more vehicles) to reach more beneficiaries. In addition, five mobile screening trucks delivered through the SIHHAT programme currently provide pap smears, colon cancer screening and mammography for refugees[116]. Home care is provided in some areas for elderly patients or those that cannot leave their homes (e.g. people with disabilities)[117].

Administrative procedures within SIHHAT and other delays on the MoH side[118] inhibited progress in delivering SIHHAT-funded mobile health care. A delay in procurement of the 102 small cars with basic equipment for health care means that this component has not yet started[119]. However, the UNFPA[120] and MdM-implemented interventions[121] mentioned above have partly filled this gap.

3.1.4. Contribution considerations

As previously stated, the Facility has significantly increased the availability of health care services beyond the state's own provision. This can be seen through Facility results which, in many cases, show that Facility targets have already been exceeded. Further to this, as discussed below, the ET finds evidence that the Facility contributed to the Turkish health system reaching the required scale to provide for refugees in a shorter time period than would have been achieved in the absence of EU assistance. This has to be contextualised within the wider support that has been provided by the Turkish government since 2011 when GoTR was 'already responding to the refugee crisis at the national, regional and local levels, and its policy decision in 2014 to allow eligible Syrians and other refugees to access health services in the same way as the Turkish population'.

At the time when SIHHAT was launched, the Turkish government had already established and brought into service 86 MHCs in 17 provinces with 175 MHUs[122] which were modelled on FMCs[123]. But one should note that, even now, not all primary health care services are provided to refugees in MHCs through Facility Tranche I funding: as stated in the SIHHAT Steering Committee minutes in January 2020, 800,000 Syrians are registered at Family Medicine/Health Centres together with other non-Syrian migrants in Turkey. These are funded by the GoTR[124].

Thus, providing services free of charge for Syrians is a financial burden on the Turkish health care system[125]. Syrians under temporary protection had also been given access to free medications from contracted pharmacies, at least until the change of legislation in December 2019 which requires refugees to pay the same contributions for their health care (aligning with what Turkish citizens must pay)[126]. As another example, while the Facility paid for the purchase of ambulances, the GoTR will bear the operational costs of these ambulances once they are in use[127].

Before Facility Tranche I funding, other previous and ongoing projects in health for refugees were funded by various agencies including the UN, other donors, INGOs and national NGOs, universities and municipalities[128].

With this in mind, the Facility's contribution to equipping the Turkish health system has been greatest in its support in employing and training Syrian health care staff, and providing additional health care facilities.

i. Employment and training of Syrian health care staff

As mentioned above, national legislation provided the 'legal instrument for employment of Syrian health care staff'[129] and Facility support provided crucial funding to help ensure that Syrian health care workers

[116] KII H33.
[117] KII H04.
[118] SIHHAT. (2020). State of Play – SIHHAT, July 2020; 8th Monthly Management Meeting – SIHHAT Project, 4 November 2019.
[119] Ibid.
[120] FICHOP 2018/01082
[121] Contracting Authority op. cit.
[122] Ibid.
[123] KIIs H01, H04, H09, H19.1, H27.1, H47.
[124] Meeting of Minutes of Steering Committee, SIHHAT. 21 January 2020.
[125] Contracting Authority op. cit.
[126] KIIs H22,2, H22.3.
[127] Contracting Authority op. cit.
[128] Ibid.
[129] KIIs H01; also KIIs H19.1, H20, H42.

could become trained and certified to take advantage of this new legislation. The Turkish government had been providing training to health care workers before the Facility Tranche I funding, although interviewees for this evaluation confirmed that the length and number of the training programmes were not sufficient to improve capacity[130].

Collaboration between the GoTR and the Facility can be seen in the establishment of training centres to train Syrian health care workers in seven provinces. These were noted in a monitoring report to be 'very effective' (although no additional detail is provided on why they are effective)[131]. The Facility provided this key funding for the training of health care workers (a large expense)[132].

The Facility Monitoring Report for the WHO project implemented through the European Union Emergency Trust Fund (EUTF) argued that 'without WHO Action the whole effort of establishing a health care system for SuTPs would not be possible since without adaptation training of the Syrian health staff as well as their continuous training the system would not be efficient and effective'[133].

It is clear that these initiatives were mutually beneficial and created the conditions within which the Facility can claim to have contributed a high proportion of the health care workforce required to serve the additional health care needs of refugees and host communities, through the financing of 3,421 health care workers.

While these achievements are significant, the availability of Syrian health care workers to meet demand needs to be increased further, and particularly where the need is greatest, as evidenced by the daily averages of patients seen by physicians. This evaluation has identified a number of constraints that currently prevent more Syrians from entering the health care workforce, including women and, while these constraints are mostly beyond the control of the Facility, there is an important advocacy role for the EU to play in seeking to influence change (see Section 6 on recommendations).

ii. Increased availability of health care facilities

While MHCs were established by the Turkish government before the Facility support, it has been recognised in a peer reviewed journal article that Tranche I support has 'contributed to the ongoing transformation of Migrant Health Centres both by providing additional resources and by bringing these more closely into the scope of EU practice and regulation'[134].

In particular, a number of interviews confirmed that the Facility has hastened the implementation of health care services, including expansion of Migrant Health Centres, which has improved access for Syrians to health care in their own language (via Syrian health care workers), compared to what the Turkish government could have done without funding[135]. One stakeholder commented:

> *Without SIHHAT, what would have been done? We would still provide all of these services through our public sources. However, would we achieve to reach these numbers? This is a question mark. We could not access the whole population. We would provide these health care services at the same scale, but I am not sure if we would reach the same this number of people we reached with SIHHAT[136].*

[130] Contracting Authority op. cit.
[131] SUMAF. (2019). Key Findings and Some Lessons Learned from Recent Action Monitoring Mission. Ankara: SUMAF. (November 21).
[132] KII H03, H20.
[133] SUMAF. (2019). Monitoring Report: WHO Action – Improved Access to Health Services for Syrian Refugees in Turkey. Qualitative Results Based Monitoring Report for Ongoing Missions. 18 March 2019.
[134] Yıldırım et al. op. cit.
[135] KIIs H04, H09, H19.1, H27.1, H47.
[136] KII H26.

As with availability of human resources, the Facility's contribution in meeting the objective of a sufficiently equipped Turkish health system has been considerable, as can be seen in the increased availability of MHCs and mobile services in particular. However, gaps still remain in achieving this outcome overall. Waiting times indicate that there are still shortages in the overall number of MHCs required to meet primary health care needs, and in secondary health care due to delayed hospital projects, which are exacerbated by their inappropriate use by refugees. The delays to the completion of the construction of the two hospitals are particularly significant, given the amount of resources committed (EUR 90 million), the share of health care funding from the Facility (around 20% of the health portfolio), and the urgency with which the need for additional hospital capacity was presented.

Box 3: A discussion on Facility bureaucracy

This evaluation has found that there is no consensus on the cause of some of the efficiency issues that have resulted in delays to Facility projects. While government interviewees felt that the rigidity of the Facility Tranche I funding mechanism has had a negative impact on availability of health services because the bureaucratic processes have resulted in delay in the availability of personnel, equipment and facilities, this is in a context where there is a need for the Facility to ensure that the EU's financial interests are protected, and comply with the requirements of the 'Financial Regulation'. This requirement applies to all financing mechanisms, to ensure EU funds are properly administered, with targeted controls and audits as well as increased transparency.

As confirmed by a representative of the EU, the MoH decided to choose the 'Practical guide on contract procedures for European Union external action (PRAG)' for the SIHHAT project, which carries with it a number of detailed requirements that must be followed for procurement: 'The MoH chose the PRAG rules for their procurement procedures and therefore must follow these.' While evidence suggests that the process of obtaining justifications and approvals for a contract addendum can cause delays, there are also examples of rapid reorientation of funds, for example in response to the COVID-19 outbreak.

While administrative procedures within SIHHAT and other delays on the MoH side[137] have so far inhibited progress in delivering SIHHAT-funded mobile health care (not yet started due to the delay in procurement of 102 small cars with basic equipment for health care[138]) this is less significant given that other Facility projects (implemented by UNFPA and MdM) have so far managed to fill this gap.

To conclude, although there has been considerable progress in increasing availability during Tranche I, with many targets having been reached or exceeded at the Facility's mid-term, some activities continue to be delayed. Further efforts will also be required to address some of the ongoing barriers to the quality and coverage of the resources and facilities that are available, such as distribution of staffing across different professions to match needs, and tackling language barriers.

iii. Integration of services into the Turkish system

As part of its contribution towards 'sufficiently equipping' the Turkish health system to 'provide quality health care to refugees and host communities in focus provinces', the Facility has been successful in supporting the integration of services into the GoTR's national health care system[139]. This objective of the Facility not only reflects the need for system strengthening, but also indicates an inclusive approach to availability, rather than a dual system. As mentioned above, this integration can already be seen in the registration of 800,000 Syrians in Family Medicine/Health Centres, along with other non-Syrian migrants in Turkey[140] and in the use of secondary health care services.

A similar conclusion was also reached by the evaluation of the EU's humanitarian response to the refugee crisis in Turkey (2019) which noted that, while the Turkish government provided considerable resources, it was unable to immediately ensure service provision at scale, and that Facility funding 'was essential to this successful transformation to a Government delivery model'[141]. Facility support filled

[137] SIHHAT. (2020). State of Play – SIHHAT, July 2020; 8th Monthly Management Meeting – SIHHAT Project, 4 November 2019.
[138] Ibid.
[139] Strategic Interview, 25 November 2019.
[140] Meeting of Minutes of Steering Committee, SIHHAT. 21 January 2020.
[141] Universalia, Landell Mills International Consortium. (2019). Op. cit.

gaps where the government did not provide services (e.g. specialised health services) and provided services to unregistered refugees.

As discussed later in this report, the MHC system is still separate from the Family Medicine/Health Centre system (although the MHC system is managed organically under the FMC, with the same provision standards), and hence full integration has not yet been achieved. The future blending of the two systems will require intermediary support, as explained above.

3.2. **Judgement criteria 9.2:** The Facility has contributed to an increased accessibility of health care services

This JC looks at access to health care for refugees and host communities. ***Accessibility*** has been defined as including: physical access (including the hours of availability of a service), financial affordability (including costs of services but also other costs such as transportation or time off work) and accessible information, for everyone without discrimination. Closely related to accessibility is health care ***acceptability***: if services are effective in terms of serving different populations based on cultural sensitivity, language, gender and age sensitivity and confidentiality[142]. Both accessibility and acceptability are considered under this JC as components of access and improved health seeking behaviours.

3.2.1. 'Increased access to health care for refugees and host communities including improved health seeking behaviours' as an outcome

This intermediate outcome can be defined as whether Facility funding has contributed to increasing accessibility of health care services across different populations (e.g. by sex/gender, age, people with disabilities, non-registered Syrian and non-Syrians, and rural/urban dwellers), and to what extent challenges to access (e.g. language barriers) are addressed. Access includes improved health seeking behaviours.

As for availability, to achieve the outcome of the Turkish health system being accessible for refugees and host communities requires a combined effort from both the Government of Turkey and the Facility, through legislation, such as the 2015 decree which gave SuTPs full access to health services, and through the technical support delivered by the Facility to widen access across different groups. An observable outcome in this regard is illustrated by the fact that, in 2020, CVME data showed that 96% of households with a sick child sought medical treatment and were able to access the Turkish health care system. MoH statistics (shared through reports against the logframe of SIHHAT) also suggest an increase in health care access and health seeking behaviour. AFAD data estimated that 60% of off-camp Syrians applied to a health care institution during 2014 (used as a baseline year) compared to the 2020 SIHHAT post-survey data which found that 82.3% of Syrian women and 66.8% of men had applied during the 12-month period[143].

Targets have been exceeded in terms of immunisations and antenatal care (ANC) suggesting that health seeking behaviour has improved, although cancer screening results are below target. However, access to health care is complex and the question explored in this part of the evaluation focuses on the extent to which the Facility has improved the inclusiveness of access.

The analysis below utilises the most recent Facility results monitoring data, with relevant results data for this JC summarised below.

[142] Evans, David B., Hsu, Justine, and Boerma, Ties. (2013). Universal health coverage and universal access. *Bulletin of the World Health Organization*, 91:546–546A; https://www.who.int/gender-equity-rights/knowledge/AAAQ.pdf?ua=1
[143] Republic of Turkey, Ministry of Health and SIHHAT. (2020). *Final Report: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection,* MOH SIHHAT/2018/SER/NEG/04. SIHHAT post survey, p.88.

Table 8: Summary of extent to which intermediate outcome achieved

Expected outcome (intermediate)	The Turkish health system is **accessible** for refugees and host communities, and across different groups (e.g. by sex/gender, age, people with disabilities, non-registered Syrian and non-Syrians, and rural/urban dwellers). This includes improved health seeking behaviours (e.g. immunisations, prenatal and postnatal care). Challenges to access (e.g. language barriers) are addressed
Observed outcome(s)	The Turkish health system has become more accessible to refugees and host communities, and health seeking behaviour is high, but there remain gaps in the extent to which some vulnerable groups are able to access health care, and there are continuing barriers to access, including language challenges, cultural barriers and low awareness
Facility results contributing to the outcome (based on output-level results as of 31/12/19 – unless otherwise noted)[144]	• In 2020, in 96% of households with a sick child, treatment was sought, and in 88% of the cases, this treatment was sought from a government facility[145] • 3.75m doses of vaccine have been provided to Syrian infants, children and women (no target)[146] • 2.66m ANC consultations (exceeding the target of 2.1m) conducted for over 751,881 women (exceeding the target of 507,500)[147] • The targets for screenings were 180,000 cervical cancer, 95,000 breast cancer, and 99,000 colon cancer screenings[148]. However, these targets are unlikely to be met during Tranche I as by July 2020 only 59,163 cervical cancer screenings, 275,497 colon and 18,492 breast cancer screenings had been completed[149]

3.2.2. Description of Facility interventions aimed at increasing access to health care including improved health seeking behaviours

In addition to those activities already described in JC 9.1 above that consider accessibility, the Facility has delivered the following activities which focus specifically on access and acceptability.

i. Health care worker training to improve accessibility and acceptability of health care

In addition to the training provided under SIHHAT (detailed in Box 2, Section 2.2, above), training is provided through the Facility to improve the accessibility and acceptability of health care for refugees in Turkey. This training is delivered by WHO, through three actions, each a continuation of the previous and based on a partnership with the MoH. These actions have delivered three types of training:

1. **Adaptation training and certification for Syrian doctors and nurses**, making them eligible for a work permit and employment by MoH. The theoretical part of the training covers: clinical supervision, mentoring and competency assessment; health promotion and health education; intervention techniques for abuse and violence; biological, behavioural and environmental studies; pharmacological studies; referral system; counselling, support and communication; health system

[144] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of December 2019). Brussels: EU.
[145] Development Analytics and Landell Mills. (2020). Quantitative Refugee Household Data Analysis Results. Slide Deck. CVME3 and CVME5 data.
[146] 'No target was set for this indicator as the objective is to ensure that a maximum number of Syrian infants are vaccinated': European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (as of December 2019). Brussels: EU. SUMAF (2020), Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities (SIHHAT) (IPA/2016/378-641), Monitoring Report, Mission No: 2, Date: 11 July 2019; MoH, SIHHAT Interim Report II (2019); SIHHAT Logframe Q3 2019; SIHHAT, Project Status Table 30 Apr 2020.
[147] SIHHAT Logframe – 28 December 20 (shared with ET by EUD PM) – including updated targets as per a 2020 contract addendum
[148]Contracting Authority: Delegation of the EU to Turkey Annex I of the Specific Conditions of the grant contract. CRIS IPA 2016/378-641. (Signed 3 September 2019).
[149] SIHHAT. (2020). State of Play – SIHHAT, July 2020.

policies; health needs assessment; health information management; ethics of professional practice and relevant legislation; patients' rights; health policy and health economics; leadership, organisation and all aspects of management; and appreciation of information technology and its application to practice. This is followed by practical training (supervised practice) supervised by Turkish health care workers from MoH, WHO experts and external evaluators. Theoretical training was delivered by projects financed through the Facility's humanitarian channel, and practical training and certification through the more recent action implemented through the EU Trust Fund.

