KONDA Barometer

THEMES

Perception of Health

October 2016

KONDA

ARAŞTIRMA VE DANIŞMANLIK

CONTENTS

1. EXECUTIVE SUMMARY 3

2. PERCEPTION OF HEALTH 4

2.1. Inequality and Discrimination in Healthcare 4
2.2. Overview 9
2.3. Healthy Living and Eating Habits 11
2.4. Relationship with Healthcare Institutions 22
2.5. Opinion on Healthcare Services 25
2.6. Discussion on the Findings on Health 35

3. RESEARCH ID 40

3.1. Overall Description of the Survey 40
3.2. The Sample 40

4. FREQUENCY TABLES 42

4.1. Profile of the Respondents 42
4.2. Opinion on Health 46

5. GLOSSARY of TERMS 55

1. EXECUTIVE SUMMARY

The survey which forms the basis of this report was conducted on 1-2 October 2016 by face-to-face interviews with 2532 individuals in 146 neighborhoods and villages of 113 districts including the central districts of 30 provinces.

THEME OF THE MONTH: PERCEPTION OF HEALTH

We handled public health as the theme of the October'16 Barometer survey. Firstly, we determined the general health of the society and analyzed the citizens' habits related to health. According to the survey, 79 percent of the society in Turkey are satisfied with their health condition, however we observe that this general opinion of satisfaction is formed irrespective of the health conditions of the individuals. We determined that currently, one in every two people suffer from an ongoing/chronic disease and again, about 40 percent of the society are on prescription drugs.

We also analyzed the interviewees' other nutrition and healthy living habits. We determined that 60 percent of the society had done no physical exercise at all in the past one week. On the other hand, we observed that 56 percent have cut down on at least one of salt, sugar or flour compared to the past. In addition, 39 percent of the society have been actively smoking (i.e. more than one cigarette a day) and 74 percent have never had any alcoholic drinks in their lives.

As a result of the analysis, we observed that the most significant differentiation in the social masses in terms of healthy nutrition and healthy living are age and gender. The majority of those who do physical exercise, smoke and consume alcohol and carbonated beverages are young people and men, however the majority of those who regularly have check-ups and are on prescription drugs are older people and women. Accordingly, those who are the least careful about their health in the society even though they do physical exercise at the highest rate are young men aged 18-32 whereas those who are the most careful about their health although they do physical exercise at the lowest rate are women aged 65 and above.

As a second aspect of the theme of health, we handled discrimination and politics in the field of health. Almost half of the society (46 percent) indicated that physicians and nurses show discriminating behavior and one third (35 percent) have directly been subject to such discrimination. The most frequently mentioned answers as the main reason of discrimination are "clothing" at a rate of 19 percent and "financial situation" at a rate of 18 percent.

Three fourth of the society indicated that they were happy with health services and again three fourth stated that during the Ak Parti government, health services have improved. This rate had been 52 percent when we last asked about health services during the Ak Parti period in 2007. It seems that in the nine years that passed, the support for the Ak Parti government about health has increased by 25 points indicating a consensus unmatched by any other social matter. 95 percent of the Ak Parti electorate indicated that health services have improved and indeed, there is considerable support from other parties: 45 percent of the CHP electorate, 67 percent of the MHP electorate and 40 percent of the HDP electorate indicated that health services have improved during the term of the Ak Parti government.

2. PERCEPTION OF HEALTH

2.1. Inequality and Discrimination in Healthcare

Ayşecan Terzioğlu, Asst. Prof.
Visiting Professor, Department of Sociology, Galatasaray University

The objective approach of the modern and biomedical model of medicine forms the basis of and dominates healthcare in Turkey and throughout the world. In this regard, since the 19th century, the biomedical model of medicine differs from older systems such as Chinese Medicine or Islamic Medicine in terms of its taking as the basis positive sciences such as biology, physics and chemistry all of which also claim objectivity and mind-body dualism. The claim of objectivity is frequently repeated as a part of the education provided in medical schools and departments of health sciences and nursing, and reinforced by the Hippocratic Oath and similar oaths taken by medical graduates altogether in graduation and oath-taking ceremonies of these departments according to which health professionals start their professional life by vowing that they will treat each patient equally regardless of their language, religion, ethnic origin, nationality or sexual orientation. However, health professionals, patients and all individuals of the society who are more or less experienced in healthcare come to develop awareness at different levels of the fact that these claims of objectivity and equality in fact are based on an idealized image of medicine.

Just like the case is in other fields such as education and business, healthcare is also very much affected by the political, economic, legal, social and cultural problems as well as the inequalities and discrimination in the society in which it exists and reproduces these problems in different ways. Asymmetrical power relations and the patterns enforced by such relations, marginalization and inequality are not only reflected on healthcare and questioned, negotiated and reproduced there, but also the institutions and actors in healthcare actively add new dimensions to these problems in the society by producing their own patterns, marginalization and inequality. Therefore, health inequality is a multi-layered and multi-dimensional matter entailing various ways of coping with and struggling against such inequality. Arthur Kleinman (1995), a physician himself, who is one of the first social scientists who has worked in this matter, reported that today, biomedical medicine has become institutionalized and been accepted throughout the world as the most common and valid medical system. Kleinman indicated that wherever we live in the world and whoever we are, we will be faced with modern medical institutions and actors many times in our lives due to conditions such as birth, disease or preserving health. Precisely due to this indispensability of medicine in our lives, Kleinman supported that social scientists who study on health and diseases must cultivate a more critical approach to modern medicine in order that modern medicine can develop more pluralistic and comprehensive discourses and implementations that handle social distinctions equally.

Analyzing healthcare in Turkey through this intellectual point of view, it is observed that this field is in the midst of many political and economic discussions. For example, the

Program of Transformation in Healthcare put into force in 2003 has become a breakthrough which the Ak Parti which has been in power since then, prides itself and brings to the fore among its successes as an important factor in the increase in its voting rates, whereas both the members of the opposition parties and health professionals as well as certain patient groups criticized the program completely or in part claiming that the program reinforced the economic inequality in healthcare despite its aim of eliminating it. This transformation program is based on a performance system claimed to "enable maximum efficiency" according to which all costs of health professionals are limited as much as possible and physicians acquire revenues in parallel to the number of patients they examine (Sönmez, 2011). This transition program appoints family health centers and social health centers for primary healthcare instead of community clinics, enabling public workers to benefit from private hospitals by joining their security and paying an extra sum most of the time, and reducing medical bureaucracy.

However, the system failed to provide sufficient financial and logistic support to state hospitals and university training and research hospitals which in turn could not keep up with increasing population and medical developments. This situation widened the gap between private hospitals and state hospitals particularly in terms of quality of service, hygiene, general procedure and bureaucracy. In addition, the Full-Day Law put significant restrictions on physicians working in state hospitals which are a part of this program against working part-time in their private clinics or private universities. Consequently, prestigious and experienced professors of prominent state hospitals such as Çapa and Cerrahpaşa of Istanbul University, left these institutions. These problems highlighted the hospital hierarchy which already existed in the society according to which a significant part of the society started to think that in case of a severe health problem, the best treatment would be provided by private hospitals or the training and research hospitals of universities followed by state hospitals. However, despite the fact that many individuals utilize all their economic and social resources in order to benefit from private health institutions, the rate of those patients who receive treatment in private hospitals makes only 10 percent of the society. This hospital hierarchy in the perception of the society prevented efficient implementation of the referral system the first step of which consisted of Family Health Centers especially in metropolises and among middle-higher classes.

The number of private hospitals rapidly increased throughout Turkey in 1990's. Further, private universities established departments of medicine, health sciences and nursing one after another in the 2000's. These developments rendered the privatization policy in healthcare all the more visible and forceful. Under these circumstances where healthcare is considered as a market, health as goods and patients as clients, any increase in the number of patients, diseases and the medication used were seen as success. The amount of drugs taken from pharmacies increased by 2.2 folds in 8 years, from 770 million boxes in 2003 to 1,7 billion boxes in 2011. (Üçer, 2012). In 2016, the number approached 2 billion

boxes.[1] Problems related to extensive drug use, such as side effects, misuse, consumption after expiration date or consumption by other patients or for other diseases will lead to graver consequences as the drug use increases, especially considering that physicians or nurses spend only 5-10 minutes for the examination of each patient, leaving them no sufficient time for explaining drug use in detail.

According to the data of the Turkish Statistical Institute, health expenditures, on the other hand, increased by 3.5 fold between 1999 and 2008 reaching 44.8 billion dollars from the initial 12 billion dollars (Sönmez, 11). Under these circumstances which might be considered as neoliberalization in healthcare, the understanding "health as much as you can afford" has been internalized, replacing preventive medicine which had been emphasized especially in the 1960's and 1970's, by curative medicine which is significantly more expensive and less efficient. This situation changed not only medical implementations but also the perception of health and discourses, since the understanding of health as a fundamental human right as stated in the constitution of WHO was replaced by an understanding of health as a personal responsibility. Consequently, preventive medicine has been mostly reduced to mandatory public spots aired by TV channels, smoking ban in public areas regulated in a repressive mindset and implemented poorly, and again forced suggestions for struggle against obesity which would be utterly unfunctional for the lower classes of the society. This erosion in the discourses and implementations of preventive medicine led to a general suspicion in the society particularly against vaccines and vaccination. For instance, as a precaution against H1N1 commonly referred to as swine flu which started as an epidemic in Turkey in the autumn of 2009 and continued until the end of 2010, the Ministry of Health took into consideration the warnings of WHO and initiated a vast vaccination campaign. However, this campaign triggered a huge argument in the society about the contents and the necessity of the vaccine, and consequently, despite all efforts of the ministry, the rate of vaccination remained less than 5 percent. In conclusion, the then-Minister of Health Recep Akdağ stated that this epidemic caused many unnecessary deaths. (Delibaş, 2013).

In parallel to the fact that the Ak Parti adopted a general discourse reducing the social role of women to motherhood, sexual health has been reflected as reproductive health. Therefore, actual access to abortion, preventive methods against sexually transmitted diseases and contraceptive methods, education and materials has been significantly restricted. Such discourses and implementations reinforcing gender inequality against women in healthcare have been protested by feminist organizations many times. Similarly, LGBTI individuals and organizations defended their rights by drawing attention to inequality and marginalization against such individuals in healthcare. One of the most frequently uttered problems in this matter has been that gender-change surgeries referred to by trans individuals are conducted only on the guarantee that the individual will not have children and after

[1] http://www.trthaber.com/haber/saglik/yillik-tuketilen-ilac-2-milyar-kutuya-cikti-169609.html

mandatory group therapy, and incompetent surgeons taking part in such operations cause tragic failures.

The fact that the understanding of health as a fundamental human right is not emphasized in access to health and choice of hospital does not mean that the patient rights concept is altogether neglected. This concept exists at least in an institutional scale as understood from the patient right offices and brochures in hospitals, the availability of a complaint line receiving patients' complaints about health professionals and various institutions advocating patient rights. Of course, it is necessary to analyze as to who uses these opportunities, how often and why.

Other types of inequality noticed in Turkey with regard to health are geographical, ethnic and global. From the 19th century to the 2000's, it had been indicated that in the distribution of health institutions, the Western part of the country was more advantaged than the Eastern part and urban areas than rural areas, and there had been a constant attempt to overcome this geographical inequality. Yet, after the mass migration in the 1990's from the Southeast to metropolises such as Istanbul and Izmir, the issue shifted to the distribution of health institutions and inequality in the access to health in different neighborhoods within Istanbul where one fifth of the national population lives. Similarly, patients with rural origin, Easterners and uninformed patients have been frequently subject to labeling and discrimination. In this regard, the patient's accent, appearance, clothing and particularly factors indicating Islamic identity such as headscarf and beard have become the major criteria in such discrimination. This situation and the general difficulty in the rural areas in accessing healthcare services led to the fact that the majority of those living in rural areas have referred to health institutions only when they were severely ill. For instance, in a study conducted by sociologist Temmuz Gönç Şavran (2013) in Eskişehir reported in the village sampling taken in connection with this province that only 12 percent of the sampling referred to health institutions before getting severely ill.

Whereas in the 2000's, both the development of medical tourism in Turkey and Turkey's transformation from a transit country to a last-stop country in global immigration caused a significant increase in the number of foreign patients coming to Turkey. In compliance with the neoliberalized understanding of health, the experience foreign patients had in healthcare and their perception by health professionals of Turkey varied in a great deal according to their legal and political positions as well as their economic power. For instance, whereas an Arab tourist coming from any Gulf country to Turkey for surgery had no problems in healthcare and had all his/her needs met, health professionals frequently used discriminating and marginalizing statements about the health conditions of Syrians who escaped to Turkey from chaos and war in their country as of 2011, such as "They spread disease in Turkey" and "They ruin Turks' health."

Another important area about health inequality in Turkey is disability about which some improvement has occurred in recent years as a result of the organizations founded by disabled people and their relatives in order to articulate their demands.

Consequently, rehabilitation and training centers for the disabled have been opened and efforts have been made in order to render urban areas more accessible for the disabled. Further, medical studies such as stem cell experiments have gained importance in order to facilitate detection of disability before birth.

Another factor that influences access to health, problems in this matter and strategies in coping with these problems has been the changing understanding of health and disease in the society and the introduction of the concept of risk into these factors which also affects the interaction among them. According to the Risk Society concept suggested by German sociologist Ulrich Beck (2007), even when individuals are healthy, they are nevertheless obliged to the opinion and statements of certain specialists about the diseases they may potentially encounter. This concept is also valid for the risk of developing diseases with genetic transition or diseases related to exposure to radiation such as cancer and helps us understand the long-term global influence of the Chernobyl nuclear accident which significantly affected Turkey. Although in recent years the government have to a large extent abandoned preventive health concept, a significant awareness has formed in this regard in a large part of the society through disease risks. The media, especially health programs on TV, and the internet, especially physician websites and patient solidarity platforms have come to the fore as frequently used sources on diseases and disease risks. As a result of this, as shown in a study examining the transformation in health news published in daily Hürriyet between 1970 and 2010, news with negative attitude towards physicians and tabloid headlines such as "Doctors left no one with a gall bladder" created mistrust against doctors (Atabek et al, 2013). This mistrust against medical experts and trust in other sources of information and expertize also led to increased problems in the relationship between the society and health professionals.

The fact that stress and depression have grown to be perceived as risk factors that cause various diseases and complicate their treatment has gotten ahead of mind-body dualism in biomedical medicine, rendering mental health more of an issue. Yet, health professionals in Turkey who still widely embrace the biomedical medicine method based on mind-body dualism, put much less emphasis on the treatment of important chronic mental diseases such as schizophrenia. They were not very willing to treat and care for these patients, as private hospitals were costly and these patients usually needed to stay in mental health hospitals for long stretches of time or sometimes for a lifetime. State hospitals, on the other hand, could not keep up with the requirements in this regard eventually becoming "warehouses" in which mental patients were locked down for purposes of isolation from the society rather than treatment.

Even though the number and conditions of mental hospitals are still rather insufficient in Turkey, stress and depression have become the most talked-about and visible health problems with a constant pursuit for new treatments. Especially among the urban middle upper classes, antidepressant drug use and seeking psychological assistance have grown to be popular and normal. Similarly, alternative medical systems and treatment methods that question mind-body dualism such as yoga,

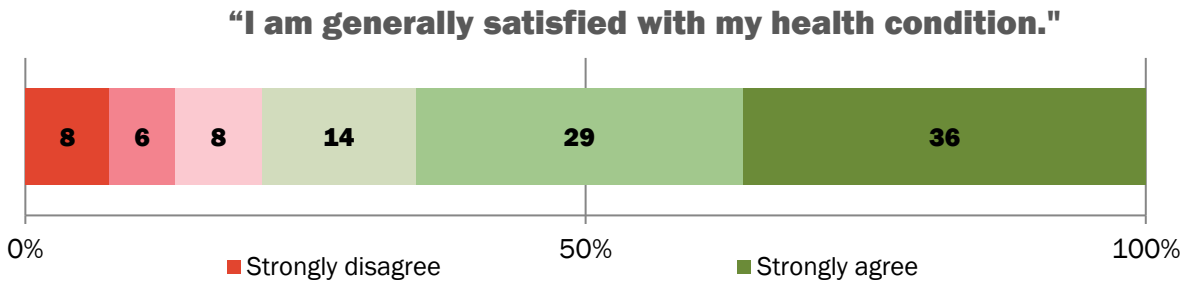
reiki, acupuncture, homeopathy and positive energy also have come to be more common.

2.2. Overview

In the field survey for the October'16 Barometer, we directed the respondents the question, "Which of the following two would scare you the most if it happened to you or your family?" Three out of every four people we interviewed provided the response of 'health problems', which makes it the most popular response option. While health has always been a source of concern for most in society, satisfaction with healthcare services and generally positive outlook on healthcare services provided by the state are shared by the overwhelming part of society, which makes it a rare occasion.

