

# SURİYELİ GÖÇMENLERİN SAĞLIK OKURYAZARLIĞI VE YAŞAM DOYUMLARININ İNCELENMESİ

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## Öz

Bu çalışmanın amacı, sağlık okuryazarlığının alt boyutları ve yaşam doyumu üzerinde yaş, cinsiyet, medeni durum ve eğitim durumu gibi değişkenlerin etkilerini incelemektir. Çalışmanın bir diğer amacı ise, Suriyeli göçmenlerin sağlık okuryazarlığı algılarının yaşam doyumları üzerindeki etkilerini araştırmaktır. Çalışma, Kilis ilinde yaşayan 18 yaş ve üzeri Suriyeli göçmenler üzerinde gerçekleştirilmiştir. Veriler 11 Aralık 2017-03 Ocak 2018 tarihleri arasında 424 katılımcıdan toplanmış ve değerlendirilmiştir. Verilerin analizinde tanımlayıcı istatistikler, iki ortalama arasındaki farkın önemlilik testi, tek yönlü varyans analizi (Anova), güvenilirlik analizi ve çok değişkenli regresyon analizi kullanılmıştır. Yapılan analizler sonucunda, yaş, eğitim düzeyi ve bir yıl içinde bir sağlık kurumuna gitme durumunun sağlık okuryazarlığının erişim ve anlayış alt boyutlarını etkilediği bulunmuştur. Ayrıca sağlık okuryazarlığının tüm boyutlarının yaşam doyumundaki toplam varyansın sadece %1.1'ini açıkladığı tespit edilmiştir.

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## EXAMINATION OF HEALTH LITERACY AND LIFE SATISFACTION AMONG SYRIAN MIGRANTS

### *Abstract*

The aim of this study to examine the effects of such variables as age, gender, marital status and educational level etc. on subdimensions of health literacy and life satisfaction. Another aim of study is to investigate the effects of health literacy levels of Syrian migrants on their life satisfaction. The implementation part of the study was conducted with 18 and over Syrian migrants who reside in the city of Kilis. Data were collected from December 11, 2017–January 03, 2018 from 424 participants and then assessed. Descriptive statistics, significance test of difference between two means and one way analysis of variance (Anova), reliability analysis and multivariate regression analysis were used in the analysis of the data. As a result of the findings taken from the analyses, age, educational level, times of go to a health institution in a year affect the access and understanding for subdimensions of health literacy. In addition to, all dimensions of health literacy explained only %1.1 of the total variance in life satisfaction.

**Key Words:** *Health Literacy, Life Satisfaction, Syrian Migrants Under Temporary Protection*

## Introduction

According to the statistics for December 2017, nearly 3 million 424 thousand Syrians have been given shelter in Turkey under temporary protected status. Only 6.87% of Syrians in Turkey live in temporary accommodation centers (camps), while the rest live in non-camp settings (Ministry of Interior Directorate General of Migration Management, 2017). Among the major problems of asylum seekers, the most prominent are health-related problems. The negative reflections of migration precipitate many health problems and psychosocial problems. Conditions surrounding the migration process are likely to increase health vulnerability especially for those who migrate involuntarily (WHO, 2010: 9). So, the migration process is typically hard in terms of both physical health and psychosocial conditions, particularly for the people who have forced to migrate such as asylum seekers, refugees and individuals who have temporary protected status. This is why we decided to work on a variable related to health such as health literacy and a variable related to psychosocial situation such as life satisfaction. It is thought that this study will contribute significantly the literature and especially the local literature.

## Health Literacy

Health literacy, among the variables examined in this study, refers to the ability to access, understand and use information to live a healthy life and improve health (Jorm, 2000: 396). To put it differently, health literacy can be defined as how well one reads, writes and understands health-related information, and as the effect of this situation on making decisions about his or her own health. Such decisions have a wide range spanning from health behavior on a personal level to interaction with clinicians and access to services (Wells, 2008: 255).