2. **Training on medical terminology for Syrian and Turkish interpreters and bilingual patient guides**; making them eligible for hire by the MoH as health care interpreters. The curriculum for the trainings and implementation of the classroom sessions was developed by experts from Health Science Ankara University, covering a range of areas of the Turkish health system and use of health services, specific medical terminology, communication skills and patient rights and privacy.

3. **Mental health and psychosocial support (MHPSS) training for Turkish and Syrian doctors,** which qualifies them to be hired by MoH to identify, support and refer cases needing mental health or psychosocial support. The training is based on the WHO Mental Health Gap programme (mhGAP). It is a standardised WHO training programme and tool used by primary care professionals to identify, diagnose, treat and refer cases needing mental health and psychosocial support in non-specialist health settings. The mhGAP training manual was translated into Turkish and adopted by the MoH in 2017.

The WHO and MoH have also designed, and continuously update, a **Continuous Medical Education Curriculum** for health care workers providing services to Syrian refugees.

ii. Provision of interpretation services in primary and secondary health care

Bilingual patient guides, some of whom have been trained through the WHO action described above, are employed by SIHHAT. By September 2020, 1,128 BPGs had been hired and were working at both primary and secondary facilities, primarily, but not exclusively, in SIHHAT focus provinces. This intervention is the Facility's most significant attempt at directly improving the acceptability of the Turkish health care system for refugees (primarily Syrians).

iii. Culturally sensitive consultation and referral

The WHO actions described in the training section above also set up and staffed (with interpreters, psychologists, social workers, outreach workers) seven Migrant Health Training Centres (MHTCs), including site preparation and supporting operating costs. These centres have served as training facilities for the practical/clinical training that Syrian health care workers must complete to qualify for a work permit and possible employment by the MoH in MHUs. The centres also provide culturally sensitive primary health care services to the local population, as well as community outreach work targeting and referring vulnerable Syrian families and providing psychosocial support.

By the end of 2019, WHO MHTCs had provided a total of 609,389 primary health consultations to both registered and unregistered Syrian refugees over approximately 2 years (57% to females and 43% to males). In the same time frame, 34,653 in-community consultations (63% female and 37% male) were provided to Syrians by psychologists and social workers in MHTCs[150].

iv. Specific targeting of women, children, and vulnerable groups

The SIHHAT vitamin supplement, vaccination and reproductive health interventions described in Box 2 (Section 2.2) specifically focused on the needs of children and women of reproductive age. A number of other Facility projects (16 projects, EUR 62 million) were funded to provide primary health services in a range of areas, and targeted many vulnerable populations including people with disabilities, women and girls (including those facing sexual and gender-based violence (SGBV)), lesbian, gay, bisexual, transgender, intersex (LGBTI+) persons, and services for unregistered refugees[151].

[150] WHO, Madad QIN Q4 2019 T04.58
[151] Universalia, Landell Mills International Consortium. (2019), op. cit.

A significant measure aiming to improve health care access for women and girls was UNFPA's Women and Girls' Safe Spaces (WGSS) at migrant health care facilities across the country – 25 WGSSs in 17 provinces according to the latest reporting. Through MHUs and health promoters, this action provided:

- **Sexual and reproductive health (SRH) services:** maternal health services (mainly antenatal and postnatal care); family planning counselling and commodities; counselling on women's health issues; provision of information, education and communication (IEC) materials about SRH; SRH outreach activities through health mediators to spread basic SRH messages within community, and identify most vulnerable cases.
- **SGBV prevention and response activities** such as psychosocial support, counselling, awareness-raising and outreach.
- **Advocacy** for integration of SRH services and institutional capacity building[152].

The health mediators are the pillars of the WGSS's success, serving as bridges between their community and the centres, and as role models for other refugee women. These mediators are chosen among refugees who have used the centres' services and formed long-term, trusting relationships with the staff. Their education levels are above average in their community, and they receive additional training on topics relevant to the centres' work.

v. Measures to make health care accessible to hard-to-reach groups

The SIHHAT component covering mobile health services aims to improve the accessibility of health care for rural-based Syrian refugees and harder-to-reach groups. Other Facility interventions, funded in its earlier years, include outreach components and mobile health care services (most notably the MdM and UNFPA actions), as detailed in Annex 1, and above in Section 3.1.

3.2.3. Contextual analysis of Facility interventions

We now present a contextualised analysis of how the support provided through the Facility has sought to ensure the Turkish health system is accessible for refugees and host communities, and across different groups. This includes an examination of the achievements of the Facility, and the strengths of its approach, while also identifying key areas in which Facility support has yet to meet its expected targets, and where further progress is required. The contextual analysis reflects on those external factors that also have an impact on the Facility's contribution.

i. Overall accessibility

A number of regulations and policies have been implemented to increase access to health care and this has largely been successful, with data suggesting that there is high uptake of services across different populations. The decree that gave Syrian refugees full access to health services, and therefore a large contribution to accessibility of health care services, was signed by the GoTR before the commencement of the Facility Tranche I funding, on 25 March 2015[153].

In 2020, in 96% of refugee households treatment was sought for a sick child, and in 88% of the cases, this treatment was sought from a government facility versus other types of services (private, NGOs, unlicensed doctors, pharmacy, or other)[154].

The number of infants immunised and antenatal consultations are all high, which is a positive indicator of accessing health promotion services as well as a demonstration of health seeking behaviour (see section ii below)[155].

In the 2020 SIHHAT post-survey of 4,841 Syrians applying to any health care organisation in the recent year (2020), 82,4% of the 3,226 who applied to state hospitals indicated that they were satisfied or strongly satisfied with the health services provided, compared to 72.4% in 2018; and 78.1% of the

[152] eSINGLE Form For Humanitarian Aid Actions 2017/00842/IR/02/01; HERA. (2019). Evaluation of Women and Girls Safe Spaces (WGSS) Project. Final Evaluation Report. Volume 1 – Main Report. 23 December 2019.
[153] https://dosyasb.saglik.gov.tr/Eklenti/1376,saglik-bakanligi-gecici-koruma-yonergesi-25032015pdf.pdf?0
[154] Development Analytics and Landell Mills. (2020). Quantitative Refugee Household Data Analysis Results. Slide Deck. CVME3 and CVME5 data.
[155] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of December 2019). Brussels: EU.

1,547 who applied to MHCs indicated that they were satisfied or strongly satisfied with the health services provided in 2020, compared to 72.2% in 2018.

In the online survey undertaken as part of this evaluation, 27% of respondents reported that there are health services they would like to, but are unable to access. As explained during follow-up interviews, these services included lack of available interpreters in the hospitals (or interpreters asking to be paid) and some medicines not being covered[156].

When asked about suggestions to improve quality of health care services, surveyed refugees identified the need for more interpreters (alongside reduced costs of dental health care, and more MHPSS services)[157]. The need for more interpreters was also identified in the follow-up telephone interviews[158] and, in the 2020 SIHHAT post-survey, 'language support (interpreter, signboards and signs in Arabic) Arabic-speaking doctors' was the most frequently stated suggestion on how to improve health care services, expressed by (17.3%) of respondents[159].

The importance of accessing health care in one's own language is also evident from interviewees who indicated that Syrian refugees may be inclined to seek care from an informal Syrian physician rather than through other available services. These informal physicians may be actual physicians from Syria or non-physicians (e.g. pharmacists) who have set up a business as an informal physician. Although this is not legal and comes at an out-of-pocket cost for the patient, this means the patient would be treated in their own language. The patients also confirmed that, if services are available for free (e.g. as they are through the MHCs), are in close proximity, and are provided in Arabic, this reduces the use of informal Syrian physicians and would increase their likelihood of seeking services at the MHC[160].

However, despite MHCs being free and services provided in Arabic, some refugees may be hesitant to access MHCs if they would like to seek services outside their province of registration.

A major issue for accessing services is that registered refugees can only access health services in the province where they are registered (except in emergencies or for vaccinations). As the 2019 evaluation of the EU's humanitarian response to the refugee crisis in Turkey found, this has an impact on ensuring full access to services: 'DG ECHO has not been able to ensure full service coverage to a significant portion of the refugee population, which is either unregistered, or registered and living outside its provinces of registration[161].' The section below will outline these challenges in more detail, including among unregistered refugees.

Thus, barriers to access remain for Syrian refugees generally, including transportation[162], language[163] and cultural barriers, and awareness of health care services[164]. As explained by an interviewee for this evaluation:

> *Physical convenience of MHCs is important and being close to where people live is important, especially for vulnerable groups who cannot use taxis, or travel long distance*[165]*.*

Several measures to address these challenges as part of Facility Tranche I have been introduced. The 2018 Needs Assessment report highlights that MHCs constitute a promising model to address the health care service provision gap to refugees at the primary level[166]. The MHC service approach aims to eliminate language and cultural barriers through the recruitment of Syrian health care workers, while also providing them training in order to maintain national and international health care standards. This also improves availability of services, as outlined in JC 9.1.

[156] Development Analytics. (2020). Online survey health section data se; Development Analytics. (2020). Follow-up phone interviews.
[157] Development Analytics. (2020). Online survey health section data set.
[158] Development Analytics. (2020). Follow-up phone interviews.
[159] Republic of Turkey, Ministry of Health and SIHHAT. (2020). *Final Report: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection,* MOH SIHHAT/2018/SER/NEG/04. SIHHAT post survey, p.474.
[160] KII H22.1.
[161] Universalia,Op cit.
[162] KII H01; Strategic Interview, 2 December 2019.
[163] Strategic interview, 2 December 2019.
[164] Universalia, op cit.; KII H31.
[165] KII H01.
[166] UK DFID. (2018). The UK's contribution to the Facility for Refugees in Turkey (FRIT): Annual Review (post April 2018). DFID; EuroPlus and Geotest. (2018). Technical Assistance to the EU Facility for Refugees in Turkey (2017/393359/1): Needs Assessment Report. Final Report 7 August 2018.

Under the Facility, there are also other good implementation examples at the local level to increase accessibility, with the potential to be scaled up in future. One example is the UNFPA-implemented Women and Girls Safe Spaces project which included outreach by health mediators in the community, and has positively impacted access. Unfortunately, because this type of work does not exist in the MoH system, the transition of the WGSS to the MoH did not include the transfer of these health mediators[167].

ii. Health literacy and health seeking behaviours

A survey presented in 2019 showed 25% of Syrian refugees had problematic health literacy, and 27% had inadequate health literacy[168]. As this data is older, it could be that health literacy has improved since then, but further data would be needed to see if improvements have been made and if these gaps still remain. SIHHAT has undertaken activities in health literacy promotion, including trying to increase awareness by Syrians of local services in health[169]. There has been no systematic evaluation of this component to assess if these activities have been successful. However, health literacy remains a challenge for Syrian refugees[170] as identified in reports and interviews, including challenges in taking medications appropriately, understanding vaccinations and reproductive health, and being able to access services including emergency services[171]. SIHHAT field observers note challenges in some E/MHCs in terms of lack of information materials (posters, brochures, videos on TV, reproductive health materials)[172].

The targets for cancer screenings in Facility Tranche I were 180,000 cervical cancer, 95,000 breast cancer, and 99,000 colon cancer screenings[173]. However, these targets are unlikely to be met as, by July 2020, only 59,163 cervical cancer screenings, 275,497 colon (target exceeded) and 18,492 breast cancer screenings had been completed[174], indicating 'low interest' for breast cancer and cervical cancer screenings[175].

There remain gaps between the host population and Syrian refugee women in some areas of reproductive health[176], as well as maternal, new-born and child health. The most recent data available in this regard is from the Turkey Demographic and Health Survey 2018 (TDHS 2018)[177], which unfortunately does not reflect the impact from any Facility funding. However, the data does show that the need and demand for family planning among Syrian women is high and needs to be addressed, and interviewees across categories noted that this remains an issue. There are also differences between the Turkish population and Syrian migrants regarding the social determinants of health (higher fertility rates; higher rates of children; early and forced marriage), and Syrian children have a higher under 5 mortality rate and higher malnutrition rates[178]. Given that these are areas that take time to witness change, they will remain priorities for future EU funding.