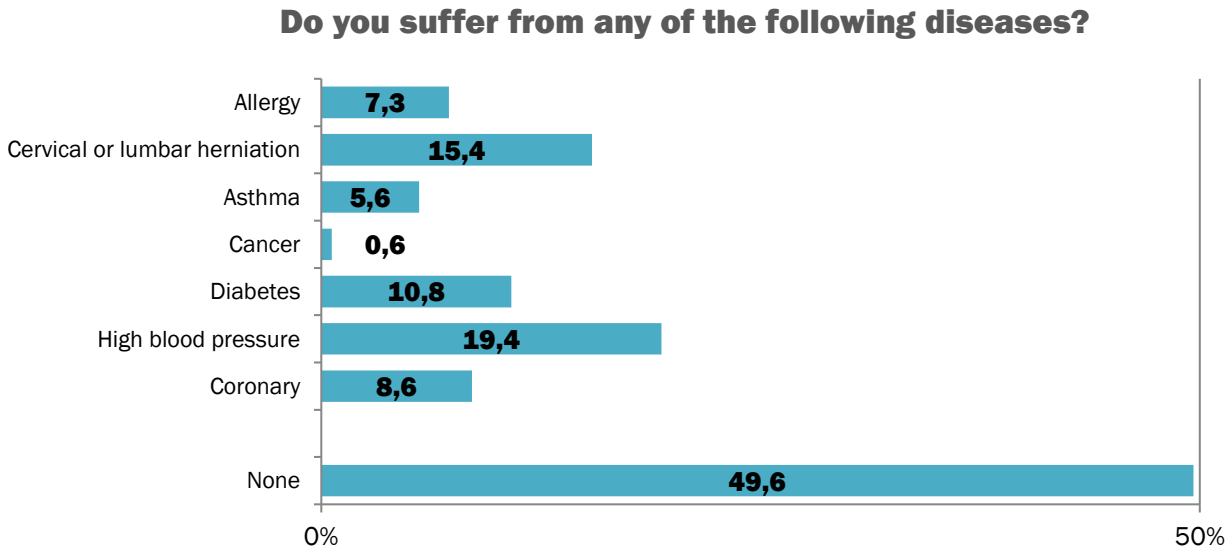
In this part of our report, we will first provide an overview of health in Turkey, by providing the data on diseases, use of medication, body-mass index and other similar data. Then, we will review the eating habits of society and examine the potential impact of these habits on health. Next, we will examine relationship of individuals with the healthcare system and healthcare institutions, and look into which healthcare institution they prefer, and when they prefer particular healthcare providers. In the following sections, we will elaborate on discrimination in the healthcare system and on the relationship between healthcare and politics.

We asked the respondents whether they were satisfied with their health condition to determine the general outlook on personal health. Four out of every five people, or in other words the overwhelming majority state that they are satisfied with their health condition, while one in five expressed dissatisfaction.



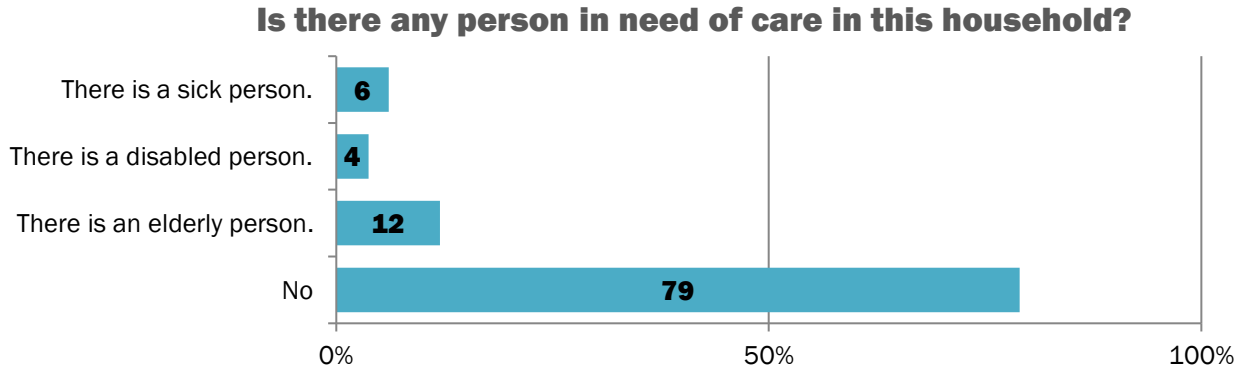
As small as the rate of those dissatisfied with their health condition may appear, one in 5, who are not satisfied with their health condition, corresponds to 11 million people.

After this question, we asked the respondents whether they had a chronic disease or health problem to find out that one out of every 2 people in society suffers from an illness to a varying severity. Suffice to say, nearly 27.5 million people in Turkey suffer from long-lasting and ongoing diseases or health problems.

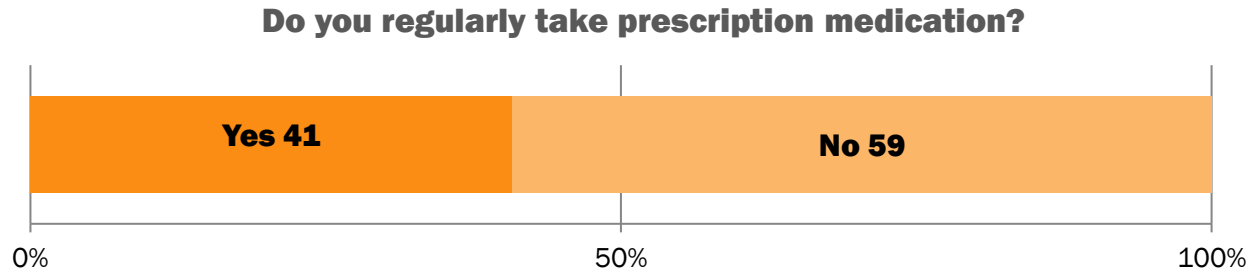


High blood pressure is the leading chronic health problem and one out of every 5 adults, or in other words 11 million people suffer from high blood pressure. It is followed, in order, by hernia (cervical or lumbar), diabetes and coronary diseases. However, what may initially appear as very low rates should not be overlooked. For example, the rate of 6 out of one thousand people who report having cancer corresponds to 350 thousand people in the adult population.

Similarly, in our visits to households to carry out face-to-face interviews on health, we also endeavored to determine the rate of households in Turkey with a person who requires regular or constant medical attention or care, by asking the respondents the following question: “Is there anyone in need of care in this household?” We found out that 1 out of every 5 households had at least one sick, handicapped or an elderly person in need of care.

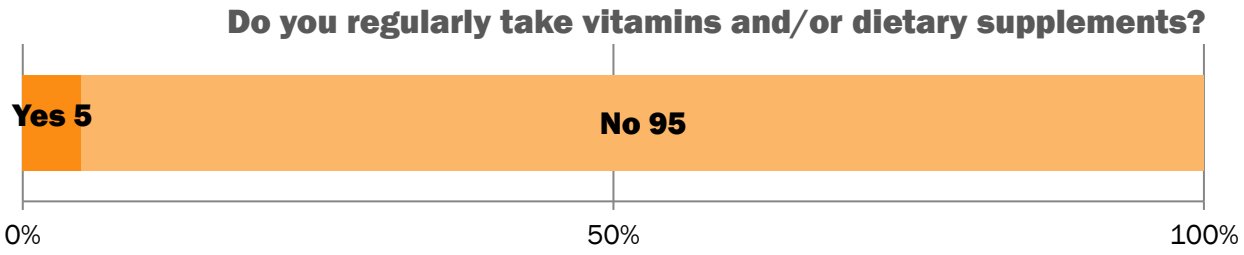


The rate of adults who regularly take medication provides another significant finding about the general health condition of the population. As shown in the graph below, nearly 4 out of every 10 people regularly use prescription drugs.



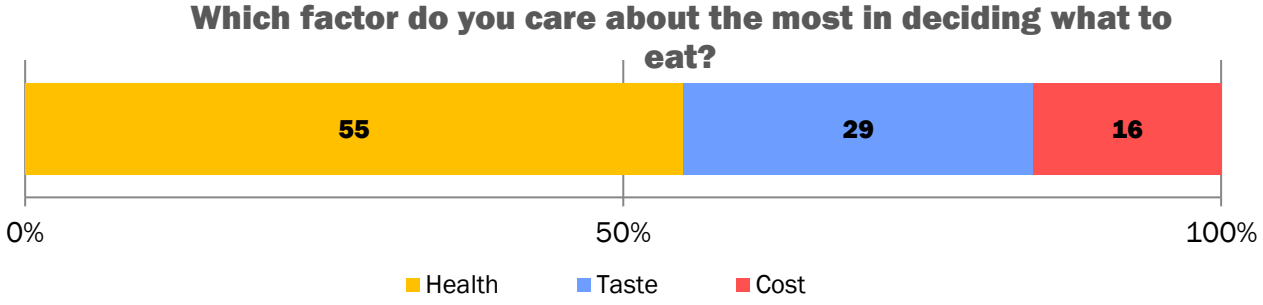
We asked the respondents whether they took any sleeping pills or anti-depressants regularly. 8 in one thousand people stated that they used sleeping pills, while 1.7 percent reported taking anti-depressants, which corresponds to 450 thousand and 900 thousand people, respectively.

Furthermore, we found out that five percent of the respondents regularly took vitamins or dietary supplements, which comes across as 2.7 million people in the adult population.



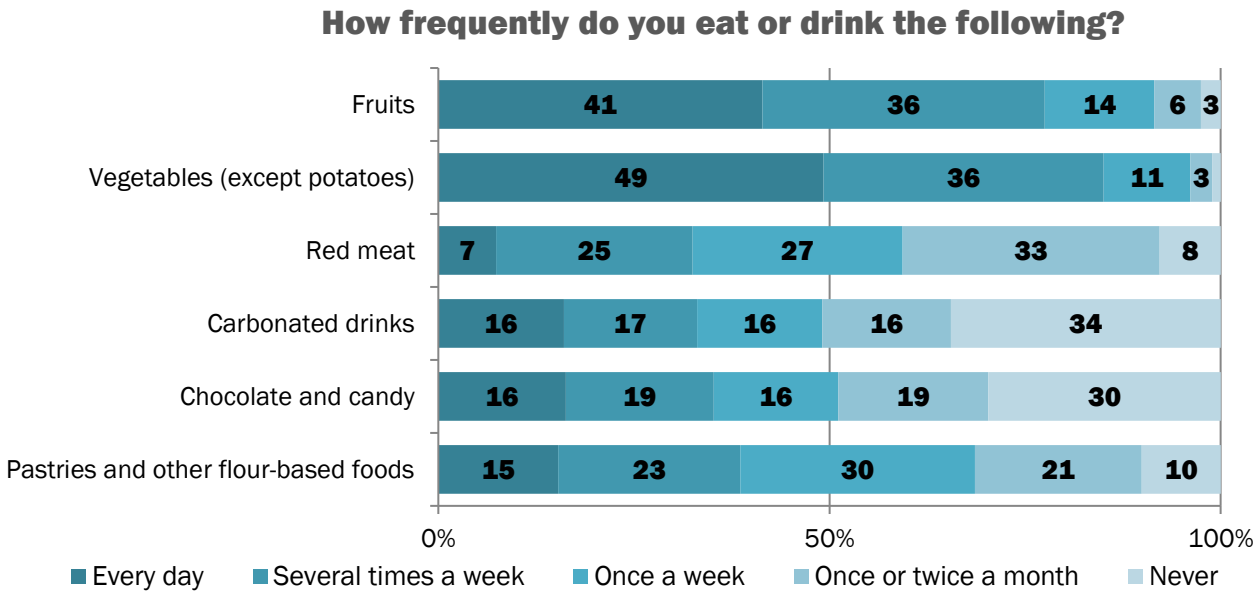
2.3. Healthy Living and Eating Habits

As noted by Dr. Ayşecan Terzioğlu in the introduction, the healthcare system in Turkey has gone through a dramatic change over the last decade, where preventive healthcare approach has been replaced by a treatment-focused healthcare approach. In this light, we asked the respondents various questions to make better sense of their healthy living and eating habits. Eating healthy foods is the most important factor in making dietary decisions for 55 percent of the public. This is followed by taste at 29 percent and cost at 16 percent.



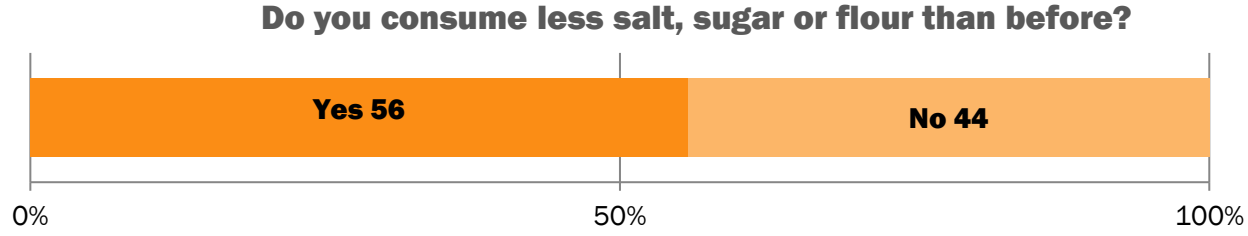
We also asked the respondents what types of food they consumed and how frequently they consumed them. The overwhelming majority state that they eat fruits (77 percent) and vegetables (85 percent) at least twice a week. The rate of those who report

eating meat on a daily basis is similar to the rate of those who state that they never eat meat. 4.5 million people in the adult population eat meat every day, while 4 million people don't eat meat at all.

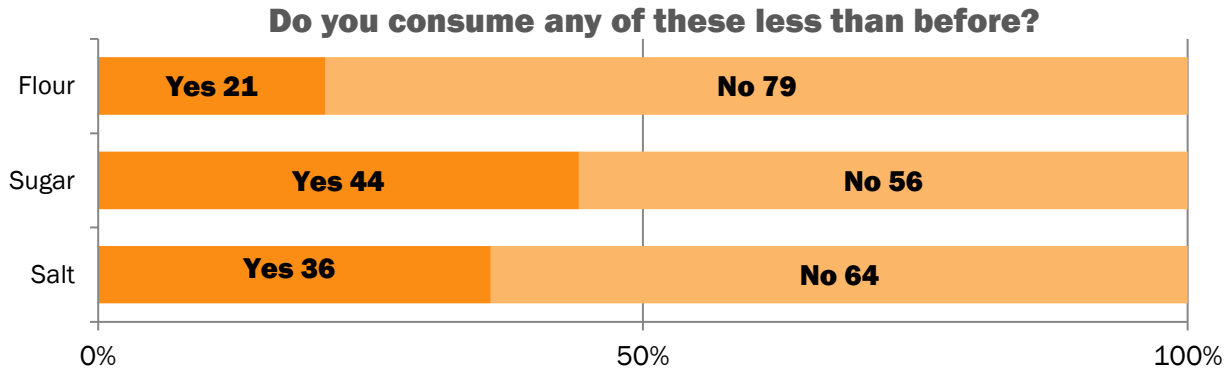


15 percent (i.e. 8 million adults) report consuming carbonated beverages (coke, 7 Up), chocolate or parties on a daily basis. It appears that society is divided in terms coke or chocolate consumption. While 33 percent state that they frequently drink coke (i.e. several times a week or every day), the rate of those who never drink coke is 34 percent. Similarly, frequent consumers of chocolate or candy make up for 35 percent and those who never eat such things correspond to 30 percent of society.

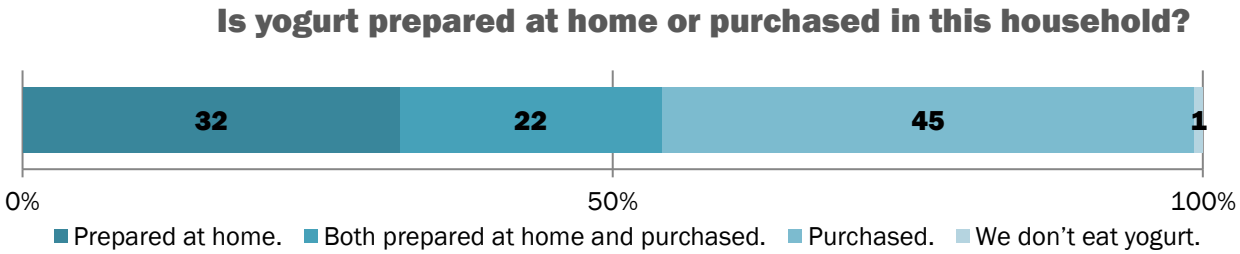
We also asked the respondents whether they have cut down on consuming salt, sugar or flour in their lives. As it can be seen in the graph below, 56 percent of society have pointed out cutting down on at least one of these items. This rate is in full confirmation with what we have found out in our **KONDA Lifestyles Research** in 2015. In other words, the rate of the respondents who cut down on at least one of the white foods has not changed over the last year.



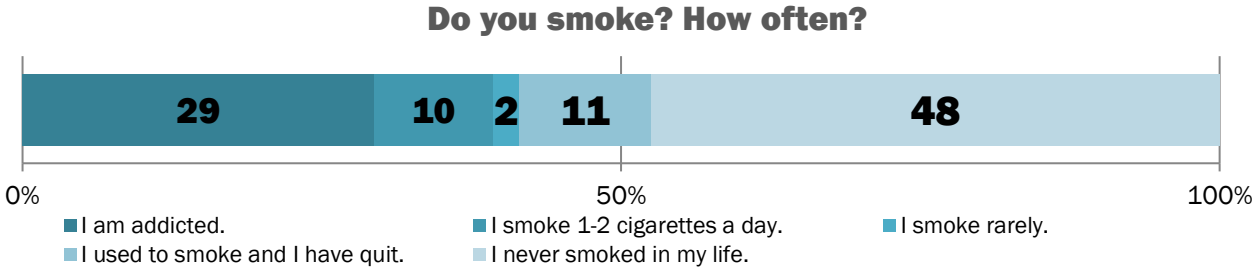
When we examine the responses for salt, sugar and flour individually, we observe that 44 percent report consuming less sugar than before, followed by 36 percent cutting down on salt. In comparison, only 21 percent state having started eating less flour-based foods than before.