After examining 17 definitions identified in the literature on health literacy in the name of Consortium Health Literacy Project European (HLS-EU), Sorensen and others (2012: 3) have described the health literacy and they stated that health literacy is linked with literacy and means that individuals have skills such as knowledge, motivation, access, understanding, assessment, and the use of health information to make decisions and evaluations on health

promotion with respect to everyday health care, disease prevention, and the lifelong protection and promotion of quality of life. Health literacy is also defined as an individual's capacity to obtain, process, and understand basic health information and services required to take appropriate health decisions (Toci et al., 2015: 667). Several studies report that literacy influences health status more strongly than such variables as income, working status, education status, race, and ethnic group (Weiss, 1992: 262; Baker et al., 1997: 1282; Sudore et al., 2006: 809). Health literacy is, therefore, one of the important factors like income, social status, physical environment etc. that affect health and must be taken into consideration.

### Life Satisfaction

Life satisfaction means that one makes an assessment of his or her life and gives information about his or her entire life cases (Diener and Diener, 1995: 654). In other words, life satisfaction refers to one's cognitive reasoning about his or her own life (Pavot and Diener, 1993: 164). The concepts of life satisfaction, happiness, and subjective well-being are interrelated and intertwined. Life satisfaction with positive affection indicates certain aspects of subjective well-being (Diener, 1984: 552-553). In general, positive evaluations of life satisfaction are related to happiness, success and healthy life, while negative evaluations of life satisfaction are related to unhappiness and depression (Proctor et al., 2009: 584). Migration is also a process that is stressful and hard to adapt and is likely to lead to many psychological problems (Ehnholt and Yule, 2006: 1199-1200). Thus, migration affects migrants' life satisfaction.

### Aim

The aim of this study to examine the effects of such variables as age, gender, marital status and educational level etc. on subdimensions of health literacy and life satisfaction. Another aim of study is to investigate the effects of health literacy levels of Syrian migrants on their life satisfaction.

## Method

### Universe and Sampling

The universe of the study consists of 18 and over Syrian migrants under temporary protection who reside in the city of Kilis. According to 2017 Ministry of Interior Directorate General of Migration Management of Kilis province and district center, the population Syrian migrants is 131.914. The sample volume in the study has been determined by a non-clustered, single – step random probability sampling method based on the primary mass ratios (Collins, 1986: 103). The size of sampling in the study to be 384 participants by taking 5% at acceptable error level, 95% confidence interval and actualization probability of event within the main mass 50%. However, in this study, a questionnaire was applied to a total of 424 Syrian migrants. Data were collected via face to face interviews that were conducted by the present researchers, between 11 December 2017 and 3 January 2018.

### Ethical Considerations

This study was approved by Ethics Committee of Burdur Mehmet Akif Ersoy University (GO2017/148). Potential participants were given a document explaining that participation was voluntary and the collected data would be used solely for scientific purposes. The informed consent was obtained from the respondents.

### Data Collection Method

The “Health Literacy Scale” developed by Toci et al. in 2013, and adapted to Turkish by Aras and Bayık Temel (2017: 85), was used to measure health literacy. This scale consists of 25 items and 4 subdimensions (access, understanding, appraisal and application). The items are rated on a 5-point Likert scale (Unable to=1, Without any difficulty=5). The internal consistency coefficient for this scale (Cronbach’s alpha) was 0.85 in the present study. Besides, the reliability coefficients for the subdimensions of the scale which are access (0.84), understanding (0.74), appraisal (0.76) and application (0.71) were calculated higher than 0.70.

The “Life Satisfaction Scale” developed by Diener et al. in 1985, and adapted to Turkish by Köker in 1991, was used in the study. The scale consists of 5

items and its items are rated on a 7-point Likert scale (1= Strongly disagree, 7 =Strongly agree). The internal consistency coefficient for this scale (Cronbach's alpha) was 0.79 in the present study.

### **Analysis of Data**

All statistical analyses were performed using Statistical Package for the Social Science Version 20.0. The significance test of the difference between the two means and one way analysis of variance (Anova) were used in order to investigate whether there are differences in the variables examined. The Tukey test was used to determine the differences between the units. In addition to, reliability analysis, correlation analysis and multivariate regression analysis were used. The level of significance was set at 0.05.

### **Limitations**

This study included only Syrian migrants aged 18 and over living in Kilis, Turkey under temporary protected status. It did not include Syrian tourists, and Syrians residing in Turkey under legal status other than temporary protected status.