The TDHS 2018 also shows relatively good child immunisation coverage for Syrian refugees when compared with the host population children. While there are gaps for specific individual immunisation schemes, the percentage of children aged 24–35 months who have received all basic vaccinations is 72% for Turkish and 64% for Syrians. This gap should be interpreted in the context of a highly mobile refugee population and the difficulty in keeping records and following the immunisation protocols with this moving refugee population. Although this survey data is older, recent monitoring data shows that

[167] HERA. (2019). op. cit.
[168] KfW, WHO. Presentation to the 3rd Joint Steering Committee Meeting. Ankara, 13 November 2019.
[169] European Commission. (2019). (November). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (as of 30 June 2019). Brussels: EU.
[170] Strategic Interview, 25 November 2019.
[171] SUMAF. (2019). Key Findings and Some Lessons Learned from Recent Action Monitoring Mission. Ankara: SUMAF. (21 November); Republic of Turkey, Ministry of Health and SIHHAT. (2019). *Pre Survey Report: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection,* MOH SIHHAT/2018/SER/NEG/04.
[172] SIHHAT. (2019-2020). Field Observers' Monthly Reports. 8 August 2019; 5 September 2019; 5 October 2019; 5 November 2019; 5 December 2019; 5 January 2020; 5 February 2020; 5 March 2020; 5 April 2020.
[173]Contracting Authority: Delegation of the EU to Turkey Anne I of the Specific Conditions of the grant contract. CRIS IPA 2016/378-641. (Signed 3 September 2019).
[174] SIHHAT. (2020). State of Play – SIHHAT, July 2020.
[175] SIHHAT Project 13th Monthly Management Meeting, 14/07/2020.
[176] Çöl, M., Bilgili Aykut, N., Usturalı Mut, A.N., Koçak, C., Uzun, S. U., Akın, A., ... Kobeissi, L. (2020). Sexual and reproductive health of Syrian refugee women in Turkey: a scoping review within the framework of the MISP objectives. *Reproductive Health, 17*(1), 99. doi:10.1186/s12978-020-00948-1
[177] Hacettepe University Institute of Population Studies. (2019). *2018 Turkey Demographic and Health Survey Syrian Migrant Sample.* Hacettepe University Institute of Population Studies, T.R. Presidency of Turkey Directorate of Strategy and Budget and TÜBİTAK, Ankara, Turkey.
[178] Ibid.

the Facility has provided over 3.75m vaccine doses to Syrian infants[179]. Interviewees also noted that Facility support has helped to increase immunisation activities[180].

TDHS 2018 data[181] (while older) also shows high performance in the availability and coverage for ANC, which is only slightly lower for Syrian refugees when compared with the host community data. The gap between non-camp and camp settings is also not significant. The ANC findings of the TDHS 2018 indicate that these health care services are provided to the refugee population in an equitable way. Data on the latest Facility results for ANC coverage indicates that work continues on a positive trajectory. However, more than one antenatal visit is recommended – WHO recommending eight ANC consultations per pregnancy[182] (although in Turkey the target is four). Antenatal visits are also critical opportunities to provide refugees with health promotion and prevention messaging, as well as screening and diagnosis[183].

iii. Accessibility of health services for refugee and host community members

The GoTR improved regulations and protocols between 2011 and 2016 to ensure Syrians have equal rights (compared to the host) in terms of health access at the primary and secondary levels, and access to free medication (the latter which has now changed as a result of December 2019 legislation, as outlined in Section 2.1)[184].

While it is not clear from documentary sources, key informants interviewed for this evaluation explained which services are available to different parts of the population. Syrians can use the online appointment system (although it is in Turkish)[185]. Community Mental Health Centres serve both Syrians and the host community[186]. Migrant Health Centres are for Syrian and non-Syrian refugees. The mobile screening trucks are only for Syrian refugees[187] but cancer screening clinics are free for Turkish people too[188]. Syrians can access Family Medicine/Health Centres (funded by the GoTR) if they choose. Syrians use the 112 emergency line[189]. In addition, Syrians did not have to make a co-payment for medications whereas Turkish citizens did, until the December 2019 legislation changed this[190].

For those refugees who are unregistered, or seeking services outside their province of registration, access is not possible except for emergencies or for vaccinations, which is a major barrier to free health care[191]. While emergency care is critical (and is offered to unregistered refugees), accessing health prevention and protection services (e.g. ANC clinics) is critical for long-term health. The section below will outline these challenges in more detail.

iv. Accessibility of health services for non-registered Syrian and non-Syrian refugees

Limited quantitative disaggregated data (e.g. by health service) is available for non-Syrians or unregistered Syrians, rendering it difficult to compare with groups in order to assess inequities.

However, there are challenges that are specific to these groups. For example, without a 'refugee ID' (*kimlik*) card, unregistered Syrians have limited access to health care services except emergency services and vaccines[192]. Evidence from CVME5 does, however, suggest that most unregistered

[179] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of December 2019). Brussels: EU.
[180] KII H26.
[181] Hacettepe University Institute of Population Studies. (2019). *2018 Turkey Demographic and Health Survey Syrian Migrant Sample.* Hacettepe University Institute of Population Studies, T.R. Presidency of Turkey Directorate of Strategy and Budget and TÜBİTAK, Ankara, Turkey.
[182] World Health Organization. (2018). WHO recommendation on antenatal care contact schedules. https://extranet.who.int/rhl/topics/improving-health-system-performance/who-recommendation-antenatal-care-contact-schedules
[183] UK DFID. (2018). The UK's contribution to the Facility for Refugees in Turkey (FRIT): Annual Review (post April 2018). DFID.
[184] EuroPlus and Geotest. (2018). Technical Assistance to the EU Facility for Refugees in Turkey (2017/393359/1): Needs Assessment Report. Final Report 7 August 2018.
[185] KII H07.
[186] KIIs H26, H42, H43.1.
[187] KIIs H27.1, H33.
[188] KII H29.
[189] KII H20.
[190] KII H26.
[191] Universalia, op. cit; Akyol-Faria, Özge. (2019). *SIHHAT Mission Report.* Mardin, 11/02/2019 to 12/02/2019. Ref. Ares(2019)924032 – 15/02/2019.
[192] Republic of Turkey, Ministry of Health and SIHHAT. (2019). Pre-Survey Study Information Sharing Meeting: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection, MOH SIHHAT/2018/SER/NEG/04, slide 11.
EuroPlus and Geotest. (2018). Technical Assistance to the EU Facility for Refugees in Turkey (2017/393359/1): Needs Assessment Report. Final Report 7 August 2018; Universalia, op cit.; KIIs H12, H21.

Syrians do still access health care (more than education services), with a likely explanation being that unregistered refugees use emergency services to meet needs that should be met by primary health care services. Unregistered Syrians cannot access their data on the electronic health care record system that collects individual-level patient data (*e-Nabiz*). As explained by one key informant[193]:

> *When SuTPs are not registered, and hopefully unregistered numbers are low now, they are served for emergency situation with medical ethics purposes and doctors' oath, but this led to a lot of complications including how to manage these expenses. The number of registered SuTPs is getting higher and complications are going down. Even if they are not registered, if it is an emergency, if it is diagnosed with a public health threat, vaccinations are free of charge. In principle the government and EU are very generous to minimise complications*[194]*.*

Unregistered patients are referred to DGMM (and in one case, it was mentioned they are reported to the police)[195].

Non-Syrians and unregistered people are more vulnerable and face greater access challenges, including changes in their rights. A change in the law in 2019 means that non-Syrians have to start paying social security insurance after one year, or they will be excluded from health services. According to the relevant legislation, 'By operation of law, general health insurance of the applicants or the beneficiaries of international protection over 18 who have been staying for more than one year beginning from the date of registration is cancelled'[196]. This was expressed as a concern in both health sector interviews[197], and protection sector interviews conducted for this evaluation.

Non-Syrians who are registered but whose status has not yet been decided, i.e. those who have been issued with a Temporary Protection ID card, are able to access the normal range of health services while their asylum application is being processed. However, non-Syrians who intend to register and/or who have received an appointment to register, but who have not yet been registered because of the registration backlog, are not able to receive health services. During the period between obtaining an appointment and getting their first registration interview, non-Syrians are treated as 'unregistered irregular migrants' and cannot receive the health services provided to registered refugees (except emergency services), even though they are recorded in DGMM's appointment database as having requested government protection[198]. The evaluation of the EU's humanitarian response to the refugee crisis in Turkey (2019) noted that there are a 'significant number' (between 250,000 and 300,000) of unregistered refugees who may not be reached by existing measures[199].

While some interviewees said non-Syrians can access MHCs[200], others said the MHCs are only for Syrians or people under temporary protection[201]. Hence, there is lack of clarity among even the staff at these facilities, as well as government staff. Preventive services are a challenge for non-Syrians, yet non-Syrian refugees with an ID number can access mobile screening trucks[202].

v. Accessibility of health services across gender groups

Both male and female Syrians seek care in public hospitals and Migrant Health Centres. According to the SIHHAT post-survey, in 2020 women were more likely to access any health care organisation (81.5%) than men (66.6%)[203] and women also have higher percentages applying to MHCs and FMCs.

Data from the same survey also shows a significant increase in the numbers of women applying to MHCs between 2018 and 2020 (increase from 30.5% to 45.6%) and FMCs (4.1% to 8.0%) while the

[193] KII H07. E-Nabiz is a cloud-based system collecting individual-level patient data from private and public providers, mobile devices and the internet.
[194] KII H01.
[195] KIIs H30, H36.1, H46.
[196] Republic of Turkey, Ministry of Interior. (2020). *On General Health Insurance of the Foreigners who are the Beneficiaries of International Protection.* (Referring to third paragraph of the 89th article titled 'Access to Assistance and Services' of the Law 6458 on Foreigners and International Protection dated 04.04.2013 has been changed according to the Law published on Official Gazette numbered 30988 on 24/12/2019). https://en.goc.gov.tr/on-general-health-insurance-of-the-foreigners-who-are-the-beneficiaries-of-international-protection--
[197] KII H11.
[198] Republic of Turkey, Ministry of Interior. (2020). op. cit.
[199] Universalia, op cit.
[200] KIIs 17, H19.1, H19.2, H24.2.
[201] KIIs H04, H24.1.
[202] KII H32.
[203] Republic of Turkey, Ministry of Health and SIHHAT. (2020). *Final Report: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection,* MOH SIHHAT/2018/SER/NEG/04. SIHHAT post survey, p.426.

proportion of men applying to MHCs and FMCs in 2020 showed no statistical difference compared to 2018, remaining far lower than for women, at 28% in 2020 (MHCs) and 2.6% in 2020 (FMCs)[204]. These trends were confirmed in interviews, where interviewees said that it is mostly women who come to the MHCs, and mostly it is women who bring their children to the MHCs[205].

MHCs and FMCs are open only during working hours[206], which may make it difficult for men who are working to attend[207]:

> *Men are very few. There are still patients whose husbands we do not know. The woman brings her child maybe 100 times, but they cannot bring their husbands here. When we ask, they say their boss would not allow them to come. They want us to prescribe medicine for their husbands. When we say they should come, they say their husbands go to work*[208]*.*

In addition, there is a stigma for accessing MHPSS assistance, especially for men[209]. Hence, a gap remains in ensuring that men access health services. Men may also be less likely to attend given the focus of E/MHCs on mother and child health[210].

From a gender analysis point of view, women face more issues overall in health care related to the determinants of health (influencing their health), and female refugees have multiple intersectional vulnerabilities in Turkey[211]. Women face discrimination (including in employment); higher health risks during pregnancy; lack of access to family planning resulting in high numbers of children; lack of education; lack of control over their own resources; child labour; child, early and forced marriage (CEFM); lack of access to services focused on sexual and reproductive health; and gender-based violence[212].

LGBTI+ populations around the world are more likely to have poorer health in a number of areas, including mental health. In terms of reaching this vulnerable population, some work has been done through the Facility to provide protection services via UNFPA and NGOs. UNFPA has seven LGBTI+ centres in Turkey with staff who are trained to work in ways that respect privacy and discretion.

However, with the transition of funding to the GoTR in the future, there is a risk that these vulnerable populations will not continue to be adequately served, as they need specific services from people who are trained, who are sensitive to the needs of LGBTI+ (and will not be discriminatory), and who can provide services with privacy and discretion[213]. GoTR services do not target LGBTI+ and research shows that LGBTI+ populations in Turkey are less likely to seek health care services at Family Medicine/Health Centres[214]. As one health interviewee explained: 'There should be specific services for these people'[215]. Issues remain for health access for LGBTI+ populations given their marginalisation, and they may be referred elsewhere or refused health care[216]. These challenges experienced by LGBTI+ refugees remain an equity concern for health under Facility Tranche I[217].

[204] Republic of Turkey, Ministry of Health and SIHHAT. (2020). *Final Report: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection*, MOH SIHHAT/2018/SER/NEG/04. SIHHAT post survey, p.430.
Republic of Turkey, Ministry of Health and SIHHAT. (2019). *Pre Survey Report: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection,* Individual Health. MOH SIHHAT/2018/SER/NEG/04, pp.72&75.
[205] KIIs H19.1, H21, H28.1.
[206] KIIs H28.1, H30.
[207] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (as of December 2019). Brussels: EU.
[208] KII H25.
[209] KII H30.
[210] KII H47.
[211] Duran, Nihan. (2018). Dual discrimination of Syrian Refugee Women in the labour markets in Europe and Turkey: Identifying the Challenges. Istanbul University Press. Volume 75, pp.43–67; TPQ. (2019). Syrian refugee women and girls in Turkey and the Istanbul Convention; June 27, 2019. http://turkishpolicy.com/article/959/syrian-refugee-women-and-girls-in-turkey-the-istanbul-convention
[212] Çöl, M. et al. (2020). Sexual and reproductive health of Syrian refugee women in Turkey: a scoping review within the framework of the MISP objectives. *Reproductive Health, 17*(1), 99. doi:10.1186/s12978-020-00948-1.
[213] KII H50.
[214] Toraman, U. and Kundakci, A. (2018). Health Care Utilization, Barriers to Care among Lesbian, Gay, Bisexual and Transgender Persons in Turkey. *International Journal of Caring Sciences,* May–August. This study was not focused on refugees specifically, but identifies the challenges that are faced.
[215] KII H30.
[216] EuroPlus and Geotest. (2018). Technical Assistance to the EU Facility for Refugees in Turkey (2017/393359/1): Needs Assessment Report. Final Report 7 August 2018, p.88.
[217] Ozturk, Serap. (2019). Assistance to the Delegation of the European Union on FRIT II Health Sector Programming. Final Project Report. Contract no: 2018/ 404–633. 29 July.

Disaggregation of data for LGBTI+ populations is a necessary pre-requisite to understand gaps and to see if programmes are filling these gaps[218], but unfortunately, disaggregated data is not available for these groups. Nevertheless, it is clear from this evaluation that Facility support delivered through NGOs and UN partners who are familiar with providing these types of services has been valuable, and that continuing this support will be vital in helping to continue addressing these gaps in services for LGBTI+ populations[219].

vi. Accessibility of health services for people with disabilities

A number of Facility-supported interventions implemented by Relief International (RI), International Medical Corps (IMC), Handicap International/Humanity and Inclusion (HI) and Médecins du Monde work to increase access to appropriate services by disabled refugees, and to provide physiotherapy services. The 2019 evaluation of the EU's humanitarian response to the refugee crisis in Turkey found that there were 'significant efforts to address the special challenges of disability by emphasising war wounded and MHPSS in their INGO health programmes'[220].