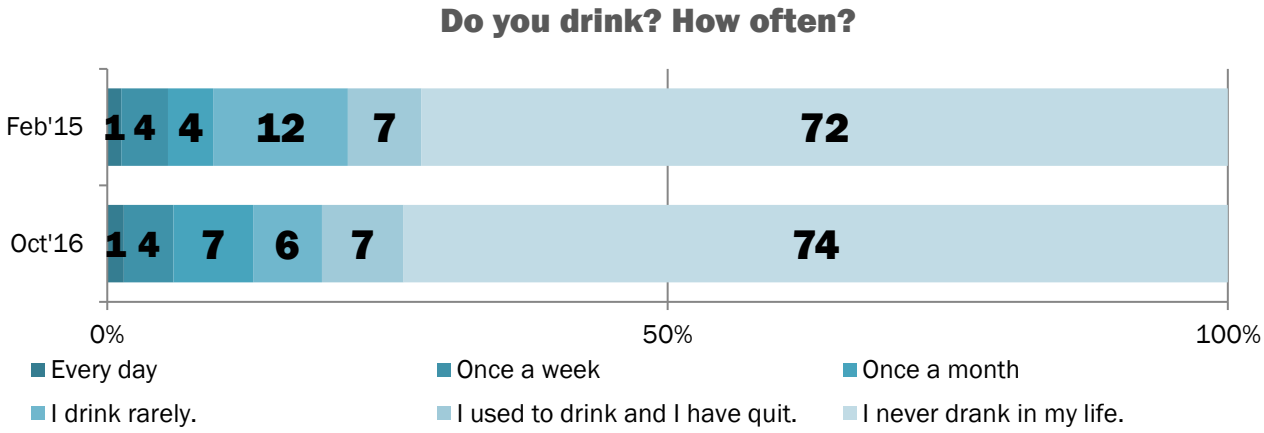
The rate of yogurt-consuming households also comes across as a significant data, although it is not a direct indicator of a healthy dietary habit. Yogurt is never consumed in only 1 percent of the households. Yogurt is purchased in nearly one of every 2 households, prepared at home one out of every 3 households, and both purchased and prepared at home in one out of every 5 households.

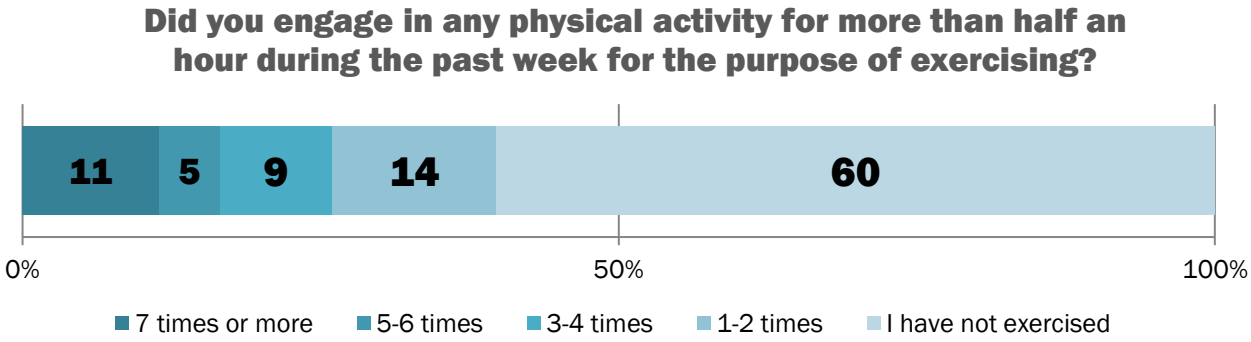


Half of the adult population report that they do not smoke. On the other hand, 29 percent report identify themselves as a smoker. In total, 39 percent smoke every day to a varying degree and the number of people who quit smoking corresponds to 5.5 million people.



We had last measured the rate of drinkers in society in our KONDA Lifestyles Research in 2015. The responses to this question in this month's research shows that the rates of drinkers and non-drinkers have not changed significantly over the past twenty months. Again, 5 percent reported drinking every day or once a week, while 3 out of every 4 people noted that they have never drunk alcohol in their lives. The greatest change is observed in the group of occasional drinkers, which grew smaller by half.



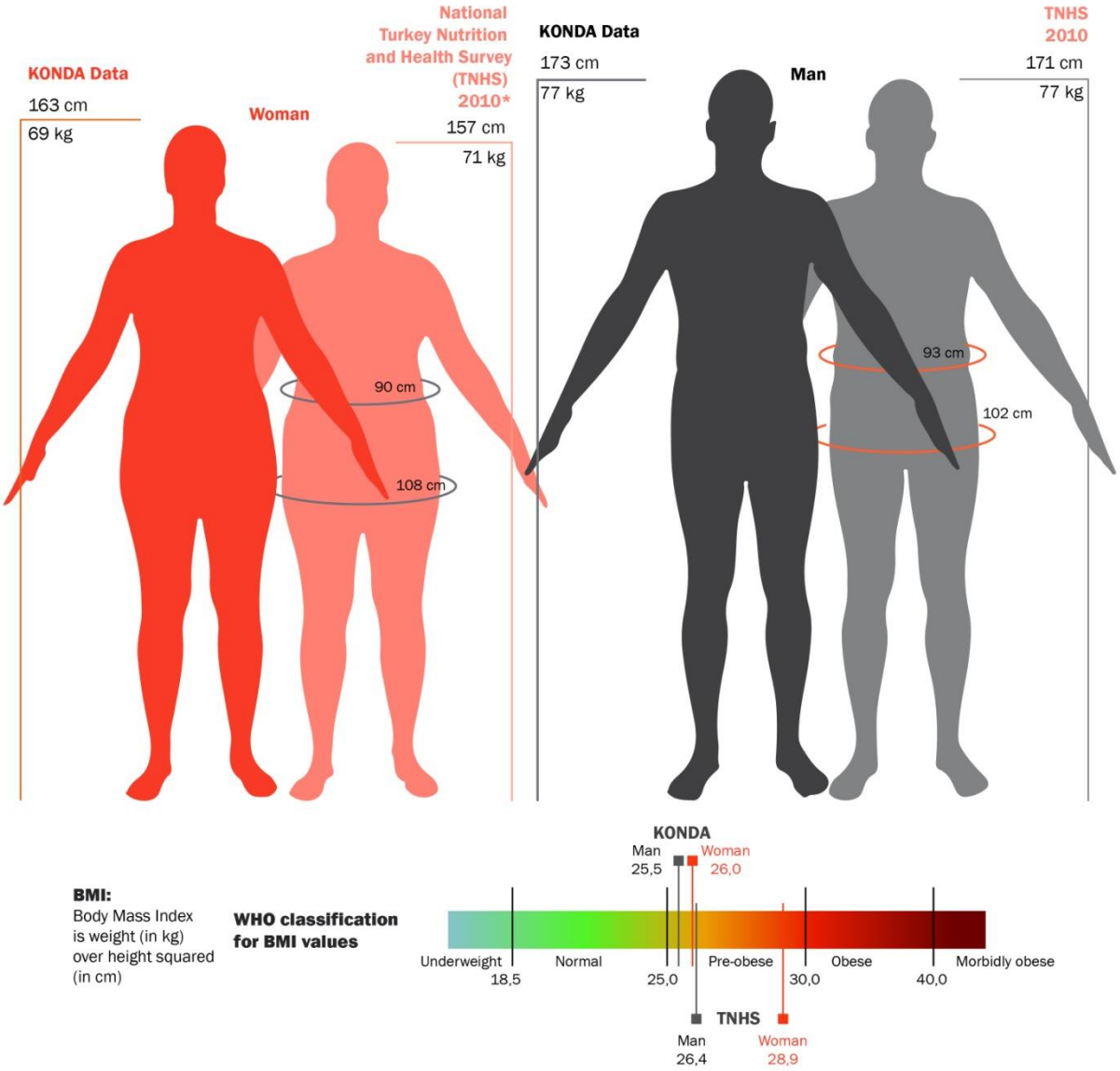


We asked the respondents their height and weight, and then calculated their body-mass index from the information they provided. According to the responses, women have an average height of 162.5 cm and average weight of 68.8 kilograms, while the same figures for men are 173.4 cm and 76.6 kilograms. Turkey Nutrition and Health Research carried out by TUIK in 2010 also provides average height and weight figures for women and men. In this research, weight and height were not asked to the participants, but instead measured by a scale and measuring tape. A comparison of our findings with the data from the TUIK research shows that both women and men are inclined to overstate their height on average, while women tend to understate their weight slightly and men are nearly accurate in their self-estimation of their weight.

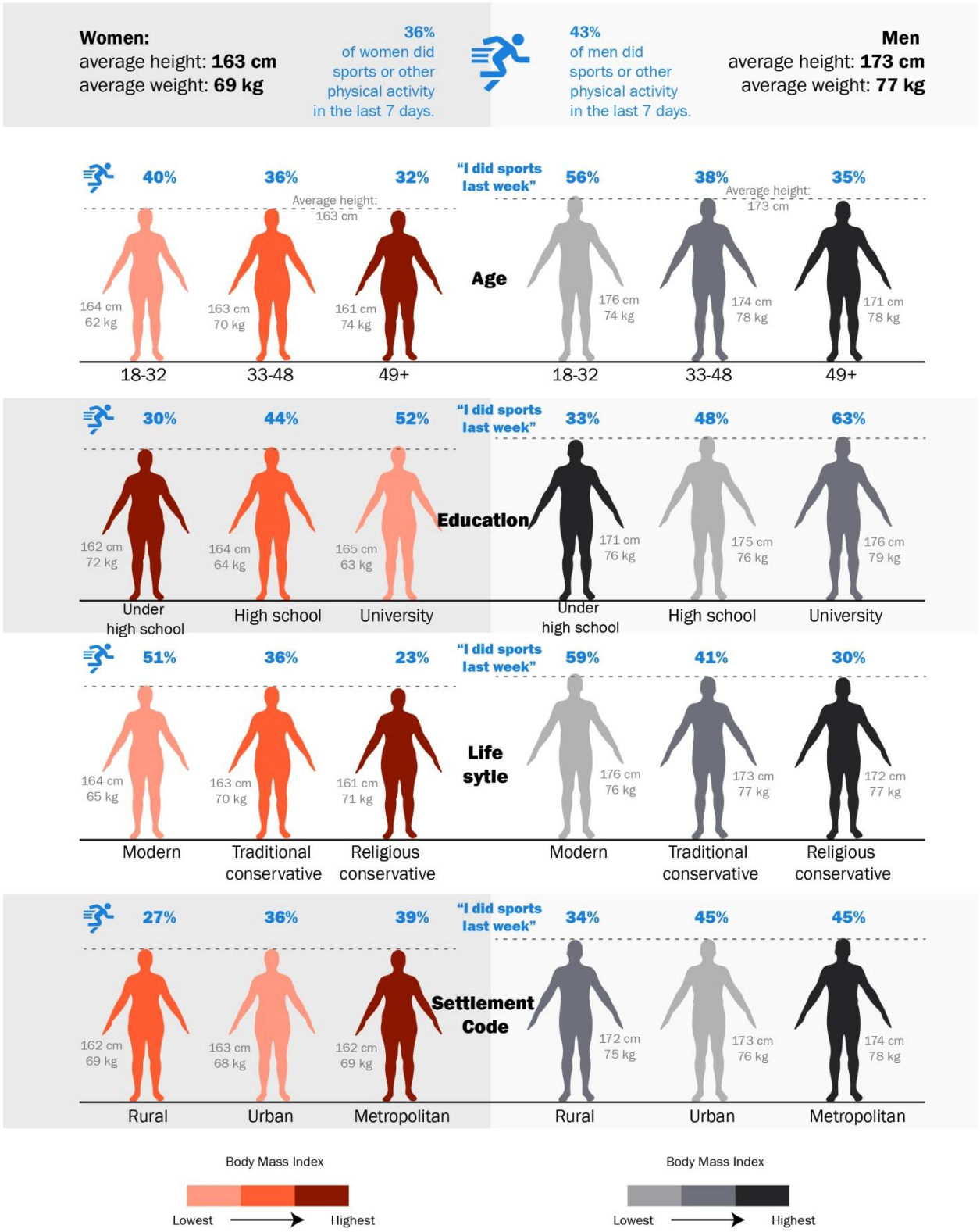
The graph on the next page demonstrates how weight and height of women and men vary by age, educational attainment level, lifestyle and place of residence. The most significant factor reflected by the graph is age difference. In this respect, healthy living and eating habits will be reviewed by different age groups in the next section. In summary of this section, we may conclude the following:

- ✓ The lesser educated are more likely to be overweight or obese than the better educated, both among women and men.
- ✓ Higher educational attainment level leads to lower body-mass index and a lower likelihood to be overweight or obese.

- ✓ Increased conservatism in terms of one's lifestyle is accompanied by greater body-mass index and a higher likelihood for being overweight or obese. The opposite is true for those who identify their lifestyle as Modern.
- ✓ Finally, average height and weight do not vary perceptibly between rural, urban and metropolitan areas, but there are significant differences in terms of body-mass index. Metropolitan residents are more likely to be overweight or obese than those living in rural areas.



* National Turkey Nutrition and Health Survey (TNHS) – 2010, General Directorate of Health Research, Ministry of Health, http://www.sagem.gov.tr/TBSA_Beslenme_Yayini.pdf
Values from "*Average weight, height and body measurements of adults (age 19 and over) in Turkey*" table are used, all visualizations are made by KONDA.


Women:
average height: 163 cm
average weight: 69 kg
36%
of women did sports or other physical activity in the last 7 days.
43%
of men did sports or other physical activity in the last 7 days.
Men
average height: 173 cm
average weight: 77 kg
"I did sports last week"
Age
40%
36%
32%
Average height: 163 cm
164 cm 62 kg
163 cm 70 kg
161 cm 74 kg
18-32
33-48
49+
56%
38%
35%
Average height: 173 cm
176 cm 74 kg
174 cm 78 kg
171 cm 78 kg
18-32
33-48
49+
Education
30%
44%
52%
162 cm 72 kg
164 cm 64 kg
165 cm 63 kg
Under high school
High school
University
33%
48%
63%
171 cm 76 kg
175 cm 76 kg
176 cm 79 kg
Under high school
High school
University
Life sytle
51%
36%
23%
164 cm 65 kg
163 cm 70 kg
161 cm 71 kg
Modern
Traditional conservative
Religious conservative
59%
41%
30%
176 cm 76 kg
173 cm 77 kg
172 cm 77 kg
Modern
Traditional conservative
Religious conservative
Settlement Code
27%
36%
39%
162 cm 69 kg
163 cm 68 kg
162 cm 69 kg
Rural
Urban
Metropolitan
34%
45%
45%
172 cm 75 kg
173 cm 76 kg
174 cm 78 kg
Rural
Urban
Metropolitan
Body Mass Index
Lowest
Highest
Body Mass Index
Lowest
Highest

2.3.1. Health and Living Habits by Gender and Age Group

As noted in the previous section, in Turkey, the most meaningful differentiation in terms of health (health condition and eating habits) is observed by gender and age. Women vs. men and younger people vs. older people diverge from each other in many respects. For example, when we examine the age groups in detail, the first thing we notice is that older people use prescription medication a lot more than younger people. However, women and men in the same age groups are also different from each other in terms of their prescription medicine use. Use of prescription medication is 8-points higher among women than men, and 13-points higher among middle-aged women than middle-aged men. Similarly, prescription medication use among women above the age of 65 is 12-points higher than men in the same age group.

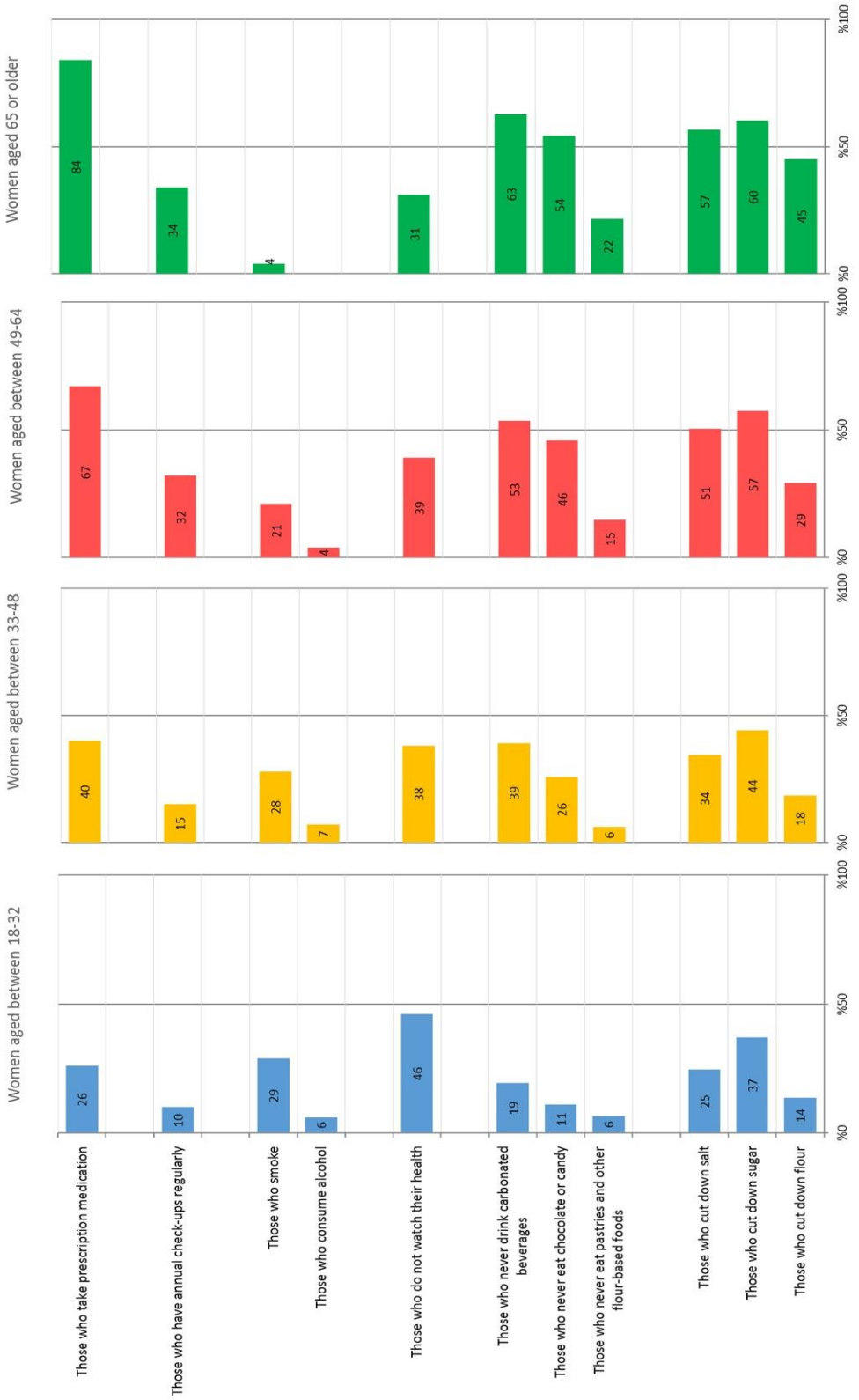
The difference between women and men by age is once again highlighted in terms of going to the doctor regularly for annual check-ups. While 10 percent of women between the ages of 18-32 report visiting the doctor regularly, the corresponding rate for men in the same age group is 5 percent. Women of all age groups are more likely than men to go to the doctor regularly for annual check-ups.