## **Results**

The descriptive information regarding the participating in the study were given in Table 1. According to this; 46.7% of the participants were between in the age group of 26-44. While 53.8% of the participants were male, 63.9% were single. Whereas 35.1% of the participants were primary school graduate; 45.0% of them declared that they had 500 Turkish Liras or less monthly income. 49.1% of the participants stated that the number of person in their family is order 4 or less. While 38.7% of the migrants stated that they have gone to a health institution 3-5 times, 12.7% expressed that they have visited a health institution 11 or more times (Table 1).

**Table 1.** Descriptive Characteristics of the Respondents

<b>Variables</b>	<b>N</b>	<b>%</b>
<b>Age(year)</b>		
≤ 25	99	23.3
26-44	198	46.7
45 ≥	127	30.0
<b>Gender</b>		
Female	196	46.2
Male	228	53.8
<b>Marital status</b>		
Married	153	36.1
Single	271	63.9
<b>Educational level</b>		
Primary school	149	35.1
Secondary school	98	23.1
High School	90	21.3
Associate	41	9.7
Undergraduate	46	10.8
<b>Monthly Income</b>		
≤ 500 TL	191	45.0
501-1000 TL	63	14.9
1001-1500 TL	79	18.6
1501 ≥	91	21.5
<b>Number of person in family</b>		
≤ 4	208	49.1
5-6	128	30.1
7 ≥	88	20.8
<b>How many times you going to a health institution in a year?</b>		
1-2	148	34.9
3-5	164	38.7
6-10	58	13.7
11 ≥	54	12.7

Considering the basic statistics about study variables in Table 2, it stands out that the appraisal (3.29±0.61) got the highest average and the understanding (3.16±0.65) got the lowest average among the health literacy subdimensions. It can be said that the perception of the participants about the life satisfaction (2.92±1.04) variable is low range in a 7-point Likert type scale. The correlations between the subgroups of the health literacy are positively low and moderate (0.155 ≤ r ≤ 0.556). In addition to there were very low correlation between life satisfaction and understanding that one of the subdimension of health literacy (p<0.05).

**Table 2.** Mean, Standard Deviations and Intercorrelations Values Regarding Research Variables

Variables	Mean	SD	1	2	3	4	5
1. Access	3.18	0.82	(1)				
2. Understanding	3.16	0.65	.556**	(1)			
3. Appraisal	3.29	0.61	.220**	.328**	(1)		
4. Application	3.25	0.62	.155**	.272**	.380**	(1)	
5. Life Satisfaction	2.92	1.04	.047	.100*	.054	.031	(1)

SD, standard deviation. \*\*Correlation is significant 0.01 (two-tailed). \*Correlation is significant 0.05 (two-tailed).

The health literacy and life satisfaction scores of the participants of the study were compared with respect to various variables, and t-test and Anova test results thereof are shown in Table 3. Considering the results of the t-test and Anova, which compare the access scores of the participants with respect to various variables, participants' access scores are observed to reveal statistically meaningful differences by age (F=4.493; p<0.05).

According to the results of the Tukey test, having been conducted to find from which groups these differences originate, participants who were 45 years old and above have been found to give lower scores to access when compared with those of other groups. Participants' scoring of access statistically varies also in terms of marital status (t= -2.128, p<0.05) as single participants are observed with higher scores (3.24) than those of the married participants (3.07). Other variables with statistically significant impact on access subdimension



are the participants educational levels ( $F = 3.339$ ,  $p < 0.05$ ), number of person in family ( $F = 3.663$ ,  $p < 0.05$ ) and times of go to a health institution in a year ( $F = 3.752$ ,  $p < 0.05$ ).

The Tukey test results reveal that among the participants, those who are graduates of primary education have lower scores (3.03) in comparison with those who are graduates of associate degree programmes (3.49). Additionally, the participants who were 11 or more times go to a health institution in a year have been found to give lower scores to access subdimension.