Home care and mobile care (discussed in the section above) are identified in some areas as a way to reach people with disabilities[221]. Stakeholders confirmed that people with disabilities are prioritised when attending MHCs and hospitals[222].

There are, however, still unmet needs (e.g. given the specific nature of the needs of the Syrian population including disabilities from war[223]) and challenges for this group, including their ability to access financial disability benefits. The challenges in getting a medical report for a disability was mentioned in documentation[224] and was a key factor inhibiting access to the financial benefits.

More than half (57%) of people reporting to have a disability in the online survey conducted for this evaluation said they had challenges accessing health services because of their disability[225]. A number of interviewees mentioned that more work could be done to ensure physical access for people with disabilities (e.g. in MHCs)[226]. Any work that has been done largely focuses on building design (e.g. washroom accessibility, handrails, ramps, braille signs)[227]. While there are protocols to ensure access to MHCs, for example, not all buildings are accessible, as was observed in the field. One of the reasons is that the MoH uses existing residential buildings within the provinces for MHCs, in order situate MHCs close to where Syrians live. Some of these buildings do not have a layout that is conducive to access for people with disabilities. For the WGSS, the final evaluation report noted that '60% of the centres were accessible for girls and women with disabilities'[228].

Often refugees experience several access gaps at the same time. As one key informant explained:

> *There is a huge gap in terms of access to services for vulnerable groups. There is a challenge to get the disability report, for instance. The situation of disabled people, even for Turkish citizens, the situation is not bright. Getting an assist device is also very difficult. It is not a budget but bureaucratic issue. This is not even easy for a Turkish citizen*[229]*.*

Work on ensuring access has focused largely on physical access for those with physical disabilities typically as a result of war injuries: 'Disability concept is mostly thought as post war scars and mostly is related with physical disability'[230]. However, research shows that, globally, there is a lack of specialised services for people with disabilities[231]. This was confirmed in interviews, along with the challenge of discrimination and the need in particular to work on reproductive services for people with disabilities:

[218] KII H02.
[219] KII H47.
[220] Universalia, op cit.
[221] KIIs H04, H12, H47.
[222] KIIs H19.1, H20.
[223] Strategic interview, 2 December 2019.
[224] Cloeters, G. and Osseiran, S. (2019). Health care Access for Syrian Refugees in Istanbul – A gender sensitive perspective. Istanbul, Turkey: Istanbul Policy Center.
[225] Development Analytics. (2020). Online survey health section data set.
[226] KIIs H01, H10, H17, H50.
[227] KIIs H01, H06, 19.1, H22.3, H27.1, H36.1, H38, H45, H48.
[228] HERA. (2019). op. cit.
[229] KII H17.
[230] KII H01.
[231] Particip. (2020). External Monitoring and Evaluation for the European Union Regional Trust Fund in response to the Syrian Crisis, the 'Madad Fund' Evaluation of Madad-funded Programmes/Projects for Health: Evaluation Report. EUROPEAID/138782/DH/SER/MULTI

Service providers do not have skills to provide reproductive health service for people with disabilities. There is a skills gap and discrimination as well[232].

As for LGBTI+ groups, there is also a lack of quantitative disaggregated data available on access for people with disabilities to understand where additional gaps may remain, as data on disabilities is not systematically collected and reported on across health services.

vii. Accessibility of health services across age groups

Disaggregated data shows that all age groups are receiving services, and there is no indication that any particular age group has an obvious gap in services. There is a focus at MHCs on women of reproductive age and their children which is not surprising given these groups make up a large portion of the population[233]. Particular gaps for children include exposure to work accidents, lack of vaccine follow-up[234], and the increased health risks of early pregnancy as a result of early marriage.

viii. Accessibility of health services for rural and urban areas

There is a lack of disaggregated data on rural and remote populations' access to health care, which is concerning since health services are better in urban than in rural areas: 'In cities, patients get better treatment'[235]. Challenges include transport costs and lack of access generally in rural areas'[236].

Mobile clinics are one response to this challenge[237]: 'In rural areas, we have mobile health care service units to provide services and they can benefit from these too'[238]. However, as explained elsewhere in this report, the procurement of mobile units by SIHHAT has not yet been completed and hence mobile health care will only improve later, when these services come on-stream.

ix. Addressing barriers to access

a. Physical access

As explained under JC 9.1, there are still limitations to ensuring adequate access outside clinic opening hours, as MHCs are only open on weekdays and during the daytime. EU staff have asked the MoH to consider modifying clinic hours, but this remains an MoH policy decision. There are also still challenges with physical access to MHCs (due to disability), as described above.

b. Discrimination

There are reported challenges of discrimination towards Syrians when receiving care in hospitals, including being insulted for having large numbers of children when attending hospital for delivery. One key informant observed as follows:

The services are not that good at hospitals because of the language barrier. Not to forget the discrimination they have to go through. Some doctors can be quite rude to Syrian patients at hospitals. Here (at MHCs), on the other hand, we speak the same language, offer psychosocial support to our patients by listening to their problems and understanding their suffering. Patients feel more comfortable coming here maybe because they feel our sympathy[239].

This was also confirmed in other documentation[240] as well as in the interviews and in the survey conducted for this evaluation, where 32% of respondents reported that they had faced discrimination or poor treatment when accessing health care[241].

[232] KII H09.
[233] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of December 2019). Brussels: EU.
[234] Ozturk, Serap. (2019). op cit.
[235] KII H01.
[236] EuroPlus and Geotest. (2018). Technical Assistance to the EU Facility for Refugees in Turkey (2017/393359/1): Needs Assessment Report. Final Report 7 August 2018, p.99, 101; KII H01; Strategic Interview, 2 December 2019.
[237] Ozturk, Serap. (2019). op cit.; KIIs H26, H33, H47.
[238] KII H04.
[239] KII H24.2.
[240] SUMAF. (2019). Monitoring Report: WHO Action – Improved Access to Health Services for Syrian Refugees in Turkey. Qualitative Results Based Monitoring Report for Ongoing Missions. 18 March 2019.
[241] Development Analytics. (2020). Online survey health section data se; Development Analytics. (2020). Follow-up phone interviews.

The challenge of social cohesion is important as it relates to health care and refugees. As research has shown, 'social and cultural barriers to integration … acculturation stress, exclusion and discrimination are additional factors that impact the health of refugees and migrants'[242].

While not an issue extensively covered in academic articles focused on health care services in Turkey per se, integration of Syrians is critical for social cohesion and this requires a vision for this integration as well as increased capacity for services (including health services)[243]. However, maintaining separate systems for primary care for refugees (MHCs) can challenge the integration of Syrians into Turkish systems. In the long run, integration of health care for the host population and refugee population will be critical for social cohesion, as outlined in Section 3.2.1.

There are some perceptions (identified across interviewee categories as a challenge) among the Turkish host population that the Syrian refugees are getting better access to service and better treatment than the host population, including home care:

> *There are some health care services that we may even not provide to our own citizens but we provide to Syrians, like home care services … We do not have separate rules for Syrians versus Turkish communities. We do not differentiate between people in terms of accessing health services we do not have that luxury. The dispensaries and centres are focused on tuberculosis and serve all people. These units do not have any budget from FRIT [the Facility for refugees in Turkey]. We provide all services by GoTR*[244]*.*

This perception was also identified in the *Syrian Barometer* study in 2019, which reflected the perception that Syrian refugees add an economic burden (including through their use of health care services), and beliefs that Syrian refugees bring diseases to Turkey that had been previously eradicated[245]. Such perceptions are also reported in the Education Sector Report for this evaluation. One (academic) interviewee mentioned that they had heard that Syrians get priority access at hospitals. However, GoTR staff confirmed that this is not the case[246], explaining instead that, sometimes, due to the lack of available interpreters, Syrians may be seen quicker at a hospital if they need an interpreter, as the interpreter will be found and then the patient brought to the front of the line so the interpreter does not have to wait with the patient and can be more efficient in their work[247].

c. Language barriers

Some of the language barriers have been addressed by hiring Syrian health care workers at MHCs to provide services that are 'culturally and linguistically friendly'[248], and through hiring of BPGs who are deployed in state hospital information desks, in Facility-funded CMHCs and in MHCs[249]. The inclusion of BPGs increases demand for services and improves the care by improving communication between the provider and the patient[250].

As also mentioned in the 'availability' section of this report (see Section 3.2.1), while the recruitment of BPGs has exceeded targets, there are still only around 39 BPGs per province, across all facilities, and a range of data sources consulted for this evaluation confirm that, given the demand, there is still a shortage of BPGs and interpreters at the hospitals. This shortage presents a further challenge to people's access to health services[251].

[242] WHO. (2018). Health promotion for improved refugee and migrant health. Copenhagen: WHO Regional Office for Europe; (Technical guidance on refugee and migrant health).
[243] Erdogan, Prof Dr M. Murat. (2019). Syrians Barometer 2019. A Framework for Achieving Social Cohesion with Syrians in Turkey.
[244] KII H04.
[245] Erdogan, Prof Dr M. Murat. (2019). op. cit.
[246] KIIs H19.1, H25.
[247] KII H46.
[248] KII H03.
[249] EuroPlus and Geotest. (2018). Technical Assistance to the EU Facility for Refugees in Turkey (2017/393359/1): Needs Assessment Report. Final Report 7 August 2018.
[250] Şimşek, Zeynep. (2016). *Syrian Families under Temporary Protection: Health Improvement Program Monitoring and Evaluation Report.* [Geçici Koruma Altındaki Suriyeli Ailelerin Sağlığını Geliştirme Programı İzleme ve Değerlendirme Raporu]. Şanlıurfa, March.
[251] Akyol-Faria, Özge. (2019). *SIHHAT Mission Report.* Mardin, 11/02/2019 to 12/02/2019. Ref. Ares(2019)924032 – 15 February 2019; KIIs H12, H22.1, H26, H41.1, H44.

The extent to which language remains a barrier[252], adversely affecting Syrian refugees' access to health care and their MHPSS needs[253], can be seen in data from the MoH pre- and post-survey data – where difficulties in accessing health care services were expressed by Syrian respondents. In both surveys, 'language problems/interpreter problems' were the most frequently cited difficulty (48.7% in 2018 and 47.8% in 2020)[254].

Some services such as MHPSS, physiotherapy, and SGBV are harder for refugees to access due to language:

> *Psychiatric interviews should be conducted in [a person's] native language. When the translator translates what the patient says, some meaning is lost in translation*[255]*.*

The language barrier in accessing MHPSS services may not be as easy to overcome given the inability for Arabic speakers (e.g. Syrian health care workers) to be employed in these professions (as explained in the 'availability' section 3.1 of this report). Services provided by Arabic-speaking psychologists and psychiatrists may be most effective to ensure people are receiving adequate care, and are able to express themselves. The need to be able to speak in one's own language (Arabic) for a higher quality of MHPSS care has also been emphasised during the field interviews:

> *It takes time for Syrians to talk. They cannot open themselves up in Turkish even if they have their courses in Turkish. Your native language is important to express yourself. Psychology and psychiatry are about talking and expressing oneself*[256]*.*

d. Affordability

For reasons explained above (see Section 2.1), affordability for Syrian refugees is less of an issue (co-payment on medications only) than for international protection applicants, for whom affordability is increasingly becoming an issue.

3.2.4. Summary of contribution considerations

Overall access to health services is undeniably high, and the Facility is able to demonstrate considerable achievements as a result of Tranche I funding to improve health seeking behaviours such as antenatal care visits and immunisations (which have both exceeded their targets). The vast majority of children and adults who needed care were able to access it, which indicates that the gap in accessibility is limited. This was also the conclusion of the evaluation of the EU's humanitarian response to the refugee crisis in Turkey (2019), which stated that 'it can be reasonably assumed that most of the registered refugee population of close to 4m has access to some…health services'.

As also concluded by that evaluation, the remarkable achievements should be considered a joint success between the Government of Turkey and the Facility[257]. The evaluation of both the humanitarian and non-humanitarian aspects of the Facility can agree with these conclusions to a point. The evaluation recognises both the critical role that the Turkish government has played in improving accessibility through legislation that opened up the health care system to Syrian refugees; and Facility support which included a wide range of interventions specifically designed to improve health awareness and tackle inequalities in access. Examples are described in this report, and include specialist services targeting LGBTI+ and persons with disabilities (especially through physical access); and removing language barriers, for example through providing BPGs, which also improves the acceptability of services. There are, however, still many challenges that need to be addressed in these areas to bring them to required scale, as described above.

The Facility's ability to successfully tackle barriers is sometimes limited to an advocacy role, for example in promoting the need for more BPGs, or continuing to advocate for extending opening hours

[252] Development Analytics. (2020). Online survey health section data se; Development Analytics. (2020). Follow-up phone interviews.
[253] EuroPlus and Geotest. (2018). Technical Assistance to the EU Facility for Refugees in Turkey (2017/393359/1): Needs Assessment Report. Final Report 7 August 2018; Bilecen, B. & Yurtseven, D. (2018). Temporarily protected Syrians' access to the health care system in Turkey: Changing policies and remaining challenges. *Migration Letters, 15*(1), 113–24.
[254] Republic of Turkey, Ministry of Health and SIHHAT. (2020). *Final Report: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection*, MOH SIHHAT/2018/SER/NEG/04. SIHHAT post-survey, p.444.
[255] KII H43.1.
[256] KII H28.
[257] Universalia, op cit.

to increase both availability (as discussed under JC 9.1) and access. The Facility also operates in a context within which there are inevitable social tensions between host and refugee populations that can lead to discrimination and a lack of social cohesion, which are also factors that can impact on its ability to ensure equitable coverage across all groups.

However, by far the most significant issue in terms of access relates to the most vulnerable members of the population, for whom there are currently considerable gaps in service and for whom barriers such as affordability/registration status are likely to present the greatest challenge. Syrians who reside outside of their province of registration (a large number or people) have limited access to health care services in accordance with Turkish law. This is also the case for unregistered Syrians (assumed to be a much smaller number). Non-Syrian refugees (those under international protection) also face significant, and possibly increasing legal barriers, to health care access, based on insurance and subsequent affordability rather than location of residence. These issues, although outside of the direct control of the Facility, are critical and significant gaps that will need to be jointly addressed.