There is also a notable difference between women and men, and younger people and older people in terms of their smoking and drinking habits. Both drinking and smoking becomes less common with older age, while the greatest difference is observed in terms of gender. 29 percent of women between the ages of 18-32 smoke, while the corresponding to men in the same age group is 68 percent. Similarly, 28 percent of women and 65 percent of men between the ages of 33-48 smoke. Other age groups reveal comparable variations; between the ages of 49-64, men smoke 2.5 times and above the age of 65, 8 times more than women.

We come across similar findings in drinking habits. Men drink more than women, as younger people do so more than older people. While only 6 percent of women between the ages of 18-32 report drinking to a varying extent, the corresponding rate for men is nearly seven times higher at 41 percent. In the 33-48 age bracket, 7 percent of women state that they drink, while the rate of men who do the same is 3.5 times higher than that, but still 14-points less than men between the ages of 18-32. Accordingly, 4 percent of women and 23 percent of men between the ages of 49-64 report that they drink. Finally, we observe that women above the age of 65 do not drink (drinkers fail to make up a statistically meaningful population). However, one in every 10 men in the same age group is a drinker.

The last graph shows eating habits by age and gender group, and by type of food. Accordingly, emphasis on taste or cost, rather than health, is greater among men than women, and younger people than older people.

The graphs below show which factors are most influential in shaping dietary decision by age group and gender, followed by graphs on frequency of smoking and drinking.


Women aged between 18-32
Women aged between 33-48
Women aged between 49-64
Women aged 65 or older
%0
%50
%100
Those who take prescription medication
Those who have annual check-ups regularly
Those who smoke
Those who consume alcohol
Those who do not watch their health
Those who never drink carbonated beverages
Those who never eat chocolate or candy
Those who never eat pastries and other flour-based foods
Those who cut down salt
Those who cut down sugar
Those who cut down flour
26
10
29
6
46
19
11
6
25
37
14
40
15
28
7
38
39
26
6
34
44
18
67
32
21
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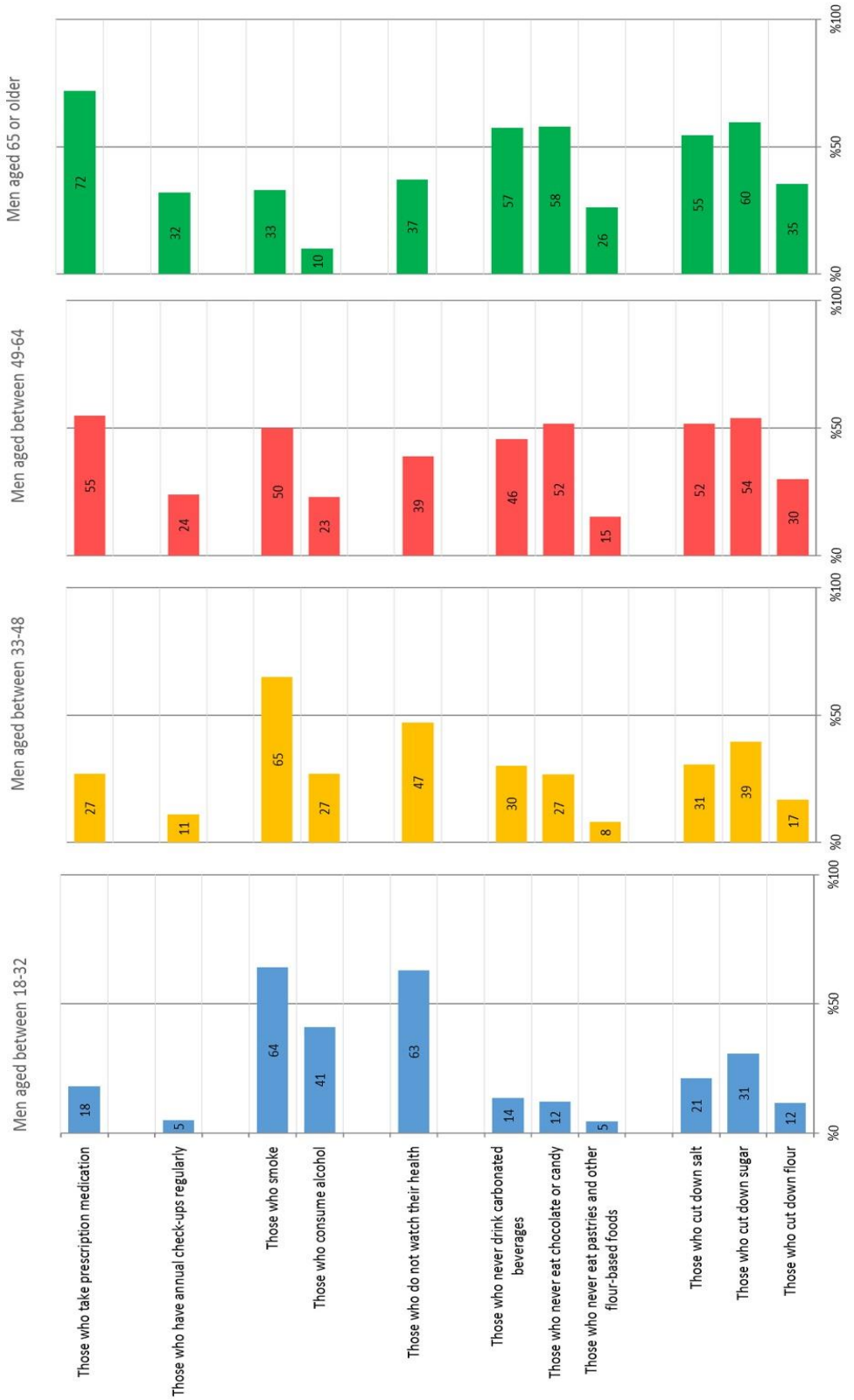
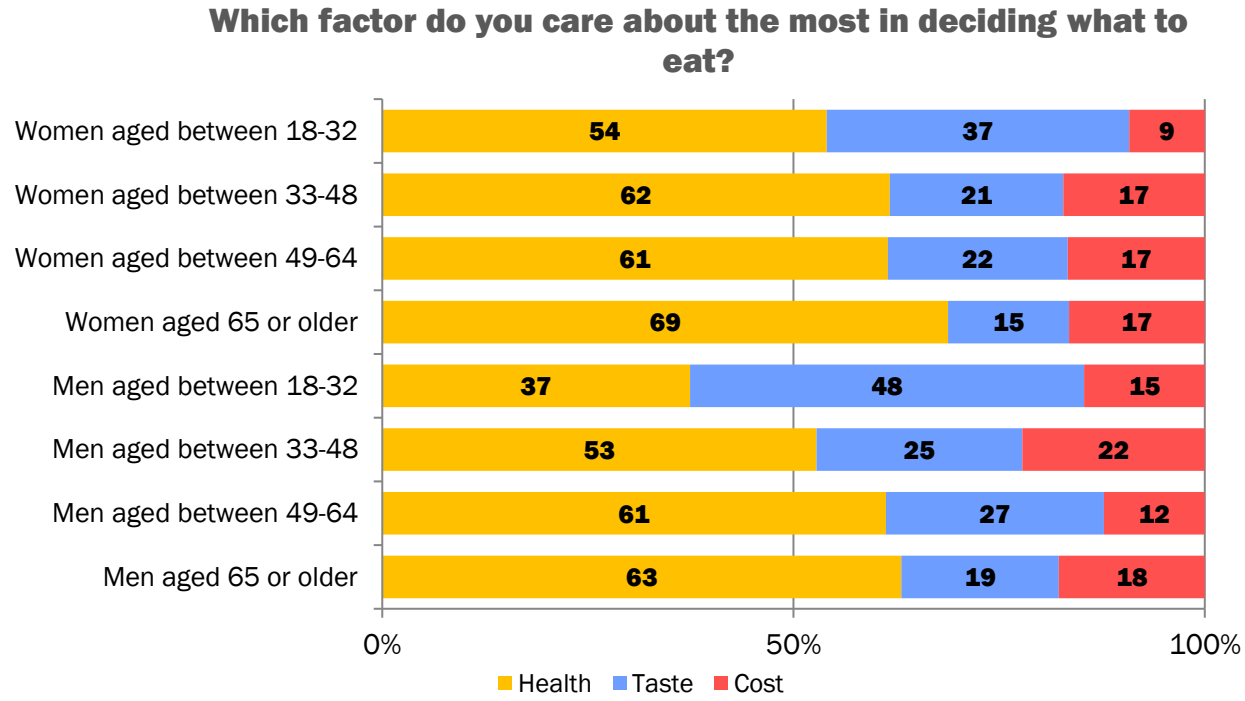
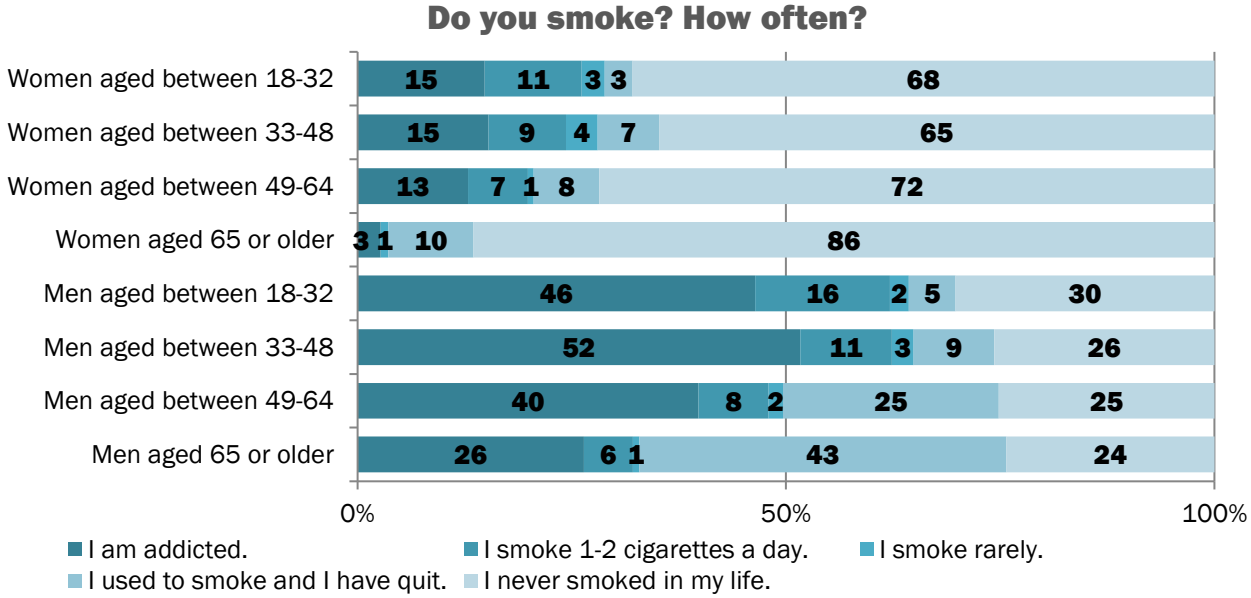
15
51
57
29
84
34
4
31
63
54
22
57
60
45


Men aged between 18-32
Men aged between 33-48
Men aged between 49-64
Men aged 65 or older
%0
%50
%100
Those who take prescription medication
Those who have annual check-ups regularly
Those who smoke
Those who consume alcohol
Those who do not watch their health
Those who never drink carbonated beverages
Those who never eat chocolate or candy
Those who never eat pastries and other flour-based foods
Those who cut down salt
Those who cut down sugar
Those who cut down flour
18
5
64
41
63
14
12
5
21
31
12
27
11
65
27
47
30
27
8
31
39
17
55
24
50
23
39
46
52
15
52
54
30
72
32
33
10
37
57
58
26
55
60
35

As it can be seen in the graph on the previous page and in the graph below, women vs. men, and older people vs. younger people are more likely to choose healthy foods. 54 percent of women between the ages of 18-32 prioritize health when choosing what to eat; however, taste is the main factor for 48 percent of men in the same age group.



The two following graphs demonstrate the frequency of smoking and drinking in different age and gender groups. As shown in the first graph below, the rate of those who have never smoked in their life varies between women and men.



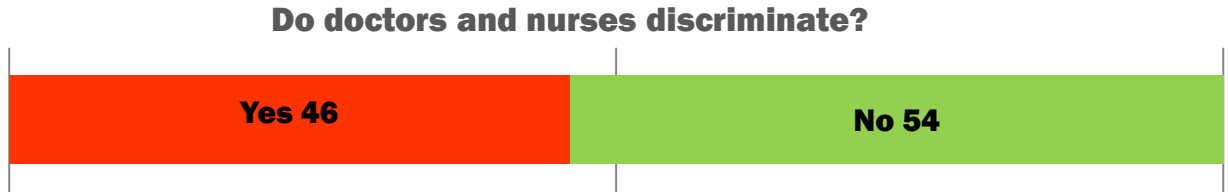
When we consider those who said “I'm addicted to smoking” and “I smoke 1-2 cigarettes a day” as smokers, we find out that a quarter of all women between the ages of 18-32 are active smokers. The corresponding rate for men in the same age group is 62 percent. Similarly, while a quarter of all women between the ages of 33-48 smoke, 66 percent of men from the same age bracket do so. Although the rate of smoking decreases in older age groups, it is still quite high. One out of every 5 women and 2 out of every 5 men between the ages of 49-64 actively smoke. The most striking finding here is the dramatic decrease in the rate of active smokers among women above the age of 65. Only 4 percent of the women in this age group report being an active smoker, while one third of all men in the same age group are active smokers.

Last but not least, when we examine how often people drink, gender emerges yet again as the main factor that makes a big difference. The rate of drinkers also falls down with older age. We observe that there are no active drinkers, or in other words those who “drink every day”, “once a week” and “once a month” among women above the age of 65. The corresponding rate among men in the same age group is around 7 percent. Young men between the ages of 18-32 drink the most, with 31 percent identifying themselves as active drinkers. However, only 9 percent of women in the same age group report the same.

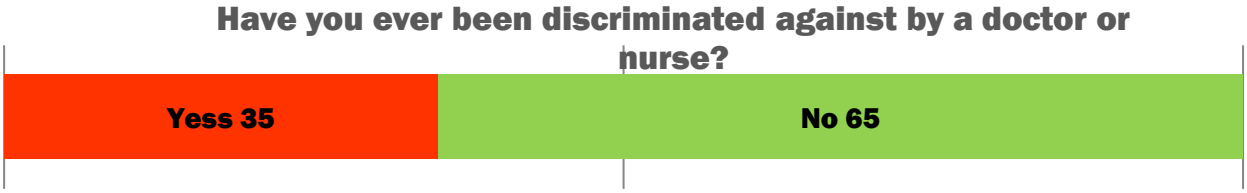
2.4. Relationship with Healthcare Institutions

2.4.1. Discrimination

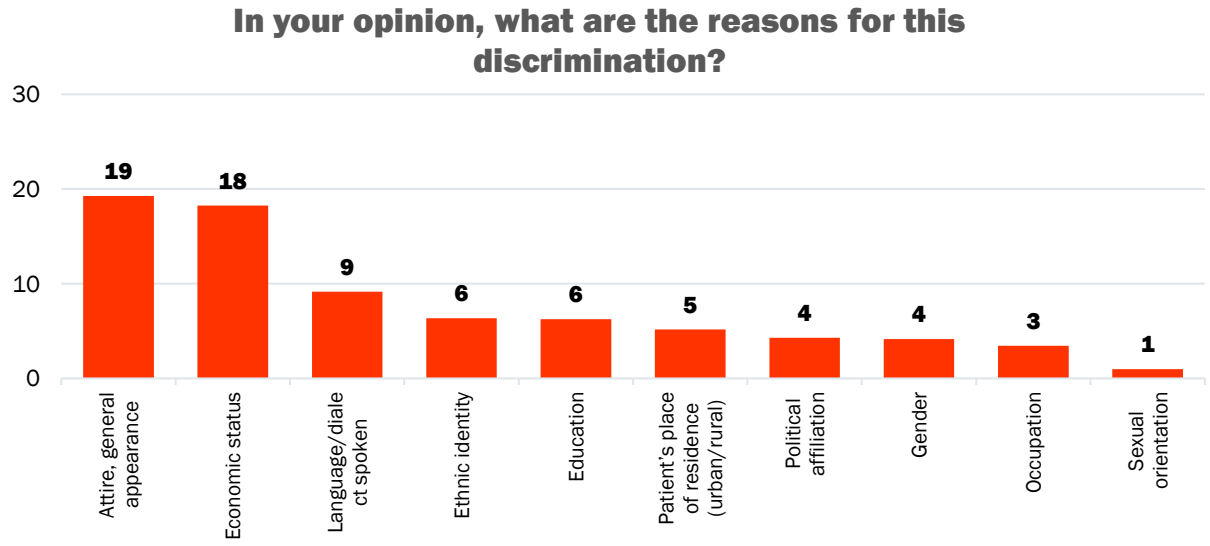
In this month's field survey, we have asked the respondents the question, "Do you think doctors and nurses discriminate?" and found out that society is divided on this issue.