**Table 3.** The Views of the Respondents on Health Literacy Sub-Dimensions and Life Satisfaction According to Individual Characteristics

Variables	Access		Understanding		Appraisal		Application		Life Satisfaction	
	M.	SD.	M.	SD.	M.	SD.	M.	SD.	M.	SD.
<i>Age</i>										
≤ 25	3.33	0.70	3.30	0.58	3.34	0.52	3.33	0.56	2.90	1.09
26-44	3.21	0.78	3.16	0.58	3.28	0.61	3.28	0.61	2.92	1.00
45 ≥	3.01	0.95	3.06	0.79	3.27	0.66	3.16	1.66	2.94	1.06
	F=4.493; p=0.012		F=3.676; p=0.026		F=0.414; p=0.661		F=2.378; p=0.094		F=0.045; p=0.956	
<i>Gender</i>										
Female	3.11	0.86	3.10	0.70	3.26	0.61	3.21	0.59	2.84	0.95
Male	3.23	0.79	3.21	0.61	3.31	0.61	3.30	0.63	2.98	1.11
	t=-1.508; p=0.132		t=-1.742; p=0.082		t=-0.896; p=0.371		t=-1.414; p=0.158		t=-1.398; p=0.163	
<i>Marital status</i>										
Married	3.07	0.83	3.11	0.66	3.29	0.58	3.23	0.57	2.89	0.99
Single	3.24	0.82	3.19	0.65	3.29	0.62	3.27	0.64	2.93	1.06
	t=-2.128; p=0.034		t=-1.185; p=0.237		t=0.004; p=0.997		t=-0.685; p=0.494		t=-0.368; p=0.713	
<i>Educational level</i>										
Primary school	3.03	0.91	3.00	0.76	3.22	0.66	3.16	0.59	2.88	1.00
Secondary school	3.13	0.72	3.22	0.55	3.37	0.54	3.40	0.63	2.88	0.88
High School	3.31	0.68	3.21	0.57	3.23	0.55	3.22	0.60	2.88	1.11
Associate	3.49	0.79	3.35	0.56	3.40	0.59	3.23	0.59	3.03	1.17

Undergraduate	3.20	0.94	3.32	0.63	3.31	0.69	3.33	0.66	3.14	1.20
	F= 3.339; p=0,010		F=4.250; p=0.002		F=1.502; p=0.201		F=2.640; p=0.033		F=0.817; p=0.515	
<b>Monthly income</b>										
≤ 500 TL	3.12	0.88	3.15	0.71	3.28	0.61	3.22	0.59	2.90	0.97
501-1000 TL	3.23	0.74	3.06	0.58	3.29	0.45	3.20	0.60	2.76	1.08
1001-1500 TL	3.25	0.84	3.19	0.64	3.29	0.60	3.40	0.63	2.92	1.07
1501 ≥	3.20	0.75	3.24	0.59	3.31	0.70	3.24	0.66	3.07	1.13
	F= 0.613; p=0.607		F=1.045; p=0.372		F=0.046; p=0.987		F=1.849 p=0.138		F=1.124 p=0.339	
<b>Number of person in family</b>										
≤ 4	3.09	0.84	3.12	0.67	3.33	0.59	3.24	0.60	2.86	0.97
5-6	3.33	0.73	3.24	0.59	3.31	0.63	3.31	0.64	2.95	1.09
7 ≥	3.18	0.89	3.16	0.71	3.16	0.61	3.20	0.60	3.00	1.11
	F=3.663; p=0.026		F=1.408; p=0.246		F=2.588; p=0.076		F=0.839; p=0.433		F=0.684; p=0.505	
<b>How many times you going to a health institution in a year?</b>										
1-2	3.19	0.78	3.20	0.64	3.37	0.59	3.40	0.64	2.87	1.00
3-5	3.30	0.77	3.25	0.56	3.25	0.58	3.20	0.59	3.07	1.08
6-10	3.03	0.85	2.93	0.70	3.13	0.57	3.10	0.55	2.60	0.87
11 ≥	2.92	1.02	3.05	0.84	3.34	0.75	3.18	0.62	2.93	1.10
	F=3.752; p=0.011		F=4.078; p=0.007		F=2.481; p=0.061		F=4.701; p=0.003		F=3.027; p=0.029	

M.=Mean; SD.=Standard Deviation, \*p<0.05

Considering the results of the t-test and Anova, which compare the understanding scores of the participants with respect to various variables, participants' understanding scores are observed to reveal statistically meaningful differences with respect to age (F=3.676; p<0.05), educational levels (F=4.250; p<0.05) and times of go to a health institution in a year (F = 4.078, p<0.05). According to the results of the Tukey test, having been conducted to find from which groups these differences originate, participants who were 45 years old and above have been found to give lower scores to access when compared with those of other groups. In addition to, those who are graduates of primary education have lower scores (3.00) in comparison with those who are graduates of associate degree programmes (3.35). Lastly,

the participants who were 6-10 times go to a health institution in a year have been found to give lower scores to understanding subdimension.