3.3. **Judgement criteria 9.3:** The Facility has contributed to an increased demand for health care services

This JC looks at the increase in demand for health services. The intermediate outcome can be defined as the increased use of health services, including primary care services accessed, and the appropriateness of use of secondary services. Demand for psychosocial services is also discussed.

3.3.1. 'Increased demand for and use of health services' as an outcome

To truly measure 'demand' for health care services, data is needed on the daily number of requests that patients make for appointments (e.g. in E/MHCs). This could then be measured against supply, and then any gap could be better understood. This data is not available as the Turkish government does not have a formal referral system or appointment system. Hence, demand will be measured by awareness of refugees about their right to access health care as well as the number of consultations over time (primary health care) via use of services, and the number of refugees who received MHPSS services, and specialised treatment in post-operative and rehabilitative care. In both these cases, the intermediate outcome of increased demand can be clearly observed, as evidenced through the Facility-level results summarised below.

Some suggestions and indications of increased use and demand for health services among Syrian refugees can be observed in the data reported by the MoH against targets set out within the SIHHAT action. The 'total number of primary health care consultations' is reported cumulatively across the four or more years of the project, and is thus difficult to interpret as increased use year-on-year, particularly when the additional complication of population increase is considered. However, the numbers of Syrian patients attending E/MHCs across target provinces in each year of the project does appear to be increasing significantly from 987,723 in 2017, to 1,143,101 in 2018, to 1,499,091 in 2019 and to 1,055,752 by September 2020 (up to Q3 only, and amid a pandemic)[258].

This part of the evaluation, therefore, focuses on the extent to which the Facility has increased demand through its awareness-raising activities, and focuses particularly on its provision of MHPSS which is a key area of support through the Facility, as shown by its achievements in delivering MHPSS to refugees.

[258] SIHHAT Logframe (December 2020) shared with evaluation team in January 2021.

Table 9: Summary of extent to which intermediate outcome achieved

Expected outcome (intermediate)	Increased demand for and use of health services by refugees
Observed outcome(s)	Demand for and use of health services by refugees has increased
Facility results contributing to the outcome (based on output-level results as of 31/12/19 – unless otherwise noted) [259]	Indicators of increased demand • 13.5m primary health care consultations have been provided to refugees, exceeding the updated target of 11m by January 2021[260] with 78.1% level of satisfaction[261]. • 49.6m secondary health care consultations have been provided to Syrian patients by 2020[262] with 82.4% level of satisfaction[263]. • 630,633 refugees have received Level 3 MHPSS services, greatly exceeding the target of 278,960[264]. The definition for this indicator is cumulative, the definition has changed, double counting is likely an issue, and this possibly includes large numbers of beneficiaries of general group counselling[265]. *It was difficult to get additional information on the context of this number in the field from the qualitative interviews, so the ET could not unpack this data to understand more accurately what services are being offered, and to help assess where gaps remain.* • By June 2020, 25,487 refugees have received specialised treatment in the area of post-operative and rehabilitative care, exceeding the target of 24,930[266].

3.3.2. Description of Facility interventions aimed at supporting increased use of health services

The activities already identified in JCs 9.1 and 9.2 indirectly aim to increase demand for, and use of, health care services, by visibly increasing availability, accessibility and acceptability by building trust in the health care system. However, the Facility's health portfolio also includes a few, relatively small, activities which specifically focus on increasing health literacy and demand for health care services in order to promote increased use.

i. Awareness-raising activities

The regional Danish Red Cross action – *Addressing Vulnerabilities of Refugees and Host Communities in Five Countries Affected by the Syria Crisis* – includes a health education component. Through the TRC community centres it supports, the action has delivered health education events covering targeted messages to women and children, family health, adolescent health, hygiene promotion, healthy lifestyles and community health. By December 2019 67,121 Syrians and host community members had attended such events, and 8,058 had then referred to an available health service[267]. Several other

[259] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of December 2019). Brussels: EU.
[260] SIHHAT Logframe (December 2020), shared with ET in January 2021.
[261] Republic of Turkey, Ministry of Health and SIHHAT. (2020). *Final Report: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection*, MOH SIHHAT/2018/SER/NEG/04. SIHHAT post survey, p.99.
[262] SIHHAT Logframe (December 2020), shared with ET in January 2021.
[263] Republic of Turkey, Ministry of Health and SIHHAT. (2020). *Final Report: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection*, MOH SIHHAT/2018/SER/NEG/04. SIHHAT post survey, p.99.
[264] European Commission. (2020). (November). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of June 2020). Brussels: EU
[265] KII H02.
[266] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (as of December 2019). Brussels: EU.
[267] Danish Red Cross, Madad QIN Q4 2019.

Facility actions also focus on MHPSS and include awareness-raising activities to encourage referrals (see also the discussion in the Protection Sector report).

ii. Information, education and communication (IEC) materials

One of the SIHHAT activities focused on increasing health literacy and demand for preventive health care services for 2m refugees through IEC materials developed, distributed and used in Migrant Health Centres. By mid-2020, SIHHAT had fully delivered this component of its programme, producing 500,000 posters, 20,000,000 brochures and disseminating five short videos. Measures directly aimed at increasing health literacy and increasing demand for services represent less than 1% of SIHHAT's activities (by financial allocation).

The WHO action (funded through the EUTF instrument of the Facility) had distributed 5,000 leaflets to Syrian refugee households by the end of 2019. WHO is currently working with the MoH to identify topics for leaflets to be distributed through its seven Migrant Health Training Centres, and has developed a survey on health literacy among Syrian refugees that will further guide the development of its health education products and activities[268]. IEC materials are also distributed by other Facility actions on a range of topics.

3.3.3. Contextual analysis of Facility interventions

i. Primary and secondary health care services accessed

Facility reporting data shows that there have been increases each year in primary care consultations. According to SIHHAT, the number of primary health care consultations in MHCs/EMHCs has increased over time from 2017 to 2020[269]. This illustrates an increase in coverage for primary care. In some cases (e.g. primary care consultations, MHPSS services), these exceed the targets set by Facility Tranche I.

There were 13.5m primary care consultations provided to refugees by the Facility (to September 2020), which exceeds the target of 11m by January 2021[270]. From SIHHAT data provided in May 2020, the total number of primary health care consultations for Syrians in the target provinces was 5,451,075 in 2019[271]. Using the estimated Syrian refugee population of 3.9m[272], in 2019, this represents 1.4 primary health care consultations per person in 2019. However, comparable data from other countries is difficult to find, given that most global data also include hospital outpatient/specialist data, making it difficult to assess the sufficiency of this coverage compared to other countries. In addition, data on the number of visits made by Syrians to FMCs is not available to better understand where refugees are accessing primary health care (readers will recall that 800,000 Syrians are registered at Family Medicine Centres along with other non-Syrian migrants in Turkey, and these are funded by the GoTR[273]).

As explained earlier in this report, MHCs funded by Facility Tranche I are the second most-frequented health care institutions after public hospitals, with 28.2% of Syrians reporting using MHCs in 2018[274], rising to 40.9% by 2020[275]. While this has increased, public hospitals remain the most frequently used facilities in 2020 (80.8%)[276].

This preference to seek treatment in hospitals occurs despite that 'the wait times at hospitals are long'[277]. In one case, a patient guide mentioned that patients may wait all day to try to see a gynaecologist at the EMHC (and may not be successful), since the gynaecologist is only available two days a week and service is provided on a first come, first served basis:

[268] WHO, Madad QIN Q4 2019 (T04.58).
[269] Data provided by email communication 15 May 2020 from Tuba ÜZEL, SIHHAT Project Management Team Reporting & ME Expert.
[270] SIHHAT Logframe (December 2020), shared with ET in January 2021.
[271] Data provided by email communication 15 May 2020 from Tuba ÜZEL, SIHHAT Project Management Team Reporting & ME Expert.
[272] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of December 2019). Brussels: EU.
[273] Meeting of Minutes of Steering Committee, SIHHAT, 21 January 2020.
[274] Republic of Turkey, Ministry of Health and SIHHAT. (2019). Pre Survey Study Information Sharing Meeting: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection, MOH SIHHAT/2018/SER/NEG/04.
[275] Republic of Turkey, Ministry of Health and SIHHAT. (2020). *Final Report: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection*, MOH SIHHAT/2018/SER/NEG/04. SIHHAT post survey, p.91.
[276] Ibid.
[279] KII H27.2.

Well, we only have one gynaecologist that comes two days a week, this causes a lot of pressure as patients might end up waiting all day without getting the chance to see the doctor[278]*.*

While there is no quantitative data available on waiting times at MHCs versus hospitals, this evaluation heard differing accounts of delays from interviewees: one patient said that waiting time can be half an hour at the MHCs to see a physician, due to overcrowding[279], and another recognised that hospital queues are much longer and they could be seen much faster at the MHC:

We can come any time; I register when I arrive to the centre. I do not need to wait the whole day for my turn to come like I would usually do if I go to the hospital … Sometimes you have to wait till 5pm at the hospital to see a doctor, here [at the MHC] it is less crowded[280]*.*

iii. Mental health and psychosocial support services accessed

a. Prevalence of mental illness

There are different rates of mental illness amongst refugees in Turkey reported in the literature, with some literature noting very high rates and others reporting lower rates. For example, one study estimated the prevalence of symptoms for post-traumatic stress disorder (PTSD) to be 19.6%, depression at 34.7%, and anxiety at 36.1% among Syrian refugees in Sultanbeyli-Istanbul[281]. A survey by WHO of the Syrian refugee population in Turkey found 23.6% and 21.9% of respondents respectively felt feelings of mild, constant or moderate depressive feelings in the last 30 days, with 13.5% citing severe constant depression[282]. SIHHAT's own surveys of Syrian refugees found that only 1.4% of men and 1.1% of women reported having depression in 2018[283]; and 0.5% (for both men and women) in 2020[284]. This gap between the higher reports by academic and WHO sources (similar to reports from Lebanon and Jordan), versus much lower needs assessment by MoH and SIHHAT cannot easily be explained. However, it is known from broader literature that exposure to war and violence has a negative impact on refugee mental health, including PTSD. In addition, refugees might be less able to recognise or willing to report their mental health struggles. Another challenge is lack of information: the SIHHAT 2018 survey determined that 'SuTP[s] don't have any information on mental illnesses although they know of names of the diseases'[285] although the 2020 post-survey conducted by SIHHAT showed increased levels of knowledge of the most commonly recognised illnesses[286]. Finally, as noted above, language barriers remain an obstacle to accessing MHPSS services. Gaps in MHPSS services are discussed further below.

b. Progress to date

Level 3: MHPSS in preventive/primary care focuses on funding for services via counselling and group trainings**.** These are often provided in EMHCs, by WHO in seven EMHCs (including individual counselling where there are psychologists/social workers, and group trainings on topics such as mental health). Also a number of implementing partners (e.g. UNFPA's WGSS) are offering counselling services (e.g. psychiatrists, psychologists) in addition to the public health system as part of the Facility funding[287]. However, the challenge with NGOs providing MHPSS services is that their services are not integrated into the government system, they are not sustainable in the long run through the GoTR, and they cannot scale up. Hence, ensuring MHPSS services that are culturally appropriate, comprehensive and offered by the GoTR is key for effectiveness and sustainability.

[279] KII H27.2.
[279] KII H27.2.
[280] KII H24.2.
[281] Fuhr, D.C., Acarturk, C., McGrath, M. et al. Treatment gap and mental health service use among Syrian refugees in Sultanbeyli, Istanbul: a cross-sectional survey. *Epidemiol Psychiatr Sci*. 2019;29:e70. Published 2019 Nov 15. doi:10.1017/S2045796019000660
[282] Mipatrini, D., Balcilar, M., Dembech, M., Ergüder, T. and Ursu, P. (2019). Survey on the health status, services utilization and determinants of health: Syrian refugee population in Turkey. WHO Regional Office for Europe.
[283] Republic of Turkey, Ministry of Health and SIHHAT. (2019). *Pre Survey Report: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection,* Health Literacy and Chronic Disease. MOH SIHHAT/2018/SER/NEG/04, p.26.
[284] SIHHAT post-survey, p.81.
[285] Republic of Turkey, Ministry of Health and SIHHAT. (2019). *Pre Survey Report: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection,* Mental Health Status. MOH SIHHAT/2018/SER/NEG/04, p.22.
[286] SIHHAT post-survey, p.671.
[287] KIIs H09, H30.

For Level 3 activities, the data for the indicator 'Number of refugees who received mental health and psychosocial support services' is 630,633 (against a target of 278,960)[288].

In 2019, 1,461 Syrian patients at E/MHCs received 1,727 sessions in 10 provinces by Quarter 4 and, in 2020, 4,787 Syrian patients had received 6,484 sessions in 11 provinces by Quarter 3[289]. DG ECHO reports that 188,441 individuals have received individual or group support in MHPSS since 2016 (via NGO IPs, most of which is presumed to represent group counselling in community centres). The increased attention of the Facility in supporting these services can be seen in that SIHHAT has recruited more psychologists and social workers in MHCs under the Facility Tranche I[290] and plans to increase this further under Facility Tranche II. In addition, with SIHHAT funding from the Facility, the MoH is recruiting psychologists and social workers for primary health care level MHPSS services focusing on seasonal migrants and mobile groups[291].

Level 4: One focus for mental health for Facility Tranche I is on the secondary level (funding for CMHCs). CMHCs' mandate is to 'address the treatment and rehabilitation of advanced mental health patients … community mental health centres have been designed as rehabilitation facilities for bipolar and schizophrenia patients'[292], in contrast to broader mental health promotion (MHPSS) among refugees. Hence, one report noted that Community Mental Health Centres are not adequately addressing needs in MHPSS across the spectrum[293.] The evaluation of the EU's humanitarian response to the refugee crisis in Turkey (2019) also identified that further services for severe mental illness were needed[294.] Overall, there is a need to ensure a balance of services for those with more minor MHPSS needs, and those with serious mental illness.

Mental health services by SIHHAT include services for outpatients (Turkish and Syrian) with severe mental illness (bipolar and schizophrenia) at Facility Tranche I funded CMHCs[295]. Table 10 below shows that the number of Syrian and host community patients has increased significantly from 2018 to 2020, as well as the number of mental health sessions. This data is not disaggregated by host community and Syrians[296].

Table 10: Number of mental health sessions delivered by CMHCs (2018–2019)

CMHCs	No. of Syrians and host communities			No. of mental health sessions			Total no. of mental health sessions
	December 2018	December 2019	September 2020	2018	2019	2020 (Q3)	
Total	530	2,120	2,315	3,948	18,321	19,873	42,142

In addition, the SIHHAT logframe data indicates that a relatively stable number of refugees in 29 target provinces received specialised treatments at mental health clinics of secondary health care facilities as per Table 11.