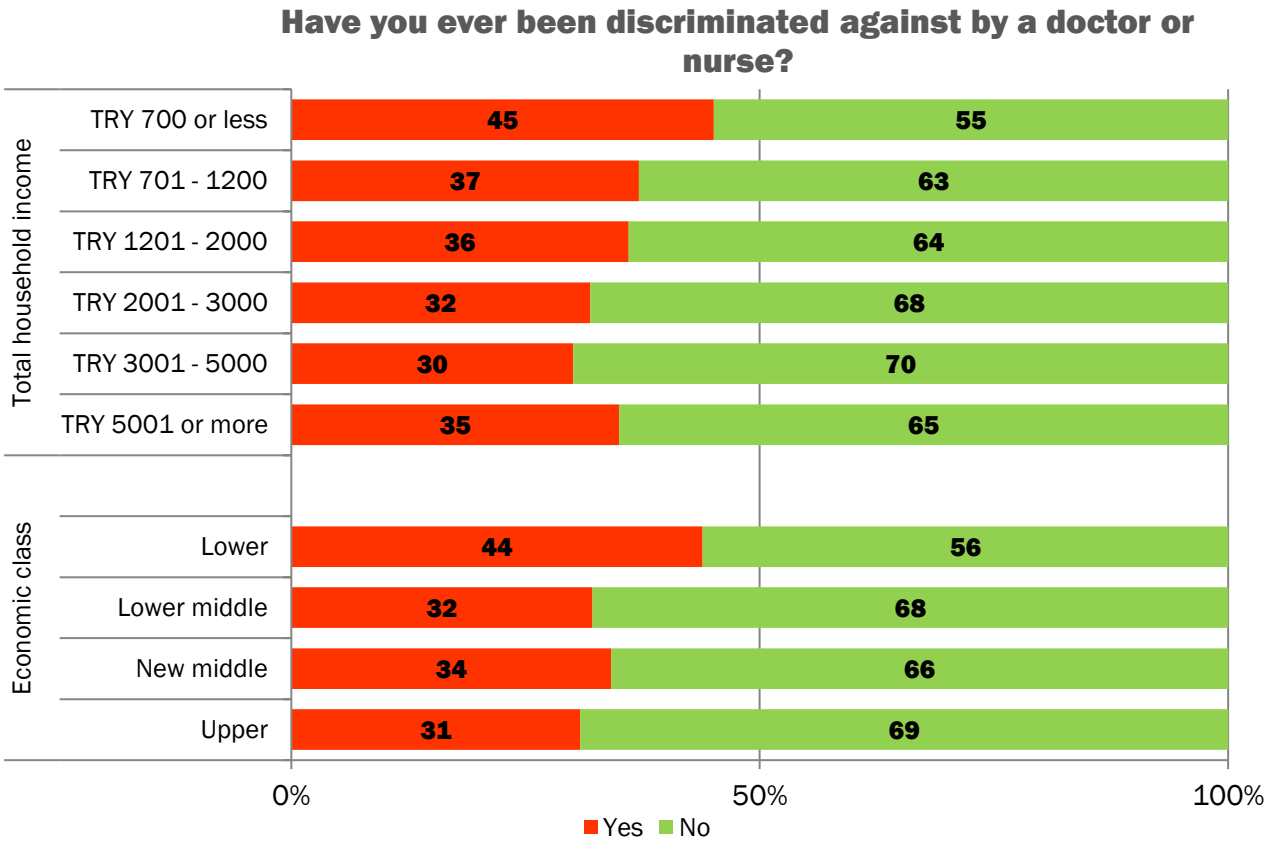
When the respondents are asked whether they had been directly subject to discrimination, we obtain a lower rate than the one shown in the graph above. Nevertheless, we still encounter a pessimistic outlook, as one in every 3 people in society report having been directly discriminated against.



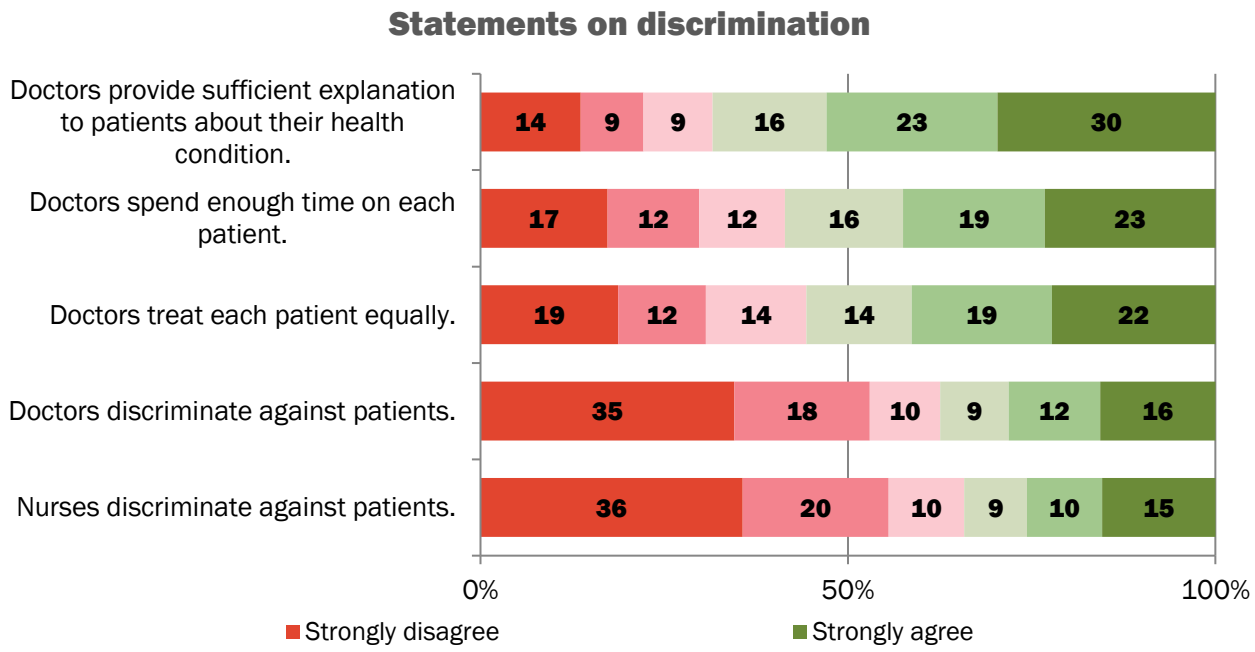
We asked the respondents who report being having been discriminated against about their opinion on the potential reason for this discrimination. According to the responses, approximately one in 5 people in Turkey believe that doctors and nurses discriminate against people on the basis of their attire, clothes, general appearance or economic status. One in 10 also thinks that people are discriminated against due to their language/dialect.



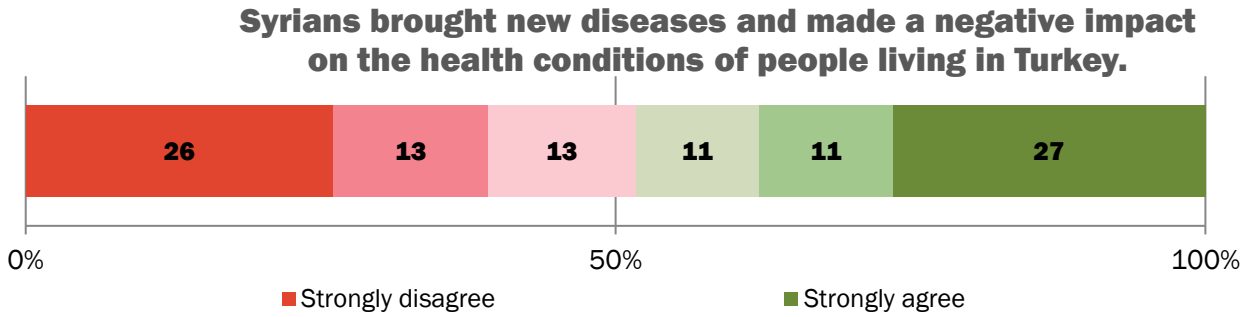
The fact that victims of discrimination associate discrimination first and foremost with difference in general outside appearance or clothes and economic status makes it necessary to investigate the class background involved in this reasoning. As it can be seen in the graph below, when we evaluate the respondents by their income level and economic class, we observe that people from the lowest income group (with a household income of TRY 700 or less) are most likely to experience discrimination, as people from lower economic class are more likely to experience discrimination than those from higher economic class.



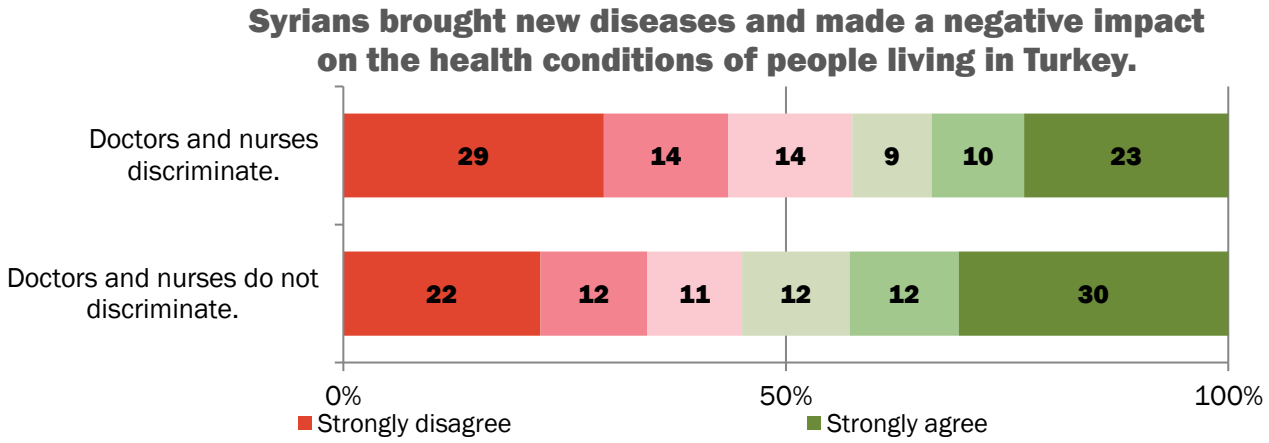
Various statements about discrimination were read to the respondents. As shown in the graph below, the opinion on the statement that doctors provide their patients with satisfactory explanations is more favorable and the opinion on statements about discrimination are less favorable. 45 percent of society think that doctors do not treat each patient equally. 63 percent state that doctors and 66 percent say that nurses discriminate against the people.



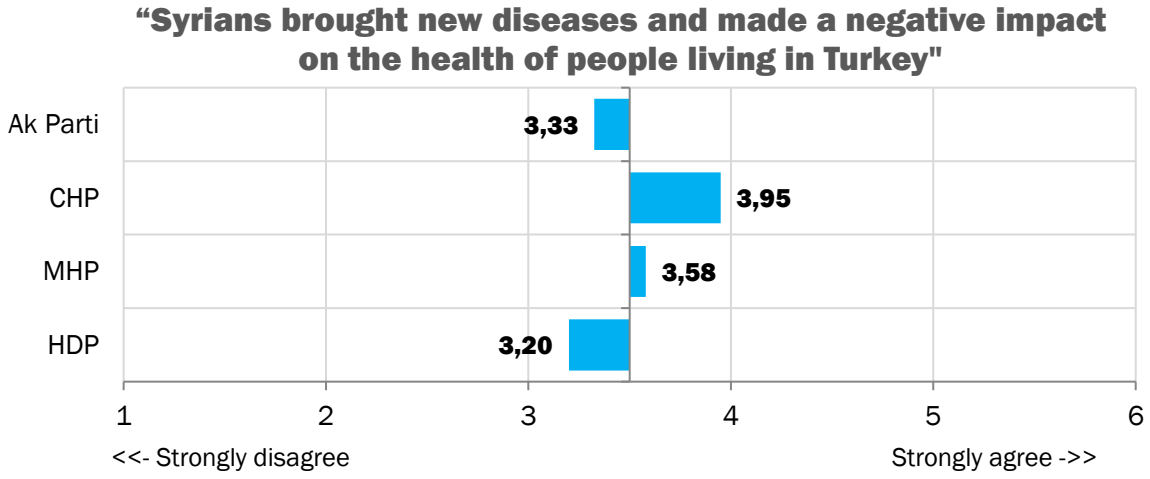
Although it is not directly related to discrimination, we found it appropriate to re-evaluate emerging prejudices against Syrians in Turkey within the perspective of the theme of health. It looks like the public is divided about the impact of Syrians on social health conditions. Half believe Syrians have brought new diseases into the country, while the other half emphasize their disbelief in such a statement.



What is interesting here is that there is not that much of a difference in opinion between those who believe and those who do not believe in discrimination by doctors and nurses. As demonstrated in the graph below, 57 percent of those who state that doctors and nurses discriminate believe that Syrians brought diseases, an opinion shared by 45 percent of those who do not think there is discrimination by doctors and nurses. In other words, people who confirm the existence of discrimination have a more negative opinion on Syrians.



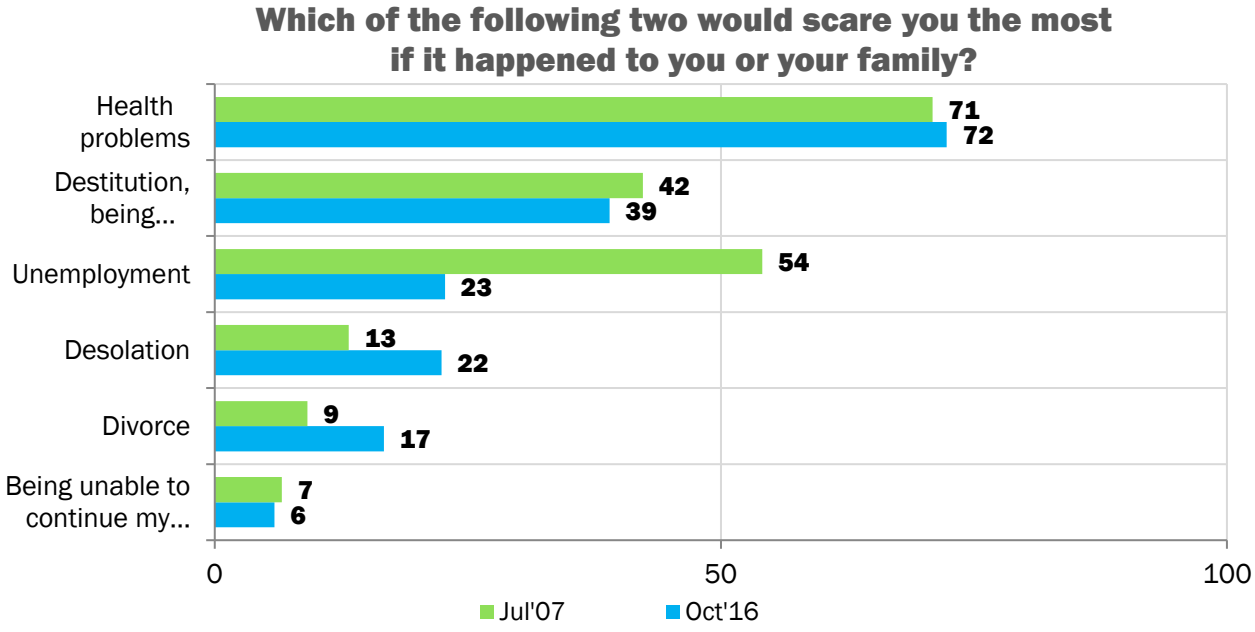
The second noteworthy finding reflected in the graph above is that the social consensus observed in satisfaction with healthcare services is replaced by polarization on politicized topics. For example, when we explore the political profile of those with a negative opinion about Syrians, we encounter that CHP voters tend to be more negative on this issue than the voters of other parties. At the same time, a significant portion of CHP voters report their satisfaction with healthcare services during the Ak Parti era.



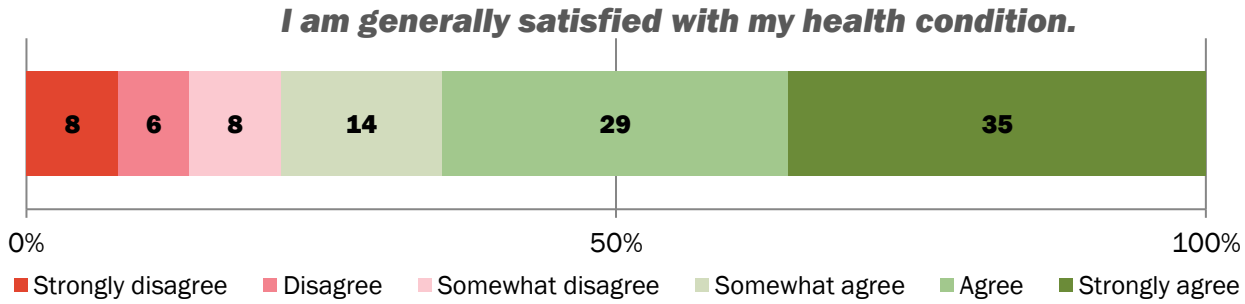
2.5. Opinion on Healthcare Services

Prior to directing the question on the monthly theme of health, we inquired about what scares the respondents the most. For this purpose, we asked the respondents to choose one of the provided options such as health problems, unemployment, destitution, being dependent on someone else and divorce. 72.3 percent of the respondents expressed that they are scared of health problems. This option was followed by destitution and being dependent on someone else, unemployment and loneliness/desolation. When we asked the same question back in July 2007, the most popular response option was health problems again, with a similar preference rate. The decrease in the rate of those who are most scared about unemployment and destitution, and the increase in the rate of those fearing divorce and desolation

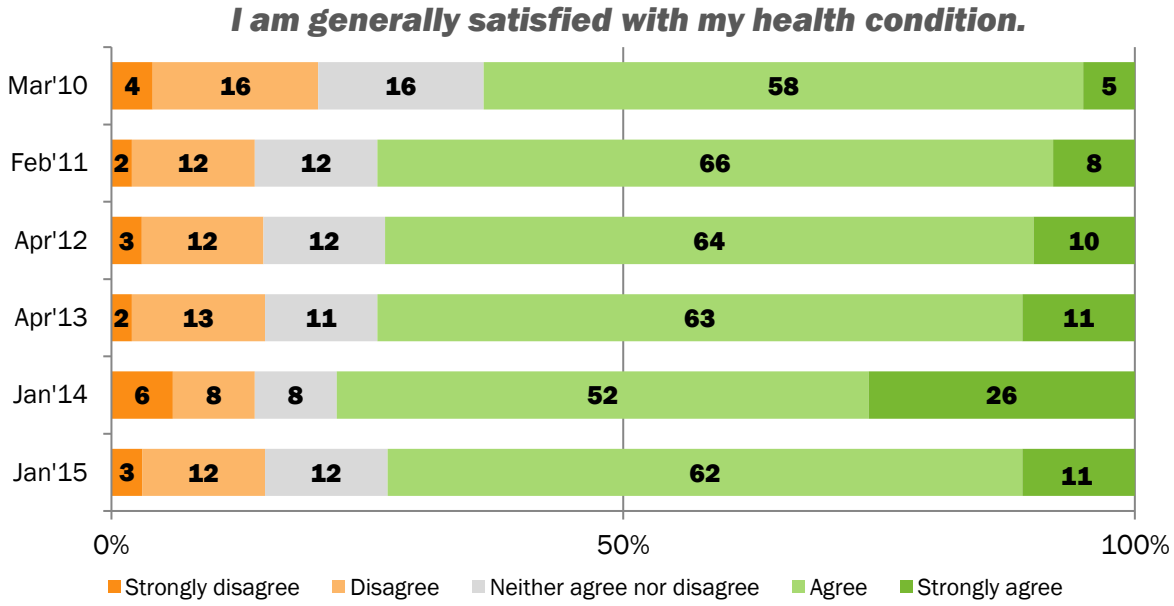
the most are striking, and we will address this issue in further detail in the section on crisis expectation.