Considering the results of the tests, which compare the participants' scorings of appraisal subdimension with respect to various variables, groups' scorings to appraisal do not seem to vary statistically (Table 3).

Considering the results of the Anova, which compare the application scores of the participants with respect to various variables, participants' application scores are observed to reveal statistically meaningful differences with respect to educational levels ( $F=2.640$ ;  $p<0.05$ ) and times of go to a health institution in a year ( $F = 4.701$ ,  $p<0.05$ ). According to the results of the Tukey test, those who are graduates of primary education have lower scores (3.16) in comparison with those who are graduates of secondary education (3.40). In addition to, the participants who were 1-2 times go to a health institution in a year have been found to give highest scores to application subdimension.

Lastly, considering the results of the Anova, which compare the life satisfaction scores of the participants with respect to various variables, participants' life satisfaction scores are observed to reveal statistically meaningful differences with times of going to a health institution in a year ( $F=3.027$ ;  $p<0.05$ ). The Tukey test results reveal that the participants who were 3-5 times go to a health institution in a year have been found to give highest scores to life satisfaction.

Table 4 indicated the results of the regression analysis carried out to reveal the effects of participants' perceptions of health literacy subdimensions on the dimension of life satisfaction. In the regression model created, the Durbin Watson coefficient is less than 2.5 and the variance inflation value (VIF) is less than 10, which indicates that there is not any autocorrelation and multicollinearity problem (Hair et al., 1998: 455). From this information, it can be said that there is not any autocorrelation and multicollinearity problem in the regression model given in Table 4. As seen on the table, the results indicated that  $R^2$  value of .011 is low and overall relationships were not significant ( $F=1.122$ ,  $p > 0.05$ ). Overall, the health literacy represents about 1.1% of the variance on life satisfaction.

**Table 4.** Multiple regression analysis between health literacy and life satisfaction

<i>Variable</i>	<i>B</i>	<i>Std. Error</i>	<i>B</i>	<i>T</i>	<i>p</i>	<i>VIF</i>
(Constant)	2.346	.362		6.486	.000	
Access	-.016	.074	-.013	-.221	.825	1.450
Understanding	.158	.097	.100	1.630	.104	1.582
Appraisal	.044	.093	.026	.472	.637	1.251
Application	-.006	.090	-.004	-.069	.945	1.204
<b><i>R = 0.103</i></b>	<b><i>R<sup>2</sup> = 0.011</i></b>	<b><i>Durbin Watson = 1.636</i></b>				
<b><i>F = 1.122</i></b>	<b><i>p = 0.345</i></b>					

\* p<0.01

Criterion: Life Satisfaction

## Discussion

Health literacy is one of the important factors directly affecting health and empowerment (Kickbusch, 2001: 294). It is clear that a high level of health literacy helps individuals to substantially facilitate their own lives and promote their quality of life. Toci et al. (2015: 667) also highlight the importance of health literacy as individuals are able to make appropriate decisions on their own health and to obtain, assess and understand basic health information and services.

Migrants are generally at a disadvantage in terms of social risks and access to services. Indeed, migrants who are mostly unfamiliar with the language of receiving country may be at risk from both literacy in the relevant language and health literacy. Thus, there is a need to expand scientific research on Syrians constituting the largest migrant group in Turkey that deals with both physical and psychosocial aspects. The literature includes a limited volume of research on the health literacy status and life satisfaction of Syrian asylum seekers, which is also an important indicator of the need for scientific research on this issue.

The aim of this study is to examine the effect of such some personal variables as age, gender, marital status and educational level etc. on health literacy and life satisfaction and to investigate whether health literacy has an impact on life satisfaction. However, according to the regression model created in the study,

health literacy explained only 1% of the total variance on life satisfaction and the resulting relationship was not significant. This result can be interpreted as follows: among the factors affecting life satisfaction of Syrian immigrants living in Turkey, those directly affecting life satisfactions, such as housing, nutrition, and security are individually much more important than health literacy.