[288] European Commission. (2020). (November). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (as of June 2020). Brussels: EU
[289] SIHHAT logframe (December 2020) provided to ET, January 2021
[290] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of December 2019). Brussels: EU.
[291] Ibid.
[292] Ozturk, Serap. (2019). op. cit, p.69.
[293] Ozturk, Serap. (2019). op. cit.
[294] Universalia, op cit.
[295] One CMHC noted they had 300 patients, with 25 being Syrian.
[296] Email correspondence with SIHHAT, 15 May 2020.

Table 11: Number of refugees in 29 target provinces who received specialised treatments at mental health clinics of secondary health care facilities

Year	No. of refugees
2017	32,985
2018	35,325
2019	34,549
2020 (to Q3)	20,533

(Source: SIHHAT logframe)

However, in the end, even the highest estimates of MHPSS services delivered to refugees in Turkey fall far short of the 20–30% of the whole refugee population that the academic and WHO studies suggested were experiencing a significant degree of stress and mental illness.

c. Training

It is critical that health care workers are trained in talking to patients about MHPSS. Some training courses in MHPSS have been held with health care workers at the community level, for example by EUTF–WHO as part of the mhGAP programme to support minor cases[297]. This training has had some impact, including reporting more mental illness cases diagnosed after the training and high satisfaction by patients in exit interviews[298].

However, there are challenges in implementation of this programme as noted by one interviewee, since there is not sufficient time to spend with patients given the number of patients a physician sees each day in MHCs, and given the gap in human resources:

> *mhGAP model is a system applied at the primary care level and services are to be given for a period of 10-20 minutes. But actually, they allocate around five minutes. This is not enough to cover mhGAP's scope. The question 'how are you?' is not a simple question. It is not like describing your physical condition. Many doctors have been trained for mhGAP, but MHCs are not structured for mhGAP setting needs, and they do not have good standards for mhGAP. They have less time in MHCs. There is also a human resource gap for mental health*[299]*.*

d. Gaps in services

Despite the Facility making progress in this area through the services identified above, there are still unmet needs for severe mental illness[300], as well as for prevention and referrals, and the different needs of specific target groups need to be addressed[301].

Interviewees and documents highlight large needs that are unmet in psychosocial and mental health services across the spectrum of services, including the need for more services for severe mental illness like PTSD[302], as well as for prevention (support and counselling at the primary care level) for depression, anxiety and stress[303]. In a survey conducted for this evaluation, 49% of respondents noted that, in the past 12 months, they felt they needed to but were not able to access help or care when they were feeling sad, upset or depressed. This was higher among women than men[304]. When asked about suggestions to improve health care services, these respondents cited more attention to MHPSS as one area for improvement.

Many interviewees (IPs and academics) said that the primary care system is not felt to be adequately equipped to support mental health generally in Turkey, neither for Turkish citizens nor refugees.

[297] KIIs H03, H12, H30.
[298] KfW, WHO. Presentation to the 3rd Joint Steering Committee Meeting. Ankara, 13 November 2019.
[299] KII H30.
[300] Universalia, op cit.
[301] Strategic interview, 2 December 2019.
[302] Universalia, op cit.
[303] European Commission. (2019). (November). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of 30 June 2019). Brussels: EU; KIIs H01, H09, H10, H11, H30, H40, H42, H44, H51.
[304] Development Analytics. (2020). Online survey health section data set.

Psychosocial support mechanisms are limited in Turkey within the social security system, for Turkish or Syrians. Healthy Living Centres that have social workers and psychologists that people can access (in the Turkish language) although the evaluation team does not have data on them. Depression and other psychosocial conditions exist, but the number of refugees with these needs that the system can support is limited by funding as well as by the limitations of the support system[305].

Effective referrals are not yet happening systematically and the evaluation has found that some NGOs are not aware of whether they can refer to CMHCs while others say they do, and there is mixed opinion on whether MHCs refer to CMHCs, with some saying they can and do, and others saying this is not possible as referrals can only be made from hospitals[306].

Gaps that remain in terms of MHPSS service relate mainly to access to Arabic-speaking psychologists/ social workers (as these are not part of the Syrian health worker strategy) and psychiatrists[307]**.** Cultural and language barriers[308], and stigmatisation in terms of getting help for mental health issues (which when addressed may increase demand even more for MHPSS services), are also challenges that need to be overcome[309].

In terms of sustainability of services and staff working in the area of mental health, it was noted in interviews and documents that there had been a successful transition of some of the services provided by WGSS, and that this was a best practice model[310]:

> *Phasing out of [Facility humanitarian funding] has succeeded in the programme. For WGSS, some of the social workers and psychologists – SIHHAT staff – have been taken over by the Ministry. This is a very good example of transitioning from [humanitarian funding]. Translators, social workers … psychologists … They have recently started to be recruited*[311]*.*

> *From the onset of the programme, the existing MoH policy and service capacity allowed the introduction of an exit strategy for the project that, through advocacy and technical and institutional capacity development measures, was able to integrate core WGSS staff and services into 24 MHCs under the SIHHAT management programme*[312]*.*

In terms of transition to the government, by the end of the first phase of SIHHAT[313], 80 of the 84 psychologists and social workers from the WGSS project are now employed, and there is a target of 75 psychologists and 150 social workers to be employed under the next phase of SIHHAT. While this indicates an acceleration since March 2020, when there were only 22 psychologists/social workers employed), accessibility issues remain due to the language difficulties described above, and it will be vital that there is careful transition planning to ensure the sustainability of services in MHPSS, including adequate staffing and training.

Regarding the gender gap, more than half (59%) of beneficiaries of MHPSS services are females[314], indicating that males are less likely to access MHPSS services which may be due to stigmatisation and/or the ability to access services when they are not working. The evaluation of the EU's humanitarian response to the refugee crisis in Turkey (2019) also found that men are less likely to participate in the psychosocial counselling sessions that were provided through Facility support[315]. It also described challenges such as the MoH not considering mental health to be urgent, and the mental health providers with the GoTR being reluctant to accept NGO referrals[316].

For these reasons, there will continue to be gaps in services from the Facility related to scope (the need to focus further in a more systematic way across all MHCs on mental health prevention and community

[305] KIIs H10; also, H11.
[306] KIIs H17, H19.1, H24.2, H42, H43.2.
[307] KII H44.
[308] KIIs H01, H22.1, H28.
[309] Ozturk, Serap. (2019). op. cit., p.29.
[310] KII H09.
[311] KII H47.
[312] HERA. (2019). op. cit.
[313] Data provided by EUD in February 2021, source: SIHHAT.
[314] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of December 2019). Brussels: EU.
[315] Universalia, op cit.
[316] Ibid.

services) and reach (the sheer number of people with mental health issues that need to receive services).

Overall, ensuring that patients are aware of available MHPSS services and know how to navigate the health care system is also important, as illustrated in the quote below by government staff:

> *Further [investment] is required especially the challenge is now to improve awareness of various actors on the health care system and the true navigation route*[317]*.*

3.3.4. Summary of contribution considerations

The outcome of increased demand and use of health services by refugees has clearly been achieved, and reflects progress made in achieving the outcomes of increased availability and accessibility. The number of primary health care consultations and specialised consultations such as MHPSS or specialised treatment in the area of post-operative care are all high, indicating good uptake of available services[318]. In all cases, as mentioned in other sections of this report, the contribution of the Facility has been significant and has complemented the contribution of the Turkish health system, which has continued to provide services to refugees using their own resources (e.g. Family Medicine/Health Centres and hospitals) – 800,000 Syrians are registered at GoTR-funded FMCs along with other non-Syrian migrants in Turkey[319].

As in all aspects of the Facility's support to the health sector, there continue to be unmet needs and improvements that would further increase the Facility's contribution. In the case of MHPSS, the Facility contribution is particularly important as health care provision in the Turkish health system is limited in this area, and there is a lack of professionals to meet demand, which is particularly high given the circumstances from which Syrians have come, and the challenges they continue to face.

The challenge, though, is the transition of such services into the Turkish health care system, and therefore their ultimate sustainability and continued use by refugees. While the Facility has made very significant progress in terms of the transition of physical health care services from humanitarian partners to the national system, the same cannot yet be said of mental health services. The Facility has measurably increased the capacity of the Turkish system to provide (and increase demand for) MHPSS interventions for refugees (from levels 1 to 4 in the pyramid described above), but the scale of this transferred and built capacity in the government mental health system is still not sufficient to address refugees' mental health needs.

There are opportunities for: (i) transition in the short term to significantly increase the number of psychologists and social workers to be recruited by SIHHAT and funded by the Facility, and to offer services for a longer period than has been possible through the Facility's humanitarian projects; and (ii) on a longer-term basis, to further integrate psychologists and social workers at the primary level in the Turkish system overall.

3.4. **Judgement criteria 9.4:** The Facility health response is relevant to the target population's identified health needs

This JC looks at whether the health services are relevant to refugees' needs. The achievement of this outcome is measured through the examination of satisfaction among refugees in terms of health services, as well as gaps remaining to meet needs. In measuring satisfaction, more consistent surveys would be needed, with comparable questions over time. However, partial data from 2019 indicates fairly high levels of satisfaction among Syrian refugees, indicating that health services are relevant. Observable gaps, however, are also apparent; these are explained below.

[317] KII H01.
[318] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of December 2019). Brussels: EU.
[319] Meeting of Minutes of Steering Committee, SIHHAT, 21 January 2020.

3.4.1. 'Health services are relevant to refugees' needs' as an outcome

Table 12: Summary of extent to which intermediate outcome achieved

Expected outcome (intermediate)	**Health services are relevant to refugees' need**
Observed outcome(s)	Health services appear to be largely relevant to the target population needs, as indicated by broadly high levels of satisfaction with health care services, but there are some notable exceptions. MHPSS services in particular remain a challenge given the structure of MHPSS services (focusing on psychiatric diseases and overlooking post-traumatic stress disorder (PTSD) and stress-induced problems), as well as cultural barriers.
Facility results contributing to the outcome (based on output-level results as of 31/12/19 – unless otherwise noted) [320]	• In the 2020 SIHHAT post-survey, satisfaction levels were fairly high among Syrians in accessing services, but lower than in 2018. In 2020, 80% (versus 91% in 2018) were very satisfied or satisfied with Family Practice Centres); 81% for private hospitals or polyclinics (versus 80% in 2018); 75% for 112 emergency services and public hospitals (versus 84% in 2018); and 64% for MHCs (versus 72% in 2018)[321] which is the lowest level of satisfaction across all the assessed services. • These rates of satisfaction in MHCs are lower in the above 2019 and 2020 surveys than the one conducted by WHO in 2017, which found 96.2% were satisfied or very satisfied with emergency services, 88.5% for hospitals, 82.5% for refugee health centres, and 82.1% for Family Health Centres[322].

3.4.2. Description of Facility interventions aimed at supporting health services being relevant to refugees' needs

All projects in Facility Tranche I were designed based on early needs assessments, including the SIHHAT project. A number of the humanitarian projects focused on services for vulnerable populations, including the work of the WGSS on providing SRH and SGBV services[323]. Numerous projects were designed according to the specific needs of a displaced population that has experienced conflict, and according to gaps in the Turkish health system, for example MHPSS and physiotherapy/rehabilitative services. Such projects and their key components are described earlier in this report (Table 5).

3.4.3. Contextual analysis of Facility interventions

i. *Patient satisfaction*

As a health system outcome, increased patient satisfaction is fairly high, as shown in Table 12 which summarises the latest SIHHAT post-survey data. Satisfaction rates do not vary widely between men and women or between age groups for public hospitals or MHCs. In the 2018 pre-survey, the top three reasons for satisfaction were (i) good medicine; treatment and nursing (implying a good quality level of care); (ii) systematic health care services such as hospital services and appointment system (implying good care coordination); and (iii) caring and attentive health care staff (implying good patient-provider communication)[324]. For survey respondents in 2020, the top two reasons were the same, while the third most important factor influencing satisfaction was experiencing 'no difficulty in health institutions' (15.9% in 2020 and 6.5% in 2018). The 'availability of interpreter' as a reason for satisfaction also increased significantly, from 1.9% in 2018 to 3.7% in 2020[325].

[320] European Commission. (2020). (May). Managing the Refugee Crisis – The EU Facility for Refugees in Turkey. The Facility Results Framework Monitoring Report: Output Achievement Progress (As of December 2019). Brussels: EU.
[321]Republic of Turkey, Ministry of Health and SIHHAT. (2019). *Pre Survey Report: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection,* Individual Health. MOH SIHHAT/2018/SER/NEG/04, p.82.
[322] Mipatrini, D., Balcilar, M., Dembech, M., Ergüder, T. and Ursu, P. (2019). Survey on the health status, services utilization and determinants of health: Syrian refugee population in Turkey. WHO Regional Office for Europe.
[323] HERA. (2019). op. cit.
[324] Republic of Turkey, Ministry of Health and SIHHAT. (2019). Pre Survey Study Information Sharing Meeting: Surveys for Health Care Needs Analysis of Syrian People Under Temporary Protection, MOH SIHHAT/2018/SER/NEG/04.
[325] SIHHAT post survey, p.437.

ii. Gaps for vulnerable populations

A number of Facility projects focused on services for vulnerable populations, including the work of the WGSS on providing SRH and SGBV services for women[326], rehabilitation services provided by IPs, and specialised LGBTI+ support provided by UNFPA. The evaluation of the EU's humanitarian response to the refugee crisis in Turkey (2019) found that health NGOs provided services that were tailored for addressing needs of many refugees who were vulnerable, yet the number of beneficiaries reached was limited compared to the needs[327].

A number of vulnerable populations have been discussed in detail above (e.g. in JC 9.2), including women, LGBTI+ populations, people with disabilities (and their families), unregistered refugees and those living in rural areas. Additional groups who are vulnerable include ethnic groups who face discrimination such as Syrian *Doms* (semi-nomadic and nomadic people) and seasonal agricultural workers[328]. Vulnerable populations may have difficulty accessing health services, due to barriers such as transportation, living far from services, their legal status, resource challenges and barriers of culture or language. They may also face poorer health as a result of poorer social determinants of health (e.g. including lower levels of income, lower levels of education, harsh working conditions). The Protection Sector report for this evaluation outlines in detail the challenges facing seasonal agricultural workers, which includes challenges to accessing health care services (besides emergency services) when workers are outside their province of registration. Also noted in this report is the sexual harassment and sexual exploitation that female seasonal agricultural workers face, which impacts their health.