Given the fact that the majority of the respondents are satisfied with their health condition and the fact that the great majority have some kind of social security, it is surprising to see that society is most scared of encountering health problems.



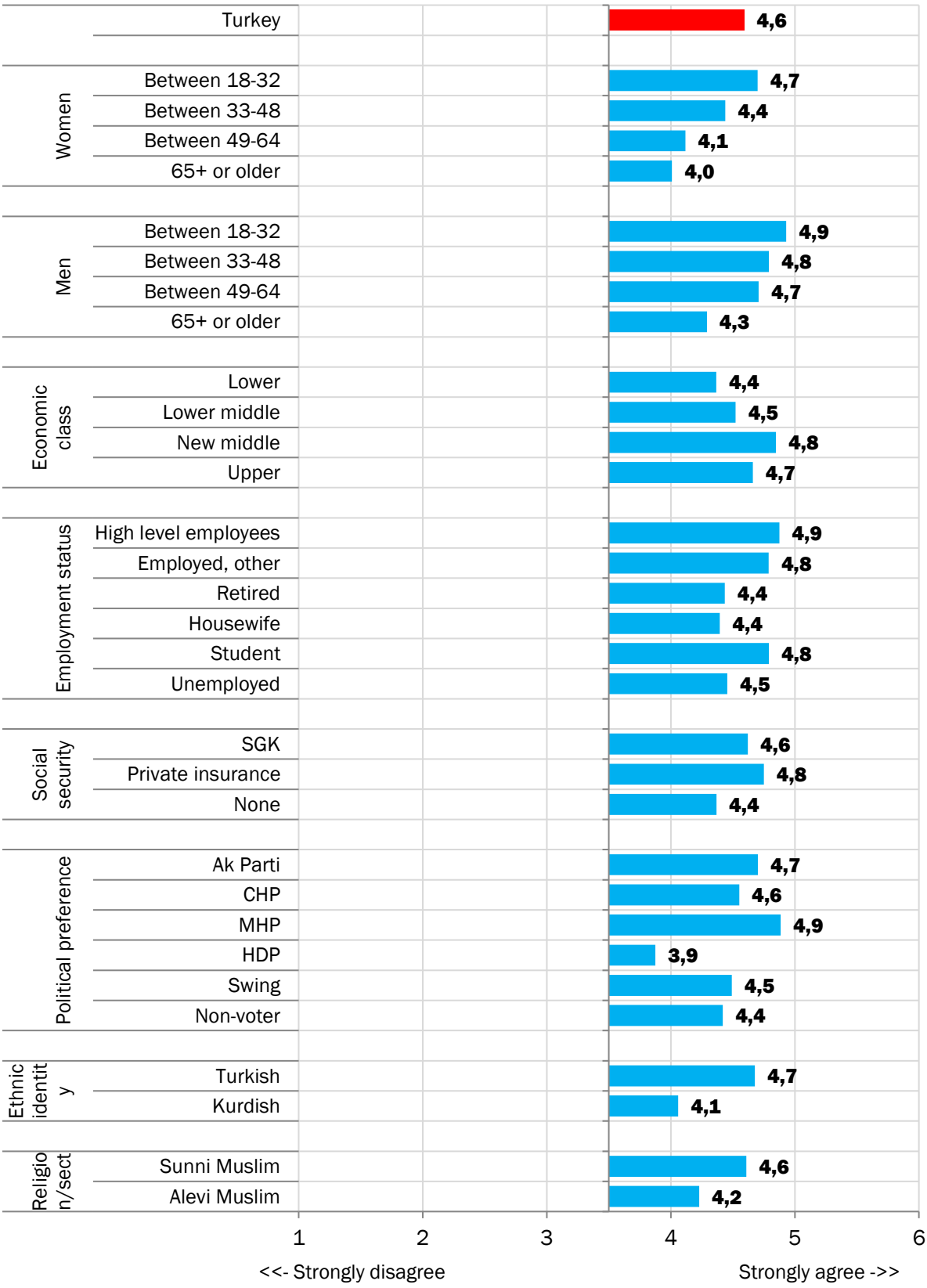
4 out of every 5 respondents (79 percent) state that they are generally satisfied with their health condition. Also, all research we have carried out since 2010 under the scope of the Satisfaction Index reveal that the majority of the people in Turkey are satisfied with their health condition. Furthermore, there is no evident relation between fearing health problems and being satisfied with the condition of one's health, and those who do and do not express being scared of health problems are equally satisfied with their health condition on average.

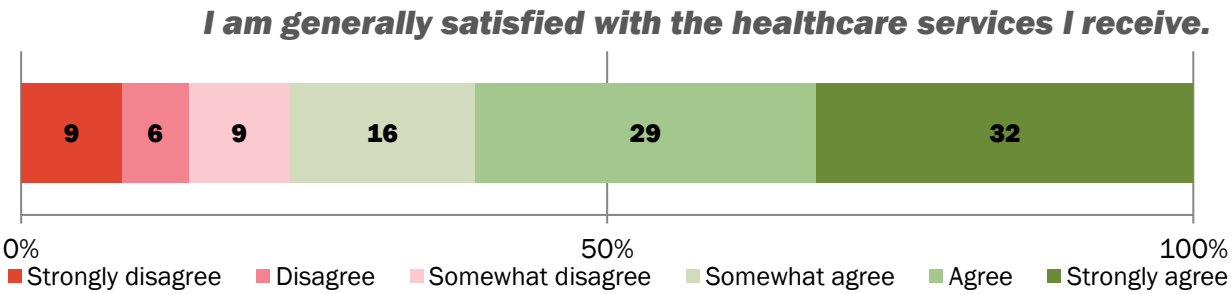


When we take a closer look at those who are more satisfied with the condition of their health than others, we observe that both demographic characteristics (such as age, gender, income, etc.) and factors such as the place where the respondents were raised, their employment status and the kind of social security they have are influential: Men, young voters, high-income earners, those who grew up in metropolitan areas, the employed, students, and those who have some kind of social security are more likely to be satisfied with their health condition in general. However, it is also possible to observe certain differences, in part due to political preference and the combined impact of these demographic characteristics: Ak Parti and MHP voters are more satisfied, while CHP and particularly HDP voters are less satisfied with the condition of their health. Likewise, Alevi Muslims are less satisfied than Sunni Muslims, and the Kurdish are less satisfied in comparison to the Turkish.

When inquired about their opinion on healthcare services they receive, almost 4 out of every 5 respondents indicated that they were satisfied. Young voters vs. older voters; those who seldom or frequently visit healthcare institutions vs. those who never visit them; those who think that doctors and nurses discriminate vs. those who do not, those who could not receive treatment for some reason against their intentions vs. those who did not experience such a problem are more likely to express less satisfaction with healthcare services.

I am generally satisfied with my health condition.

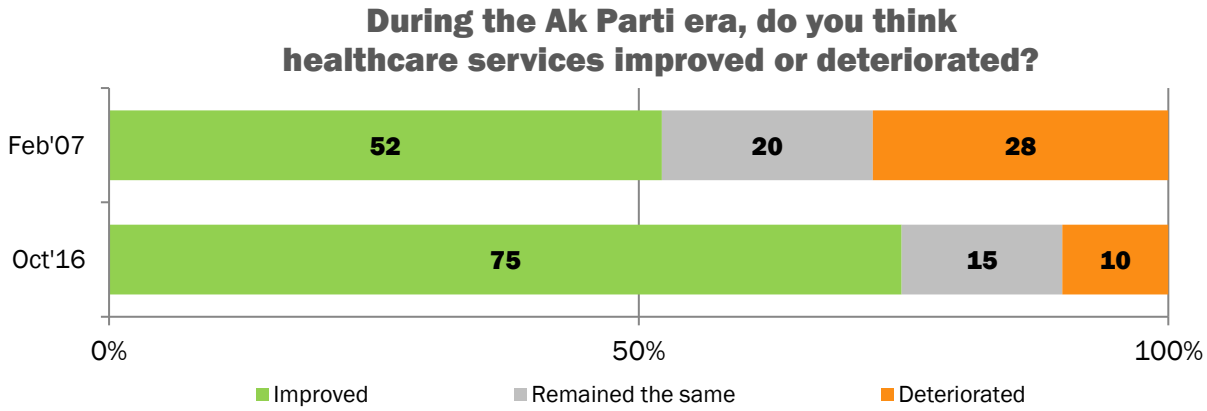




Bearing all that in mind, it should be reminded that satisfaction with healthcare services is essentially shaped by political preference and lifestyle. Religious conservatives, the Turkish, those who cover their head, Ak Parti voters, presidential system supporters, Sunni Muslims, the pious, villagers or rural residents are significantly more satisfied with the healthcare services they receive.

It is indeed striking that the respondent's opinions on healthcare services are influenced by their respective relationship with healthcare institutions, political preference and lifestyle. Economic class, however, does not seem to have much influence on how the respondents perceive healthcare services.

The impact of political polarization becomes much more evident when we analyze the responses provided to the question on satisfaction with the state of healthcare services during the Ak Parti era. This month, we once again asked the question, "During the Ak Parti era, do you think healthcare services improved or deteriorated?", which was previously used in a research carried out in February 2007, and 75 percent of the respondents stated that healthcare services have improved during the Ak Parti era. The corresponding rate in 2007 was 52 percent.

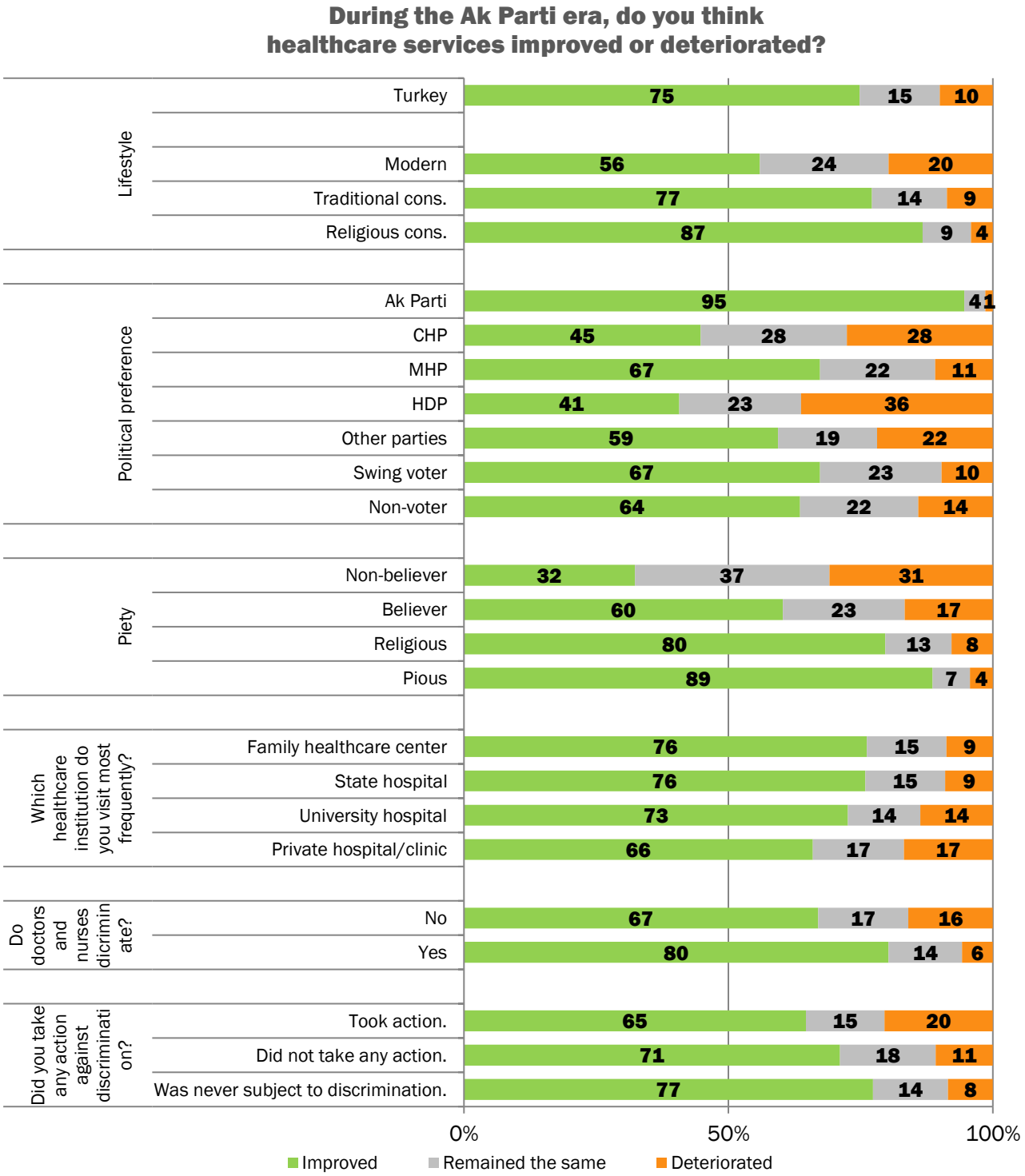


Since 2007, we had the chance to address the state of healthcare services during the Ak Parti era from different perspectives, and we were able to observe that people are more satisfied than unsatisfied in general, with the tendency of being satisfied following an upwards trend over time. The findings of this month's research imply that although the respondents tend to evaluate healthcare services during the Ak Parti era from a highly polarized perspective, those who think that healthcare

services improved still make up the majority in all groups, even in groups with the most negative opinion on this issue.

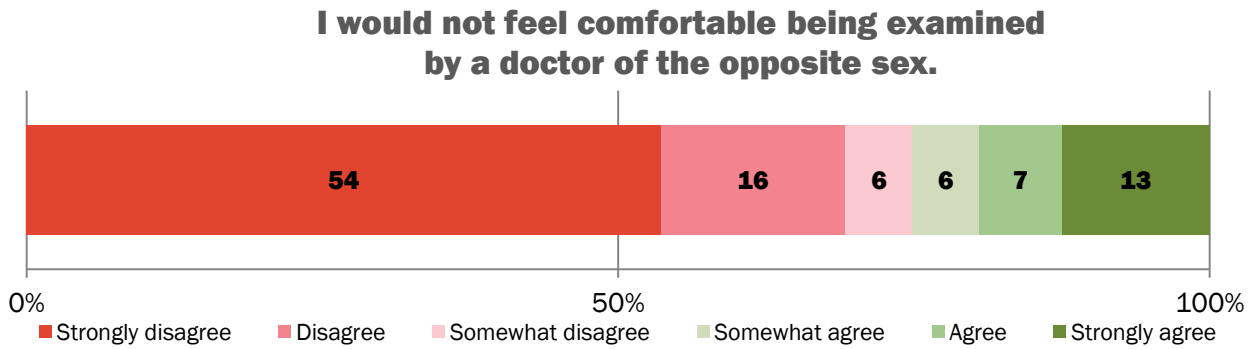
The difference of opinion on healthcare services during the Ak Parti era is mainly shaped by political preference and lifestyle. The graph below demonstrates that opinions on healthcare services vary considerably by lifestyle, political preference and degree of piety. On the other hand, frequency of visiting healthcare institutions and healthcare provider preference are also important. The respondents who visit healthcare institutions more frequently, the elderly, and the respondents who prefer state institutions (such as community healthcare centers) are more likely to think that healthcare services have improved during the Ak Parti era.

However, analysis of the responses by being subject to discrimination or not yields a very interesting finding. Among the respondents who think that healthcare staff discriminate, the rate of those who think that healthcare services have improved is 80 percent. On the other hand, the corresponding rate among the respondents who think that healthcare staff do not discriminate is 65 percent. Similarly, respondents' opinions are also influenced by whether they have been subject to discrimination in a healthcare institution or not, and whether they took any action against this discrimination or not.