According to the research results, the participants had a moderate level of health literacy and a low level of life satisfaction. The Syrian migrants had the highest level of health literacy in the appraisal subdimension, while they had the lowest level of health literacy in the understanding subdimension. The most important reason why the level of understanding subdimension is low seems to be due to the language problem of migrants. Wångdahl et al. (2014) surveyed refugees in Sweden and found that the majority of refugees had limited or poor health literacy. Şeker and Boysan (2013) found that Iranian asylum seekers had low scores of life satisfaction. Research on Bosnian refugees living in Norway also reported that the life satisfaction of refugees was very low (Selm et al., 1997: 145). Bowen (2002, 69) reported that refugees in Texas had a moderate level of life satisfaction. Şeker and Sirkeci (2014) analyzed the life satisfaction of female of Turkish origin living in the UK and found that migrant female had high scores of life satisfaction.

According to the research results based on the responses of Syrian migrants included in the research, the participants' scores of health literacy in access and understanding subdimensions showed statistically significant differences according to age. Accordingly, Syrian migrants aged 25 and below had higher scores than other age groups. Baker et al. (2002) reported that health situation of old and non-white individuals with low income were more disadvantageous compared to those with adequate health literacy. Nguyen and Reardon (2013) found that English proficiency and ethnicity/race played an important role especially in the health of older migrants. Guerra and Shea (2007) found a correlation between inadequate literacy and old age, gender, and minority ethnicity.

In this study, the participants' perceived health literacy in four subdimensions and their perceived life satisfaction statistically significantly not differed by both gender and monthly income. However, male had higher scores than female.

This result is associated with the fact that male are more involved in social life compared to female. Similarly, Şeker and Boysan (2013:32) reported that male Iranian asylum seekers had significantly higher scores of life satisfaction compared to female. Life satisfaction and by extension subjective well-being is obviously related to economic status and prosperity (Myers and Diener, 1995: 12-13). In their research conducted in China, Hong and Shuo (2016) showed that such factors as health status, economic status, and educational status had a significant impact on the life satisfaction of young migrants. The present study also found that the Syrian migrants with a high level of income had higher mean scores of life satisfaction compared to others. Accordingly, it seems that Syrians with higher incomes are more involved both in social life and in working life and thus have greater life satisfaction.

According to the research results, the participants' perceived health literacy in the access subdimension statistically significantly differed by marital status and the number of person in family. Accordingly, those who are married and those with a lower number of people in family had lower access scores.

The research results showed that the participants' perceived health literacy in the access, understanding, and application subdimensions statistically significantly differed by educational status. Accordingly, primary school graduates attained the lowest score in all these dimensions. Baker et al. (1998) argued that individuals with inadequate functional health literacy were two times more at risk of hospital admission compared to those with adequate functional health literacy. More recent research also reported that limited literacy is independently associated with an almost 2-fold increase in mortality especially in the elderly (Sudore et al., 2006: 810).

The research results also showed that the participants' perceived life satisfaction and their perceived health literacy in the access, understanding, and application subdimensions statistically significantly differed by the times of go to a health institution in a year. Accordingly, the participants admitting to a health institution 3 to 5 times in a year had the highest scores of life satisfaction. Thus, it seems that the more times people admit to a health institution, the greater life satisfaction they have depending on the increased levels of accessing, communicating, understanding, and applying.

## Conclusion

In conclusion, the research results showed that the health literacy and life satisfaction of Syrian migrants living in Turkey under temporary protected status varied according to several variables. Additionally, the level of health literacy was moderate and the level of life satisfaction was low in general for the entire group. Efforts to increase the life satisfaction of immigrant groups surveyed in this study also help to accelerate the integration process and to promote the psychosocial welfare of immigrants. Thus, it seems to be appropriate that extensive work related to these points are planned and organized by central and local government authorities, public and private health industries, social service organizations, and non-governmental organizations. Especially some works which focus on integration and psychosocial support can increase immigrants' life satisfaction. Such works should benefit from especially professionals working directly with migrants (social workers, community care workers, health care workers, nurses, psychologists, etc.). Finally, it is thought that future research conducted with larger samples and in geographically more diverse regions can provide more effective results on Syrians in Turkey.

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