There is a misconception among some people working for the GoTR that, if services are provided to the general population, this means that everyone has equal access to health care, as illustrated by this quote: 'With disadvantaged groups they can go to the hospital and get access to all services'[329].

However, ensuring everyone has equal access to health care may need targeted outreach, tailored services and modifications. Not all people (particularly vulnerable groups) will feel comfortable in accessing health services (including MHPSS services). However, some of the projects funded under the Facility Tranche I (e.g. SIHHAT) are not yet at the point of reaching out to hard-to-reach populations, instead focusing on providing services to as many people as possible given the number and concentration of refugees, especially Syrians. Some targeting of vulnerable populations was undertaken in Facility Tranche I as outlined above, especially those projects financed through the humanitarian instrument.

There is a risk that vulnerable populations will be left out if they are not further targeted. As one informant noted: 'There is a need that these large-scale interventions by the UN and the EU have a lens of vulnerability, they can be more friendly for access'[330]. Lack of data disaggregated by vulnerable groups remains a gap[331], and there is not a wide understanding in the health community of why it is important to collect this type of data, as illustrated in this quote: 'We don't discriminate for people with disabilities. It is a patient with a headache, not a disabled person with a headache'[332].

iii. Gaps in rehabilitation and devices

The 2019 evaluation of the EU's humanitarian response to the refugee crisis in Turkey (2019) confirmed that there were gaps in terms of access to rehabilitation and access to some devices such as prosthetics for those wounded in the war[333] and this was further supported by interviews held during this evaluation[334].

iv. Gaps in data on non-communicable disease

The MoH health information system has not yet started to systematically collect data on non-communicable diseases (NCDs) at the primary level for Turkey as a whole. This is planned for 2020. This is a data gap for the host community as well as refugees, and therefore it is difficult to ascertain

[326] HERA. (2019). op. cit.
[327] Universalia, op cit.
[328] Ozturk, Serap. (2019). op cit.; KIIs H11, H47.
[329] KII H04.
[330] KII H09.
[331] KIIs H01, H02, H07.
[332] KII H05.
[333] Universalia, op cit.
[334] KIIs H04, H10.

the impact of Facility Tranche I on this. One 2016 report on NCDs and Syrian refugees, *Health Status Survey of Syrian Refugees (SuTPs) in Turkey: Non-communicable Disease Risk Factors Surveillance among Syrian Refugees Living in Turkey*, found that Syrian refugees were at high risk of NCDs.

Only 0.3% of the Syrian refugees aged 18-69 were at low risk of NCD compared to 41.1% at moderate risk (with 1–2 risk factors) and 58.7% in high risk (with 3–5 risk factors). Having 3–5 risk factors was more common among men (61.3%) than women (56.1%). 45.7 % of men and 46.1% of women in the 18–44 years age group are considered at high risk. A strikingly high percentage of men (81.7%) and women (87.1%) aged 45–69 years have high combined risk factors (more than three risk factors)[335].

A needs assessment on NCDs found that disease management and treatment were not prioritised, and there is a lack of an NCD management system or algorithm. More training in NCDs for health care workers is needed, and relevant health communication needs to be prioritised[336].

Health promotion and prevention should be important areas of focus in the coming years, given these reported risk factors, and their impact on health.

v. Gaps in maternal and child health

A number of gaps remain in terms of maternal, new-born and child health. Syrian migrants have higher unmet needs for family planning, a higher under 5-years mortality rate, lower percentages of mothers receiving four or more ANC visits, lower vaccination rates for children, and higher malnutrition rates.

Family planning is a pressing priority. Overall, 43% of currently married Syrian women in Turkey use a method of family planning[337]. The current total fertility rate among Syrian migrants in Turkey is 5.3 births per women; 39% of Syrian adolescents have begun childbearing, 31% of Syrian adolescents have had a live birth, and 9% of Syrian adolescents are currently pregnant with their first child[338].

vi. Gaps in determinants of health

Health care services are only one of the determinants of health. Broad determinants of health beyond health care often prove to be more important to a person's health status, including determinants such as education, gender, income and culture[339]. A number of determinants of health need to continue to be addressed, in order to underpin improved health status of Syrians, including ensuring adequate housing, adequate protection including addressing SGBV (see the Protection Sector report for this evaluation), adequate nutrition, addressing poverty (see the Socio-economic Sector Report for this evaluation), addressing low educational attainment (see the Education Sector Report for this evaluation), ensuring continued language support, and addressing cultural issues that negatively influence health (e.g. social norms regarding child, early and forced marriage)[340].

Child, early and forced marriage (CEFM) and adolescent birth rates are high in the Syrian population[341]. The Protection Sector report for this evaluation outlines many of the key protection factors on child marriage, including the cultural barrier that most Syrian adults see CEFM not as a protection problem but rather as a solution to protection concerns. In the health interviews, this was identified as a challenge that remains, including the link with CEFM to poverty[342]. The Protection Sector report also notes that the Facility has made efforts on CEFM, but that little progress has been achieved. Additional group sessions (e.g. empowerment, awareness-raising) in this area and in the area of SGBV prevention would be useful at the primary health level, but will not address the broader cultural challenges and policy changes needed to address CEFM over the long run[343].

[335] Balcilar, M. (2016). Health Status Survey of Syrian Refugees (SuTPs) in Turkey: Non-communicable Disease Risk Factors Surveillance among Syrian Refugees Living in Turkey. October. Ministry of Health of Turkey, and WHO. https://sbu.saglik.gov.tr/Ekutuphane/kitaplar/suriyeli%20m%C3%BClteci%20ingilizce.pdf
[336] KfW, WHO. Presentation to the 3rd Joint Steering Committee Meeting. Ankara, 13 November 2019.
[337] Hacettepe University Institute of Population Studies. (2019). op. cit.
[338] KIIs H04, H05, H09, H10, H21, Hacettepe University Institute of Population Studies. (2019). op. cit.
[339] WHO. (2018). Health promotion for improved refugee and migrant health. Copenhagen: WHO Regional Office for Europe; (Technical guidance on refugee and migrant health).
[340] KIIs H04, H05, H09, H10, H21, Hacettepe University Institute of Population Studies. (2019). op cit. WHO. (2018). Health promotion for improved refugee and migrant health. Copenhagen: WHO Regional Office for Europe; (Technical guidance on refugee and migrant health).
[341] KIIs H04, H05, H09, H10, H21, Hacettepe University Institute of Population Studies. (2019). op cit.
[342] KII H10.
[343] KII H09.

3.4.4. Summary of contribution considerations

The Facility health response is relevant to the target population's identified health needs. Health services appear largely relevant to the target population's needs given high reported satisfaction levels (even though these decreased from 2018 to 2020, according to the SIHHAT surveys).

Many needs identified in the previous needs assessments have been addressed by Facility funding, but there is room for further improvement including ensuring language barriers are addressed and addressing discrimination at hospitals.

The Facility Tranche I has contributed to increased attention to the most vulnerable within the refugee population, which likely would not have occurred without the Facility funding of INGOs. Health services appear to be largely relevant to the target population's needs, although as noted above there is scope to reach more vulnerable groups (LGBTI+, people living with HIV, people living with disabilities, rural refugees) at the required scale. This will be important to track over time and support in the future.

The Facility Tranche I included some focus on MHPSS services as outlined under JC 9.3, which played a significant role in addressing some MHPSS needs. However, more work needs to be done in this area to meet the needs including more services and personnel, and attention will be needed to ensure a successful and sustainable transition of MHPSS services from humanitarian partners and INGOs to the Turkish health system.

3.5. Evidence confidence

Data issues are identified as a major limitation to the overall report, in particular the lack of access to GoTR data. Lack of detail, lack of concrete outcome data, and poor-quality data have been identified as issues by other reviews and evaluations related to Facility Tranche I[344]. SUMAF's monitoring of EUTF noted 'logframe flaws and insufficiently developed and precise indicators'[345].

[344] UK DFID. (2018). The UK's contribution to the Facility for Refugees in Turkey (FRIT): Annual Review (post April 2018). DFID; Universalia, op cit.
[345] SUMAF. (2019). Monitoring Report: WHO Action – Improved Access to Health Services for Syrian Refugees in Turkey. Qualitative Results Based Monitoring Report for Ongoing Missions. 18 March 2019.

4. Facility response to the COVID-19 crisis

4.1. Impact of COVID-19 on refugees in Turkey

While refugees' health care access has been maintained during the pandemic, they have faced several challenges with regard to routine health care and access to sexual and reproductive health (SRH) and MHPSS services**.** According to the survey carried out by Relief International with the sample size of 879 respondent refugees in five provinces (Istanbul, Izmir, Manisa, Gaziantep, Kilis and Hatay-Reyhanlı), 87% of respondents reported that they had access to health services prior to COVID-19 but only 25% of respondents had access to those services since COVID-19 was announced as a pandemic[346]. As for the host population, access to health care has been interrupted due to concerns around contracting COVID-19 or due to advice to stay at home. There is no data that is disaggregated on COVID-19 cases by the host community compared to refugees.

COVID-19 has disrupted MHPSS in most countries[347]. As stated by the United Nations (2020a), reproductive health services, MHPSS services that are currently being provided at Migrant Health Centres have not been fully accessed and utilised. Having access to MHPSS is particularly important given that COVID-19 may create stress, fear and anxiety for people about uncertain conditions created by the pandemic; and loneliness, feeling isolated, being unemployed or being exposed to domestic violence, among others, may increase the need for MHPSS support. Despite the importance of these supports especially during the COVID period, 'the hotlines established by MoH to offer psychosocial support during Covid-19 do not have language options for refugees and migrants'[348]. Therefore, one should recognise that a language barrier to access these services has been persistent for refugees amid the pandemic crisis.

In addition, while both registered and unregistered refugees can also access COVID-19 tests, and treatment free of charge[349] (including screening of those suspected of having COVID-19 so that they can be referred to hospitals[350]), language is, again, a barrier during the diagnosis process[351], given that interviews for contact tracing cannot be effectively carried out, and health personnel are unable to conduct qualified interviews in a foreign language. There is also an added concern that testing positive can cause fear of deportation for some refugees[352].

4.2. Facility response

In addition to other support measures in Turkey, the Facility has allocated resources totalling around EUR 65 million to the response to COVID-19 through the following redirection of Facility savings/ contingency budgets. This has been allocated for personal protective equipment (PPE) and other relevant supplies and equipment, as well as funding for awareness campaigns to a number of partners including the MoH, UNDP, WHO, Danish Red Cross and other NGOs. The total amount from the EU for these health-related projects is EUR 11,317,516.

While interviews were not undertaken with the Turkish government on the COVID-19 emergency funding, interviews with EC stakeholders for this brief assessment confirmed that the reallocation of

[346] Relief International (2020). Impact of the COVID-19 Outbreak on Syrian Refugees in Turkey: Results from Rapid Needs Assessment conducted in Istanbul, Izmir, Manisa, Gaziantep, Kilis and Reyhanli. 21 May 2020. https://reliefweb.int/report/turkey/impact-covid-19-outbreak-syrian-refugees-turkey-results-rapid-needs-assessment
[347] World Health Organization. (2020a). COVID-19 disrupting mental health services in most countries, WHO survey. 5 October 2020. https://www.who.int/news/item/05-10-2020-covid-19-disrupting-mental-health-services-in-most-countries-who-survey
[348] United Nations (2020a). *COVID-19 Socio-Economic Impact Assessment Report.*
[349] Association of Public Health Specialists (2020). Pandemi Sürecinde Göçmenler ve Mültecilerle İlgili Durum [in Turkish]. Retrieved from: https://korona.hasuder.org.tr/pandemi-surecinde-gocmenler-ve-multecilerle-ilgili-durum/ [Access date: 26 October 2020]
[350] Karadag, C.O, Çınar, E., Cevik, M., Mardin, D., Nergiz, A. & Karabey, S. (2020). Situational Brief: Report on Forced Migrants and COVID-19 Pandemic Response in Turkey. Retrieved from: Https://Www.Researchgate.Net/Publication/342276414_Situational_Brief_Report_On_Forced_Migrants_And_Covid-19_Pandemic_Response_In_Turkey [Access date: 26 October.2020]
[351] Association of Public Health Specialists (2020). Pandemi Sürecinde Göçmenler ve Mültecilerle İlgili Durum [in Turkish]. Retrieved from: https://korona.hasuder.org.tr/pandemi-surecinde-gocmenler-ve-multecilerle-ilgili-durum/ [Access date: 26 October 2020]
[352] ibid.

contingencies and savings was a rapid and smooth process, and SIHHAT contingencies (1.5%) were the first mobilised[353].

The greater challenge for SIHHAT, however, was on the institutional side, and particularly a lack of data on specific needs, which meant that the Facility provided EUR 4.75 million to the Ministry of Health with very limited information on whether its use would meet the most urgent needs, and also the extent to which it was the best use of funds given that the Turkish government reportedly had sufficient PPE in stock, and was able to send excess stock to other countries early on in the pandemic[354]. The planning of this response would have benefited greatly from more data from the provincial level, for example on population and patient load in different locations, which would also have enabled the EU to provide support where it is was most needed.

The equipment provided through the funding is typical as needed for a health system for prevention and protection during a pandemic, including masks for refugees as well as PPE for health care staff. Fortunately, SIHHAT already had good levels of this type of equipment in stock before the pandemic which meant that, despite a delay in procurement of some equipment (delivered in August 2020), the most urgent needs were met and excess will be transferred to SIHHAT II[355]. Without further data on needs, it is difficult to assess whether the current funding is sufficient, and what levels of funding will be required for future adaptations to Facility interventions.

4.3. Impact of COVID-19 on Facility results

In addition to the support provided through the Facility, information from the Action-Level COVID-19 Impact Report (4th Round) prepared by the SUMAF technical assistance team[356] summarises the impact on both Facility Tranche I projects – SIHHAT and WHO projects. Given that these are at their final stages of implementation of Facility Tranche I, the delays are not significant, although both have been extended to compensate for delays due to COVID-19. In the WHO project, training and surveys were initially delayed, but later replaced with online data collection and analysis, and a new online training platform which is expected to increase numbers of people trained, and thus improve the meeting of training targets.

The SUMAF report shows that the greatest impact has been on the construction of the hospital in Hatay, rated as ‘quite serious impact’ given the delays in activities as a result of COVID-19. As both hospital constructions (Kilis and Hatay) were already delayed prior to the outbreak, these delays will further impact on the opening of these hospitals, and hence further delay improvements to access to secondary health services.