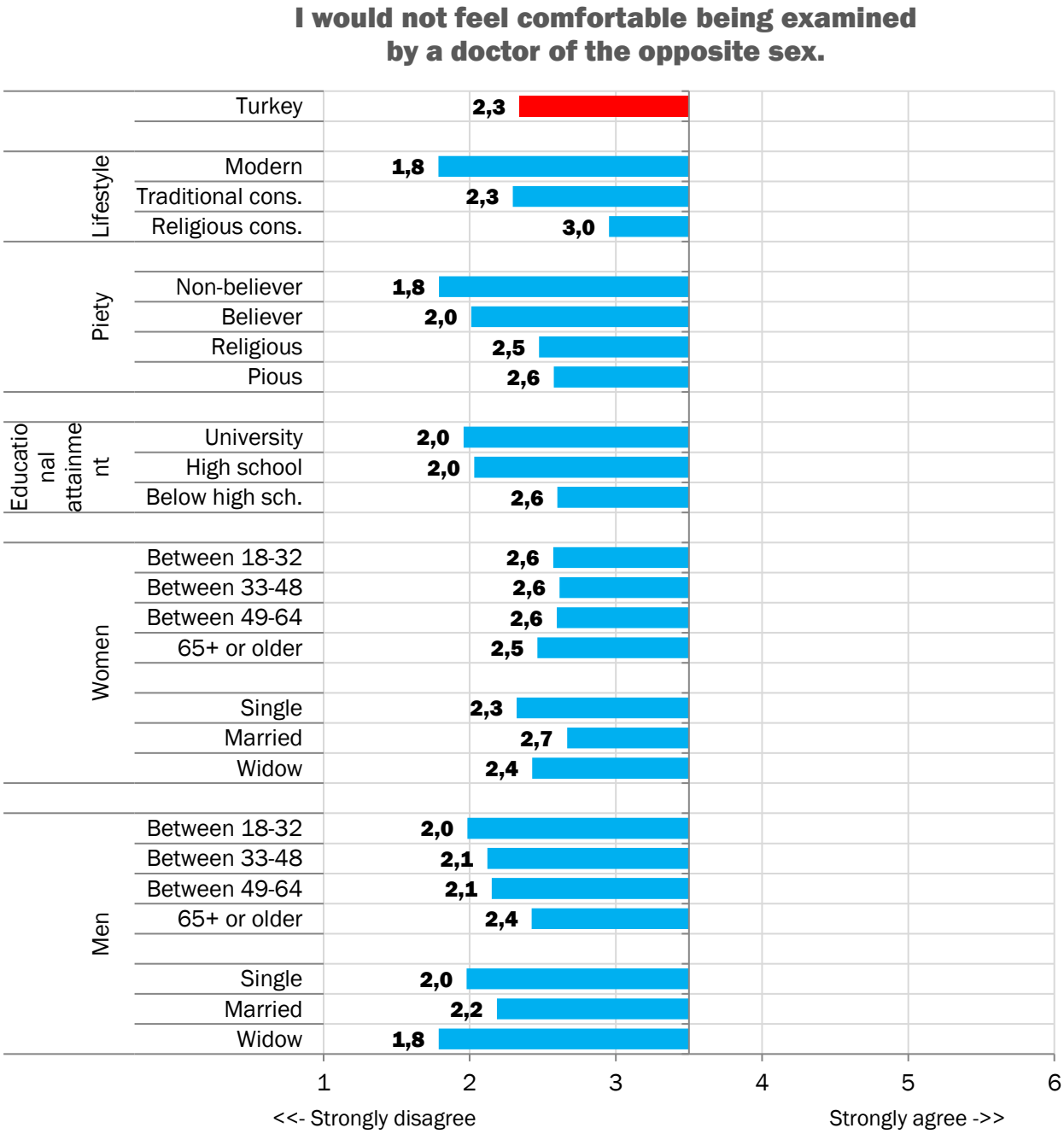
2.5.1. Gender and healthcare

The two questions we asked the respondents as part of the monthly theme of health address the relation between gender and health, and the responses vary the most by lifestyle.

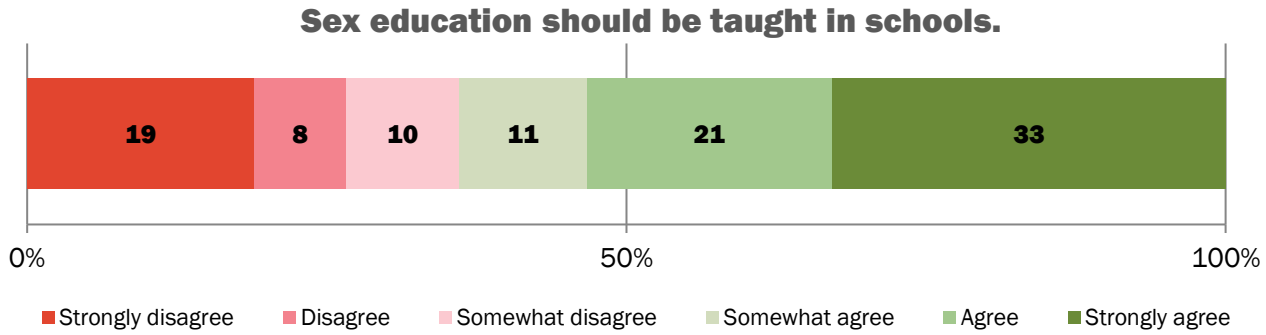


In Turkey, objection to examination of a female patient by a male doctor is widespread, and it is usually the patient's husband who makes the objection. In this month's report, we inquired whether the respondents feel uncomfortable being examined by a doctor of the opposite sex or not, and found out that 54 percent of the respondents definitely do not feel uncomfortable with this at all, with 75 percent indicating that they do not have a problem with being examined by a doctor of the opposite sex. Religious conservatives, those who are more religious and those with an educational attainment below high school are more likely to feel uncomfortable about being examined by a doctor of the opposite sex.

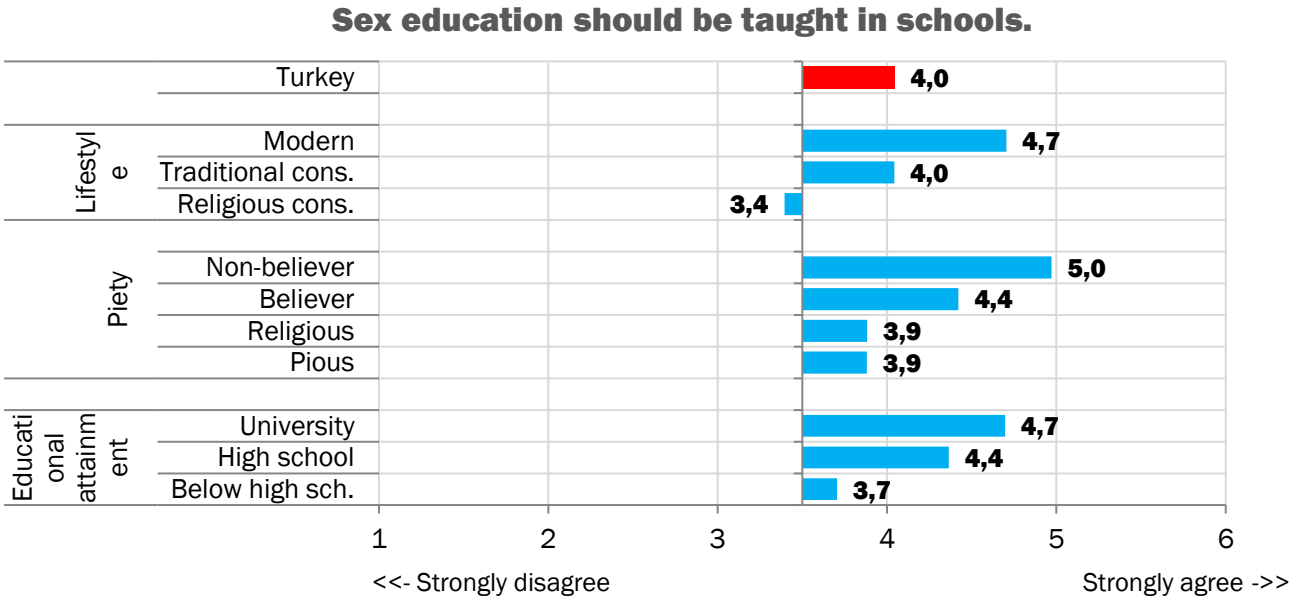
Anecdotal evidence provides confirmation. In comparison to men, women indeed feel more uncomfortable being examined by a doctor of the opposite sex and the rate of discomfort does not vary significantly by age. Married women tend to feel the most uncomfortable. Men feel rather comfortable being examined by a doctor of the opposite sex; yet, older men are more likely to feel uncomfortable.



Sex education (protection against sexually transmitted diseases, protection against unintended pregnancy, sexual health, etc.) in schools is another area where the relation between gender and health is clearly revealed. 64 percent of the respondents (in other words, 2 out of every 3 respondents) support sex education in schools. The high rate of support for sex education in schools may also imply the demand and the need for such education.



The fact that the rate of support for sex education is higher among moderns, the better educated, and those who are less religious shows that opinion on sex education is highly influenced by lifestyle. It also implies that the concept of "sex education" has been understood accurately by the respondents although they were not provided with any further explanation during the field survey.



2.6. Discussion on the Findings on Health

Ayşecan Terzioğlu, Asst. Prof.
Visiting Professor, Department of Sociology, Galatasaray University

It is noteworthy that 72.3 percent of the attendees to the survey answered that the most fearful thing that might happen to them and their families would be "Health Problems." Such fear involves not only the loss of health and inability to lead a healthy life but also the fear of becoming needy and dependent on medical institutions or other family members. Thus, 39 percent of the interviewees indicated as the most fearful condition, indigence and being in need of others. The fear of becoming dependent on medical institutions, healthcare personnel and relatives due to health problems is more common in relation to chronic diseases that result in long terms of unwellness and treatment such as diabetes and diseases the effectiveness of the treatment of which is unpredictable such as cancer due to the fact that in Turkey the prevalence of such diseases has increased in recent years and they have become more visible. In addition, fear of health problems is further explained by the fact that as described by German sociologist Ulrich Beck (2012) via the risk society concept, the risk of becoming ill is at least as fearful as the disease itself and the identification and understanding of these risks have increasingly become more dependent upon the professional knowledge and skill of medical experts.

Daily habits such as eating, drinking, smoking and consuming alcohol are mainly shaped by this perception of health risk. For example, those who eat fruit and vegetables frequently (everyday or 2-3 times a week) make 77.5 percent and 85 percent of the interviewees, respectively. On the other hand, the rate of those who frequently consume pastry is only 38.8 percent whereas the rate of those who frequently consume sweet beverages such as Coke and soda is 33 percent. The other influential factors are individual eating habits, regional cuisine, buying power and information people receive from the media and social media about nutrition. Since the daily lives of the interviewees could not be observed in the framework of this survey (e.g., no opportunity to examine the kitchens and refrigerators of the interviewees) it might be arguable as to what extent people were anxious about "giving the correct answer" and hence answered the questions realistically, because since being healthy and preserving health are currently considered as personal responsibility and healthy nutrition is an essential part of this responsibility, individuals try to meet this responsibility and convince themselves and others around them. Similarly, the fact that a high rate of interviewees never or rarely smoke or consume alcohol might be connected to this risk perception and the fact that these habits do not comply with Islamic and conservative life style and beliefs. Indeed, analyzing the cross-tables in which different variables are taken together, 52 percent of the Ak Parti electorate having a conservative structure in general never smoke and 11 percent used to smoke but then quit. As for alcohol, the rate is much higher within the Ak Parti electorate: 84 percent indicate that they never consume alcohol whereas 7.6 percent stated that they used to consume alcohol but now quit.

In this survey, the greatest exception about preserving health and healthy living has been the fact that 60.2 percent of the interviewees indicated that they did not do any physical exercise within the past week. This might be explained by lack of established exercising habits, insufficient opportunities for sports especially in towns and rural areas and such opportunities being not available for women, old people and people of lower socio-economic classes as well as the high prices of fitness centers.

More than half of the participants (54.9 percent) receiving information on health from health institutions have trust in these institutions. Further, television (19.7 percent) and the internet/social media (15.9 percent) stand out as major sources of information.

The fact that cancer was mentioned at low rates throughout Turkey (0.6 percent) among the diseases from which the participants stated they suffered, is related to the fact that this disease is a taboo which people refrain from talking about. On the other hand, blood pressure (19.4 percent) and herniated disc (15.4 percent) are deemed normal/natural at certain age groups, hence are easily mentioned. Similarly, in terms of gender, especially elderly (65+) women mention diseases more easily than men. For example, 70.3 percent of women in this age group state that they have blood pressure problems whereas this rate is only 42.6 percent among men of the same age group. At this point, not only the variability in the perception of a disease according to gender but also how blood pressure problems are defined (according to the doctor or the individual himself/herself) matter.

It is a noteworthy finding of the survey that the rate of those participants who did not visit a health institution at all (25.4 percent) or did only once or twice (31 percent) in the past one year is rather high. This might be explained by the presence of young participants and their lack of time. About preventive medical applications, i.e. those medical applications implemented before getting ill, only 16.7 percent of the participants refer to health institutions for regular/annual checkups whereas the high rates of feeling ill (43.3 percent), suffering severe pain (41.2 percent) and failure of self-healing attempts (19.9 percent) when referring to health institutions are striking. This finding complies with the complaints of health professionals that patients refer to them very late and only at the last minute. Further, a significant part of the participants refer to alternative medical experts (17.7 percent).

About referral to alternative medical experts, the three-fold difference between the Eastern regions (36.9 percent) and the Western regions (11.9 percent) of Turkey is outstanding which shows the inadequacy of healthcare services provided in the Eastern regions and also the pursuit for alternatives in these regions due to the high rate of discrimination in healthcare services. In addition, the Eastern and Western parts of Turkey differ in terms of regular annual checkups: In the Western regions, 17.8 percent of the participants have regular checkups whereas this rate drops down to 13.1 percent in the Eastern regions. Similarly, the rate of those who refer to family health centers is 27.9 percent in the Western regions which rate decreases

to 17.2 percent in the East. These two data show that especially in the East, preventive medical services are not sufficiently utilized.

State hospitals are also highly preferred at a rate of 54.8 percent due to their availability, ease of access and operation on state insurance, yet one fourth of the participants (25.9 percent) stated that they preferred family community health centers. 39.6 percent of the participants emphasized quality of service in their choice of health institutions which is an indication of the fact that they wish to receive high quality service in a matter having vital importance.

Although satisfaction with the healthcare service received is generally high, a significant rate of the participants confirmed that doctors do not spend sufficient time for patients (41.6 percent), provide sufficient explanation (31.6 percent) or treat each patient in the same manner (43.3 percent). At this point, it is necessary to keep in mind the high number of patients that refer to state hospitals and the excessive bureaucracy such as patient recordal and follow-up. It is a significant finding that when discrimination by physicians and nurses is directly questioned, the rate is still high at a rate of 37.5 percent for physicians and 34.1 percent for nurses. Nurses establish closer relations with patients and are closer to middle class patients in the social and medical hierarchy, therefore they have significant responsibility in reducing discrimination in health institutions. For this aim, nurses must be sensitive towards the social positions and problems of patients. It is significant that among the most important reasons of discrimination there are class and status indicators such as clothing, general appearance (19.3 percent), financial situation (18.2 percent) and language/accent (9.2 percent). These are the indicators of discourses common among health personnel about rural, ignorant, Eastern (usually meaning Kurdish) and uninformed patients. Analyzing the cross-tables, we observe that particularly the HDP electorate consisting mostly of Kurds complain about discrimination. 53 percent of this electorate stated that doctors behave in a discriminating way whereas 51 percent complained about nurses in the same matter. As the reason for discrimination, this group emphasized characteristics such as language/accent (28 percent), financial situation (26 percent), clothing/general appearance (22 percent) and ethnic group (21 percent) all of which make their differences from other people living in Turkey more visible. Another similar indicator is that even though the participants from the Eastern regions of Turkey indicate that they are subjected to discrimination by doctors at a rate of 43.2 percent, this rate drops down to 36.1 percent among the Western participants. It is observed that the rate of those who indicate that they have never been subject to discrimination by doctors or nurses is 69.4 percent in the West whereas this rate drops down to 48.1 percent in the East.

As much as the health personnel, common views and values in the society also affect health issues. For example, conservativeness and religiousness in the society and the government policies that reinforce such tendencies are revealed in 25.1 percent of the participants who indicate that they would be uncomfortable to be examined by a physician of opposite sex and the 36.1 percent who state that they do not support sexual education in schools. The fact that the participants who

support sexual health education at the highest rates are men at the age of 18-32 (38.8 percent) and women again at the age of 18-32 (37.9 percent) might be explained by the fact that this age group is the most sexually active and especially in women, the most biologically reproductive one. However, it is interesting that the support decreases to 34.2 percent among women at the age of 33-48 whereas there is a much more dramatic decline among men of the same age group down to 29.9 percent.

Similarly, the opinion popular among health professionals in that the Syrians coming to Turkey since 2011 bring various diseases with them thereby making people living in Turkey unhealthy is shared by almost half of the participants (48.3 percent) despite lack of any medical evidence in this regard. Therefore, discrimination in healthcare is not peculiar to health professionals but is also common in the rest of the society. In this regard, the fact that the rate of those who agree with the view that people coming from Syria ruin the health of people living in Turkey is much higher among the participants from the East of Turkey (34.3 percent) than the participants from the West of Turkey might be the indication of both the inadequacy of healthcare services provided in the Eastern region and also the urgency and severity of the health problems in people escaping Turkey from the Syrian border at the Eastern part of Turkey. In this region, Syrians are given initial health checks, and the war wounds and traumas are attempted to be healed.

In conclusion, the difference between the East and West of Turkey with regard to benefiting from preventive medical services and discrimination in healthcare is important and policies should be developed in order to close this gap in the advantage of the Eastern region. Similarly, in the creation of health policies, especially with regard to preventive medicine, policies should be developed in consideration of discrimination in terms of financial situation, education, age and gender as much as regional differences in a way to cover different parts of the society.