For other projects, such as those implemented by Médecins du Monde, as far as the evaluation team can judge from project documents, MdM moved its protection counselling services online and adapted its content to the additional stress factors of Covid-19, but did not initiate new services.

The UNFPA project (2017/91003) supporting Social Service Centres (SSCs) was in the process of closing when COVID-19 struck, but still made some minor adjustments for COVID-19. First, some of the final planned activities and training sessions were cancelled due to COVID-19, and the production of some final guidelines and training packages were delayed. Second, with the COVID-19 pandemic, specific measures had to be introduced at the SSCs in line with the restrictions and lockdowns. During the pandemic, the coordination of social service activities were delegated to the governorships. The SSCs continued service provision. The SSC service providers contributed to these efforts through calling the most vulnerable individuals (elderly, people with disabilities and chronic diseases, etc.), assessing the needs, providing support with their shopping and other basic needs. Online training for ‘psychosocial support during the COVID-19’ was conducted for 94 psychologists and social workers. In some SSCs, staff worked with rotations until 1 June. The group activities and household visits (except in emergency cases) were also suspended.

[353] Interviews, November 2020.
[354] Aljazeera. (2020). UK: Turkish PPE arrives as data suggests more dying from COVID-19, 22 April 2020. https://www.aljazeera.com/news/2020/4/22/uk-turkish-ppe-arrives-as-data-suggests-more-dying-from-covid-19; Interviews, November 2020.
[355] Interviews, November 2020.
[356] SUMAF. (2020). Action-Level COVID-19 Impact Report (4th Round). Ankara; SUMAF, 23 October 2020.

Through a modification request, the UNFPA project (2019/91008) obtained agreement from DG ECHO to initiate new activities for the vulnerable community that they were supporting (LGBTI community, persons living with HIV and sex workers), including one-time rental support for 285 vulnerable households, the distribution of COVID-19 response kits made available by other organisations, as well as delivering 400 UNFPA kits to their clients.

Overall, these delays will not have a major impact on the evaluation results outlined in this report. However, the impact of COVID-19 on health services overall and for refugees in particular (given their vulnerability) will need to be an important focus for EU funding going forward. The delay of seeking health services for other health issues, the mental health impact, as well as the impact of infections of COVID-19 will have major effects on the health of refugees that will need to be addressed. These health effects will be amplified by the negative impacts of COVID-19 on the social determinants of health as well (e.g. increased gender-based violence during the pandemic, lack of access to schooling for refugees during the pandemic, lack of access to income and employment during the pandemic).

5. Conclusions

The Facility has contributed to an overall increase in the availability, accessibility and use of health care services by refugees. Refugees are generally satisfied with the services, although further work remains. Gaps remain in some services and for certain populations.

5.1. Conclusion 1

The Facility has made a significant contribution to the overall availability of health care services, through its support in training and provision of health care workers, and health care facilities, particularly in primary health care. However, there are several challenges in ensuring adequate availability and distribution of personnel where they are most needed, and across all professions, including barriers resulting from employment regulations and language. The availability of secondary health care facilities has been impacted by delays in construction of two hospitals, and by the decreasing, yet still high rate at which secondary health services are accessed in preference to using primary health care facilities.

5.2. Conclusion 2

The Facility has contributed to an increased accessibility of health care services. The Facility funding has helped with increasing accessibility of health care services across populations in terms of providing physical access, financial affordability and culturally acceptable services. Many challenges still remain for accessibility, including ensuring adequate physical access (the fact that MHCs are only open on weekdays and during the daytime limits accessibility for many people (e.g. people who work)), challenges with physical access (due to a disability), discrimination in hospitals, and some challenges to cultural appropriateness (e.g. language barriers) that are particularly important in relation to ensuring access to MHPSS.

5.3. Conclusion 3

The Facility has contributed to an increased use of health care services, and addressed gaps in services. The vast majority of children and adults who needed care were able to access it, which indicates that the gap in overall access is small. However, unregistered refugees and non-Syrians have difficulty accessing health services, as do Syrian refugees living outside the province where they are registered. Furthermore, some specific gaps remain in terms of vulnerable groups (LGBTI+, people living with HIV, rural refugees, people with disabilities) and in specific services (MHPSS, SGBV). While this responsibility for addressing these gaps lies with the GoTR, the Facility can continue to advocate to the MoH for changes in regulation and practice to address these gaps in service.

5.4. Conclusion 4

Refugee health needs are high because they are exacerbated by social determinants such as poverty, high fertility, early marriage and lack of education; therefore a comprehensive approach to refugee health would consist of both reducing those determinants as well as providing relevant services to meet the needs. Regarding the overall relevance of health services, the evaluation team concluded that the Facility's health response was relevant to the target population's identified health needs, as confirmed by refugee satisfaction levels (e.g. with MHCs), although satisfaction levels have decreased between 2018 and 2020.

5.5. Conclusion 5

The Facility Tranche I allowed for an acceleration of services provided by allowing the purchase of equipment, opening more MHCs and providing funding for the employability of Syrian physicians and

nurses in MHCs (which would not have been possible under the previous Turkish legislation). There has been a great influx of Syrian refugees into Turkey in a short period of time, and this has been met by a commitment on the part of the Turkish government to address health needs, with funding from EU in Facility Tranche I.

5.6. Conclusion 6

While the Facility has made very significant progress in the transition of health care services from international (mostly humanitarian) partners to the national system, which was recommended by the European Court of Auditors in their report of 2018[357], more needs to be done to increase capacity of the Turkish system to provide a full range of (and increase demand for) MHPSS interventions for refugees, and reproductive health services. There are a number of key areas that will require continued collaboration between the Facility and the MoH, including how best to engage the Syrian health care workforce, transition of MHCs to the government health system in ways that maintain the cultural sensitivity provided by MHCs and BPGs, and supporting secondary services to address gaps.

[357] European Court of Auditors. (2018) Special report No 27/2018: The Facility for Refugees in Turkey: helpful support, but improvements needed to deliver more value for money, Brussels. EU.

6. Recommendations

This section presents the recommendations made by the evaluation team to the European Commission. These are the result of the evaluation findings, conclusions and a participatory process with EC staff to arrive at recommendations that are relevant and actionable. The first recommendation here is Strategic recommendation 9 from the main report. The remaining recommendations are specific to health. All recommendations are directed to the European Commission services, in cooperation with the Government of Turkey.

Strategic recommendation	Links to EQs	Time frame
Strategic recommendation 9: Integrate migrant health care into the mainstream health system	Conclusions 2, 4, 7	
Who: EC services, in close cooperation with GoTR		
How:		
9.1 Develop a plan with the MoH for integration of MHCs and EMHCs	EQ 9	Immediate
9.2 Develop a plan with the MoH for equivalency for Syrian health care workers[358]	EQ 9	Immediate
9.3 Advocate for the mainstream health system to increase the provision of appropriate mental health services to refugees	EQ 9, 11	Immediate

Recommendations on Health	Links to EQs	Time frame
Health sector recommendation 1: Continue to address the social determinants of refugee health		
Who: EC services, in close cooperation with GoTR		
How:		
1.1 Ensure that support for refugees is provided in a holistic way, meeting their basic economic and education needs, and thereby prevent ill health among refugees	EQs 8, 9, 10	Immediate

[358] Concrete steps that could be taken include: (a) Improvement to work conditions, e.g. entitlement to annual leave, access to childcare and transportation, and improvement in physical infrastructure; (b) Provide incentives for physicians to work in provinces where there are vacancies, either facilitating family relocation, or bridging the cost-of-living gap in expensive locations (e.g. large cities); (c) Provide time for Syrian health care workers to learn Turkish/study for equivalency exam and expand existing provision (via WHO) of Turkish language training as part of a broader strategy for sustainability and integration of refugees into the Turkish system; and (d) Ensure continuous quality in-service training.

Recommendations on Health	Links to EQs	Time frame
1.2 Recognise, in the recommended strategies, policies and legislation to address gender inequality and social cohesion, that these are also important drivers of refugee health	EQs 2, 6	Immediate (in conjunction with strategic recommendations 2, 3)
Health sector recommendation 2: Address remaining gaps in access to health care services		
Who: EC services, in close cooperation with GoTR		
How:		
2.1 Advocate, and provide support for expanding the scope and reach of mental health services and psychosocial support across the continuum	EQs 2, 9, 11	Immediate, and medium term (for components after MHC integration)
2.2 Increase the provision of sexual and reproductive health services, and consider the provision of home visits/outreach activities with midwives, nurses and social workers to increase health literacy	EQ9	Immediate
2.3 Increase access to health care services by extending the opening hours of MHCs (and the FMCs once integration occurs); and/or providing home visits/outreach activities with midwives, nurses and social workers; and/or mobile health services	EQ9	Immediate and medium term
2.4 Ensure physical access to all MHCs for those with disabilities	EQ9	Immediate
2.5 Reduce language and cultural barriers to secondary health care services (and to primary health care services, once MHC integration is complete), through increased use of bilingual patient guides	EQ9	Immediate
2.6 Augment efforts to increase the health literacy of refugees, to ensure that refugees access primary health care services rather than secondary care at hospitals where applicable. In order to support this, intensify collaboration with frontline community volunteers/social workers/outreach workers	EQ 9	Immediate
2.7 Increase collaboration with NGOs in health care service provision, to strengthen the alignment and relevance of the Facility and advocate for continued improvements to the operational and regulatory environment for NGOs working in Turkey on delivery of services (including health) which target the most vulnerable	EQ9	Immediate

Recommendations on Health	Links to EQs	Time frame
2.8 Ensure adequate reach as well as safe and equitable access to health services for vulnerable refugee and host populations (e.g. LGBTI+, people with disabilities, people in remote areas, socially marginalised groups, people living with HIV)	EQs 2, 9, 11	Immediate
2.9 Advocate for regulatory reforms to extend health insurance to non-Syrian refugees after one year, and to allow all refugees to access appropriate health services outside their province of registration	EQs 2, 9, 11	Immediate
Health Sector Recommendation 3: Improve the quality of health programming through client consultation and enhanced use of health data		
Who: EC services, in close cooperation with GoTR		
How:		
3.1 Advocate for the Ministry of Health to share refugee health data (while respecting Turkish privacy regulations), and in particular to provide full and direct access to data from Facility-funded programmes	EQ 9	Immediate
3.2 Ensure that data is disaggregated by key populations, so that the planning and adapting of interventions can ensure that all populations have adequate access to health care. This includes collecting, disaggregating and making available the data on vulnerable populations, including vulnerable host populations	EQs 2, 9	Immediate
3.3 Continue to equip and encourage health service providers to analyse and use health information for strategic and operational planning, through advocacy and training	EQ 9	Immediate and medium term
3.4 Advocate for more bottom-up engagement with refugees and affected populations in planning and decision-making regarding health programming, policies and services (following a rights-based approach)	EQs 3, 9	Immediate

Annex 1: Details of Facility Tranche I actions

Instrument	IP	Approx. EU contribution (EUR)	Action
IPA II	Ministry of Health (MoH)	300,000,000	Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities (SIHHAT) – see details in Box 2
	Council of Europe Development Bank (CEB)	50,000,000	Health Infrastructure in Kilis
	Agence Française de Développement (AFD)	40,000,000	Construction of a State Hospital in Hatay
EU Trust Fund (Madad)	World Health Organization (WHO)	11,500,000 9,641,130 2,000,000	Improved access to health services for Syrian refugees in Turkey. This provided support and staffing of 7 Migrant Health Training Centres (MHTCs) with translators, psychologists, social workers, outreach workers etc. which provide culturally sensitive primary health care consultations, and community outreach consultations. Continued by more recent EUTF action[359]
Humanitarian	UNFPA United Nations Population Fund (UNFPA)	5,962,031 4,590,000	Improving access of most vulnerable refugees, particularly women, girls, and key refugee groups to sexual reproductive health (SRH) and better protection services including sexual and gender-based violence (SGBV) in Turkey through **20 women and girls' safe spaces (WGSS**). All centres except those implemented by the Community Volunteers Foundation have been integrated into MoH Migrant Health
	Relief International (RI)	3,000,000 4,000,000 2,129,525	Lifesaving Emergency Assistance for Protracted Conflict in Syria (LEAP)and Strengthening Access to Specialised Health Services for Refugees in Turkey for Conflict-Affected Syrians (SASH) and Tranche III (SASH II). LEAP, a project operating mainly within Syria, also supported mental health centres and teams in Gaziantep, providing prosthetics and a rehabilitation centre. This support was continued by SASH I and II and expanded to Ankara, Istanbul, Hatay, Kilis, Izmir and Manisa by 2019[360]
	Médicins du Monde (MdM)	9,000,000	Strengthen the longer-term resilience of refugees and migrants by improving the level of their emotional, mental and physical well-being

[359] WHO (2019), Progress report to European Union Regional Trust Fund in Response to the Syrian Crisis 'Improved access to health services for Syrian refugees in Turkey' TF-MADAD/2017/T04.58, May 2019.
[360] eSINGLE Form for Humanitarian Aid Actions 2017/00840/FR/01/01; eSINGLE Form For Humanitarian Aid Actions 2015/00470/FR/01/01; eSINGLE Form For Humanitarian Aid Actions 2016/00886/FR/01/01

Instrument	IP	Approx. EU contribution (EUR)	Action
		3,000,000	Contribute to sustainable integration of refugees into host population
		6,975,996	Provision of medical relief to refugees and migrants in Turkey through direct support to health facilities and implementing partners
	International Medical Corps (IMC)	2,284,993 3,397,256 3,453,723	Provision of lifesaving health, physical rehabilitation, mental health, SGBV and protection services in Turkey; and improving the well-being of Syrian refugees through physical rehabilitation, protection mechanisms and primary health care services in southern Turkey through 11 mobile and 6 static rehabilitation units and 2 primary health care centres in south-eastern Turkey between 2015 and 2017. With the roll-out of SIHHAT these were converted to MHUs
	Handicap International/ Humanity & Inclusion (HI)	931,676	A multi-stakeholders and multi-sectoral response mechanism to improve access to inclusive and quality services for the most vulnerable Syrian and non-Syrian refugees including people with disabilities in west Turkey (Izmir and Istanbul city). Support to two rehabilitation centres in Hatay and MHPSS activities in Gaziantep and mainstreaming/inclusion activities
		1,409,033	Emergency intervention for the most vulnerable Syrian-crisis affected people in Turkey
	GOAL	412,263	Improving the health and protection of vulnerable Syrian and marginalised migrants in southern Turkey through two new MHUs in Adana – with direct construction and refurbishment of new clinic space – while increasing the capacity of three existing facilities with non-medical staffing, medical and non-medical equipment