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3. RESEARCH ID

3.1. Overall Description of the Survey

The surveys that this report is based on has been conducted by KONDA Research and Consultancy Limited (KONDA Araştırma ve Danışmanlık Ltd. Şti.).

The field survey was conducted on 1-2 October 2016. This report presents the political trends, preferences and profiles of the adult population above the age of 18 in Turkey, within the dates of the field survey.

The survey is designed and conducted with the purpose to determine and to monitor trends and changes in the preferences of respondents who represent the adult population above the age of 18 in Turkey. The margin of error of the survey is +/- 1.7 at 95 percent confidence level and +/- 2.3 at 99 percent confidence level.

3.2. The Sample

The sample was selected through stratification of the data on population and educational attainment level of neighborhoods and villages based on the Address Based Population Registration System (ADNKS), and the results of the November 1st 2015 General Election in neighborhoods and villages.

First, the administrative units were grouped as rural/urban/metropolitan, and then the sample was created based on the 12 regions.

Within the scope of the survey, 2532 respondents were interviewed face-to-face in 146 neighborhoods and villages of 113 districts - including central districts - of 30 provinces.

Provinces visited	30
Districts visited	113
Neighborhoods/villages visited	146
Number of respondents	2532

Among the 18 surveys conducted in each neighborhood, quotas on age and gender were enforced.

Age group	Female	Male
Between 18-32	3 respondents	3 respondents
Between 33-48	3 respondents	3 respondents
49 and above	3 respondents	3 respondents

	Level 1 (12 regions)	Provinces visited
1	İstanbul	İstanbul
2	Western Marmara	Balıkesir, Tekirdağ
3	Aegean	Denizli, İzmir, Kütahya
4	Eastern Marmara	Bursa, Eskişehir, Kocaeli, Uşak
5	Western Anatolia	Ankara, Konya
6	Mediterranean	Adana, Antalya, Hatay, Mersin
7	Central Anatolia	Kayseri, Sivas
8	Western Black Sea	Samsun, Tokat
9	Eastern Black Sea	Giresun, Trabzon
10	Northeastern Anatolia	Erzurum, Kars
11	Middle Eastern Anatolia	Malatya, Van, Elazığ
12	Southeastern Anatolia	Diyarbakır, Gaziantep, Şanlıurfa

The distribution of the respondents by region and place of residence is shown in the table below.

	Survey location	Rural	Urban	Metropolitan	Total
1	İstanbul			18.4%	18.4%
2	Western Marmara	.7%	2.6%	.7%	4.1%
3	Aegean	1.3%	6.0%	5.5%	12.9%
4	Eastern Marmara	2.0%	3.6%	5.9%	11.5%
5	Western Anatolia	.7%	1.8%	7.7%	10.2%
6	Mediterranean	2.0%	5.6%	5.7%	13.3%
7	Central Anatolia	.7%	2.5%	1.0%	4.2%
8	Western Black Sea	2.1%	2.8%		4.9%
9	Eastern Black Sea	.7%	2.1%		2.8%
10	Northeastern Anatolia	1.5%	1.4%		2.9%
11	Middle Eastern Anatolia	1.4%	2.8%	.7%	4.9%
12	Southeastern Anatolia	2.1%	3.5%	4.3%	9.9%
	Total	15.2%	34.8%	50.0%	100.0%

4. FREQUENCY TABLES

4.1. Profile of the Respondents

Gender	Percent
Female	48.3
Male	51.7
Total	100.0

Age	Percent
Between 18-32	33.0
Between 33-48	33.3
49 or above	33.7
Total	100

Educational attainment level	Percent
Illiterate	7.0
Literate without degree	3.2
Primary school degree	33.7
Secondary school degree	13.3
High school degree	27.4
University degree	14.0
Masters/PhD	1.3
Total	100

Household size	Percent
1-2 person(s)	17.7
3-5 people	64.6
6-8 people	15.3
9 people or more	2.3
Total	100

Lifestyle cluster	Percent
Modern	23.8
Traditional conservative	49.9
Religious conservative	26.3
Total	100

Employment status	Percent
Civil servant	4.5
Private sector	7.1
Worker	9.6
Small retailer	6.8
Merchant/businessman	1.5
Self-employed	1.7
Farmer, agriculturist, stock breeder	3.8
Employed, other	5.3
Retired	13.0
Housewife	30.2
Student	8.8
Unemployed	5.4
Disabled	2.4
Total	100

Where did you grow up?	Percent
Village	33.8
Town/district	23.1
City	28.0
Metropolitan area	15.0
Total	100.0

Marital status	Percent
Single	22.4
Engaged	1.3
Married	70.4
Widow	4.7
Divorced	1.1
Total	100.0

Head cover status	Percent
No head cover	27.3
Headscarf	49.4
Turban	9.4
Chador	0.5
Bachelor male	13.4
Total	100.0

Ethnic identity	Percent
Turkish	82.3
Kurdish	12.3
Zaza	1.1
Arab	1.3
Other	3.0
Total	100.0

Religion/sect	Percent
Sunni Muslim	93.5
Alevi Muslim	4.4
Other	2.1
Total	100.0

Level of religiosity	Percent
Non-believer	2.8
Believer	24.7
Religious	58.8
Pious	13.6
Total	100.0

Economic class	Percent
Lower	20.0
Lower middle	30.8
New middle	25.7
Upper	23.4
Total	100.0

Do you own a car in your household?	Percent
Yes	45.9
No	54.1
Total	100.0

Monthly household income	Percent
TRY 700 or less	6.4
TRY 701 - 1200	10.9
TRY 1201 - 2000	42.0
TRY 2001 - 3000	21.3
TRY 3001 - 5000	14.4
TRY 5001 or more	5.0
Total	100.0

TV channel preferred to watch the news	Percent
Does not watch	5.6
A Haber	7.5
ATV	18.2
CNN Turk	5.3
Fox TV	14.3
Haberturk	2.3
Halk TV	2.0
IMC TV	1.9
Kanal 7	1.5
Kanal D	7.1
Kanaltürk	0.0
NTV	4.6
Roj/Nuçe/Sterk	0.4
Show TV	6.1
Star	3.0
TRT	14.3
Ulusal	1.0
Local channels	4.7
Total	100.0

Type of housing	Percent
Squatter / apartment without external plastering	7.7
Single family, traditional house	32.2
Apartment	51.5
Housing complex	8.5
Very luxurious apartment, villa	0.2
Total	100

4.2. Opinion on Health

Which of the following two would scare you the most if it happened to you or your family?	Percent
Unemployment	22.7
Being unable to continue my education	5.9
Health problems	72.3
Divorce	16.7
Destitution, being dependent on someone else	39.0
Desolation	22.4
Total	100.0

How often do you eat fruits?	Percent
Every day	41.4
Several times a week	36.1
Once a week	14.0
Once or twice a month	5.9
Never	2.5
Total	100.0

How often do you vegetables (except potatoes)?	Percent
Every day	49.2
Several times a week	35.8
Once a week	11.1
Once or twice a month	2.8
Never	1.1
Total	100.0

How often do you eat pastries and other flour-based foods?	Percent
Every day	15.3
Several times a week	23.3
Once a week	30.0
Once or twice a month	21.3
Never	10.1
Total	100.0

How often do you drink carbonated beverages such as coke, 7 Up, etc.?	Percent
Every day	16.0
Several times a week	17.0
Once a week	16.0
Once or twice a month	16.4
Never	34.5
Total	100.0

How often do you eat red meat?	Percent
Every day	7.4
Several times a week	25.1
Once a week	26.8
Once or twice a month	32.9
Never	7.8
Total	100.0

Do you consume less salt, sugar or flour than before? If you have cut down on any of them, which one?	Percent
Salt	36.1
Sugar	44.2
Flour	20.9
No	44.4

Do you regularly take vitamins and/or dietary supplements? Which of the following do you take?	Percent
Prescription medication	40.7
Non-prescription medication	5.2
Sleeping pill	0.8
Vitamin, dietary supplement	4.5
Anti-depressant	1.7

Is yogurt prepared at home or purchased in this household?	Percent
Prepared at home.	32.0
Both prepared at home and purchased.	22.1
Purchased.	45.1
We don't eat yogurt.	0.7
Total	100.0

Which factor do you care about the most in deciding what to eat?	Percent
Health	55.1
Taste	29.3
Cost	15.7
Total	100.0

Did you engage in any physical activity for more than half an hour during the past week for the purpose of exercising? (grouped)	Percent
I have not exercised	60.2
1-2 times	13.8
3-4 times	9.4
5-6 times	5.1
7 times or more	11.4
Total	100.0

Do you smoke? How often do you smoke?	Percent
I have never drunk in my life.	47.8
I used to drink and I quit.	10.9
I drink rarely.	2.2
I smoke 1-2 cigarettes a day.	9.9
I am addicted to smoking.	29.3
Total	100.0

Do you drink? How often do you drink?	Percent
I have never drunk in my life.	73.5
I used to drink and I quit.	7.3
I drink rarely.	6.1
Once a month	7.1
Once a week	4.5
Every day	1.5
Total	100.0

From which source do you generally receive health related information?	Percent
Healthcare institutions	54.9
Pharmacy	3.5
TV	19.7
Internet/social media	15.9
Friends and acquaintances	6.0
Total	100.0

Do you suffer from any of the following diseases? If yes, can you specify which one?	Percent
Coronary	8.6
High blood pressure	19.4
Diabetes	10.8
Cancer	0.6
Asthma	5.6
Cervical or lumbar herniation	15.4
Allergy	7.3
Other	9.0
None of the above	49.6

How many times have you visited a hospital/clinic/community healthcare center during the past year?	Percent
Never	25.4
1-2 times	31.0
3-4 times	18.1
5-10 times	18.1
11-20 times	5.8
More than 20 times	1.5
Total	100.0

Have you visited one of the following due to a health problem during the past year? If yes, which?	Percent
I was not able to afford it.	5.0
I was not able to get permission from work.	1.3
I had other things to do./I could not find the time.	6.7
The line was too long.	4.2
There were no slots available.	2.4
The treatment I needed was not offered where I live.	2.2
Other	2.6
Something like this did not happen.	75.7
Total	100.0

When or how do you go to the doctor?	Percent
Regularly/annual check-ups	16.7
When I suspect I am sick	15.8
When I feel sick	43.3
In case of severe pain	41.2
When I am not able to cure myself	19.9

Which healthcare institution do you visit most frequently?	Percent
Family healthcare center	25.9
State hospital	54.8
University (Training/Research) hospital	9.0
Private hospital/clinic	10.2
Total	100.0

Can you briefly explain why you visit this institution most frequently?	Percent
Ease of access	32.0
Service quality	39.6
Economic reasons	21.1
Other	7.4
Total	100.0

Is there any person in need of care in this household?	Percent
There is an elderly person.	12.0
There is a handicapped person.	3.7
There is a sick person.	6.0
No.	79.0

I am generally satisfied with my health condition.	Percent
Strongly disagree	7.5
Disagree	5.8
Somewhat disagree	7.8
Somewhat agree	13.7
Agree	29.3
Strongly agree	35.9
Total	100.0

I am generally satisfied with the healthcare services I receive.	Percent
Strongly disagree	8.4
Disagree	5.4
Somewhat disagree	8.6
Somewhat agree	15.9
Agree	28.8
Strongly agree	32.8
Total	100.0

I would not feel comfortable being examined by a doctor of the opposite sex.	Percent
Strongly disagree	53.6
Disagree	15.6
Somewhat disagree	5.7
Somewhat agree	5.6
Agree	7.0
Strongly agree	12.5
Total	100.0

Syrians brought new diseases and made a negative impact on the health conditions of people living in Turkey.	Percent
Strongly disagree	26.1
Disagree	13.1
Somewhat disagree	12.5
Somewhat agree	10.5
Agree	11.3
Strongly agree	26.5
Total	100.0

Sex education should be taught in schools.	Percent
Strongly disagree	19.0
Disagree	7.6
Somewhat disagree	9.5
Somewhat agree	10.6
Agree	20.5
Strongly agree	32.8
Total	100.0

Doctors provide sufficient explanation to patients about their health condition.	Percent
Strongly disagree	13.7
Disagree	8.5
Somewhat disagree	9.4
Somewhat agree	15.5
Agree	23.2
Strongly agree	29.7
Total	100.0

Doctors spend enough time on each patient.	Percent
Strongly disagree	17.3
Disagree	12.5
Somewhat disagree	11.7
Somewhat agree	16.1
Agree	19.3
Strongly agree	23.2
Total	100.0

Doctors treat each patient equally.	Percent
Strongly disagree	18.7
Disagree	11.9
Somewhat disagree	13.7
Somewhat agree	14.3
Agree	19.1
Strongly agree	22.2
Total	100.0

Doctors discriminate against patients.	Percent
Strongly disagree	34.6
Disagree	18.4
Somewhat disagree	9.6
Somewhat agree	9.3
Agree	12.5
Strongly agree	15.7
Total	100.0

Nurses discriminate against patients.	Percent
Strongly disagree	35.7
Disagree	19.9
Somewhat disagree	10.3
Somewhat agree	8.5
Agree	10.2
Strongly agree	15.4
Total	100.0

Nurses discriminate against patients.	Percent
They do not discriminate.	53.8
Gender	4.1
Economic status	18.2
Language/dialect spoken	9.2
Political affiliation	4.3
Sexual orientation	1.0
Ethnic identity	6.4
Education	6.2
Occupation	3.4
Attire, general appearance	19.3
Patient's place of residence (urban/rural)	5.2

If any doctor or nurse discriminated against you, have you taken any action about this?	Percent
Yes, I have.	9.0
No, I have not.	25.9
I have not encountered any discrimination.	65.1
Total	100.0

Can you briefly explain why you visit this institution most frequently?	Percent
Ease of access	32.0
Service quality	39.6
Economic reasons	21.1
Other	7.4
Total	100.0

5. GLOSSARY of TERMS

All findings in Barometer reports are based on answers to the questions directed to respondents who were interviewed face-to-face in field surveys. Some questions and response options are then used in the rest of the report in short or simplified form. For example, the respondents who respond to the question on how religious they see themselves as "a person who is a believer, but does not fulfill religious requirements", are shortly identified as "believers" in the report. This glossary is prepared for both the readers who receive the report for the first time and the readers who need further clarification on the terms. The first table provides a list of the terms and their explanations, and the following tables list the questions and response options which establish the basis for these terms.

Term	Definition
Alevi Muslim:	A person who identifies his/her religion/sect as Alevi Muslim
Lower middle class:	Households with an income per capita in the 60 percent segment but which do not own a car
Lower class:	Households whose income per capita is in the lowest 20 percent segment
Arab:	A person who identifies his/her ethnic origin as Arab
Headscarf:	A woman who does not cover her head or a man with a headscarf or whose spouse does not cover her head with a headscarf
Chador:	A woman who wears chador or a man whose spouse wears a chador
Religious:	A person who tries to fulfill the requirements of the religion
Religious conservative:	A person who identifies his/her lifestyle as religious conservative
Traditional conservative:	A person who identifies his/her lifestyle as traditional conservative
Ideological:	A person who states a party as the closest to his/her political view
Believer:	A person who believes in the requirements of the religion, but does not fulfill them completely
Non-believer:	A person who does not believe in the requirements of the religion
Urban area:	Settlements with a population of more than 4000 (differs from the official definition)
Rural area:	Settlements with a population of less than 4000 (differs from the official definition)
Kurdish:	A person who identifies his/her ethnic origin as Kurdish
Leader follower:	A person who states that he/she trusts in or favors the leader of a certain party

Metropolitan:	Settlements which are located within the integrated boundaries of the most crowded 15 cities (differs from the official definition)
Modern:	A person who identifies his/her lifestyle as modern
No cover:	A woman who does not cover her head or a man whose spouse does not cover her head
Non-partisan:	A person who states that none of the parties represent him/her
Pious:	A person who fulfills the requirements of the religion completely
Late-decider:	A person who states that he/she makes a decision based on the election campaigns
Sunni Muslim:	A person who identifies his/her religion/sect as Sunni Muslim
Partisan:	A person who states that he/she/they always vote for that party
Turban:	A woman who wears a turban or a man whose spouse wears a turban
Turkish:	A person who identifies his/her ethnic origin as Turkish
Upper class:	Households whose income per capita is in the highest 20 percent segment
New middle class:	Households whose income per capita is in the 60 percent segment and which own a car
Zaza:	A person who identifies his/her ethnic origin as Zaza
Multiple Correspondence Analysis *(MCA)*	It is a data analysis technique for nominal categorical data, used to detect and represent underlying structures in a data set. It is used for applying Correspondence Analysis (CA) to large data sets with more than two variables. MCA was shaped with the work of mathematician and linguist Jean-Paul Benzécri in 1960s, and MCA-related studies and publications proliferated after the translation of research on Jean-Paul Benzécri and MCA in the 1980s and the use of this method by the French sociologist Pierre Bourdieu.

5.1. Questions and Response Options

Which of the three lifestyle clusters below do you feel you belong to?
Modern
Traditional conservative
Religious conservative

Do you cover your head or does your spouse cover her head when going out of your home? How do you cover your head?
No head cover
Headscarf
Turban
Chador
Bachelor male

We are all citizens of the Turkish Republic, but we may have different ethnic origins; which identity do you know/feel that you belong to?
Turkish
Kurdish
Zaza
Arab
Other

Which religion or sect do you feel you belong to?
Sunni Muslim
Alevi Muslim
Other

Which of the below describes you in terms of piety?
A person who does not believe in the requirements of the religion
A person who believes in the requirements of the religion, but does not fulfill them completely
A person who tries to fulfill the requirements of the religion
A person who fulfills the requirements of the religion completely

Which of the reasons below influence/determine your political preferences?
I/we always vote for that party.
It is the party closest to my political view.
I trust/favor its leader.
None of these parties represent me.
I make a decision based on the election campaigns.
Total

Settlement Code (Data obtained from the sample)
Rural
Urban
Metropolitan

Economic classes (determined by using household size, household income and car ownership)
Lower class
Lower middle
New middle
Upper class