The Long-Term Care response to COVID-19 in Turkey

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1. Key points

- As of June 10, Turkey has ranked the 11th country in terms of the highest number of COVID-19 cases. The mortality rate has been low (even given the likelihood of underreporting) partly due to the demographic characteristics, early lockdown measures, and health sector capacity enhanced by the private investment of recent years.
- A strict lockdown measure (curfew) for people 65+ and children under 20 was in effect between March 22 and June 9. Lockdown measures have been successful in first reducing and then bringing under control the transmission numbers. Yet, age-based curfew has also been denounced by the NGOs advocating for elderly rights.
- Along with the two guides circulated by the Ministry of Family, Labour and Social Services strict prevention and protection measures have been enforced in the care facilities. The visits have been suspended, the residents have been closely monitored (through symptomatic checks and tests) and the suspect cases have been transferred to the hospitals immediately. The staff worked on stable 14-day shifts and were tested before being admitted to the nursing homes.
- Day-care centres have been temporally closed. The home-based care services of the municipalities have continued.

2. Introduction

This report provides preliminary observations on the LTC responses to COVID-19 in Turkey. The report is based on the review of, firstly, the official documents including the measures to combat and prevent the spread of the COVID-19 in the population and in care facilities and; secondly the official statements and daily data revealed via printed and social media. The live discussions through internet platforms (e.g. webinars, internet TV) with the participation of the Ministry administrators, non-governmental organizations (NGOs), and care institution staff were also followed. Short telephone interviews were conducted with the municipality social and health care administrators, and NGO representatives. When further administrative data is made available, the report will be updated accordingly.

The first COVID-19 case in Turkey was confirmed on 11 March 2020. As of June 10, the total number of COVID-19 positive cases has reached 173,036, 4,746 COVID-19-caused deaths and 146,839 recovered patients have been registered, and 2,451,700 tests have been conducted. As a country with a population of over 83 million, the mortality rate related to the COVID-19 is 2.74%. The most heavily affected cities are Istanbul, Ankara, Izmir, and Konya; yet COVID-19 cases have been seen in the entire country. The majority of the cases are registered in Istanbul which constitute 60% of the total cases in the country. No administrative data on the regional and provincial distribution of the cases, or the gender and age distribution has been published so far. According to a recent statement of the Minister of Health, 93% of the COVID-19 caused deaths are aged 65 or older.
Although Turkey is the 11th country in terms of the highest number of COVID-19 cases as of June 10, viii the low mortality rate has been puzzling. The likelihood of underreporting is being scrutinized in the media. ix Nevertheless, Turkey seems to have managed to keep the mortality rates low due to partly demographic characteristics (comparatively lower percentage of the population over 65), early lockdown measures, and health sector capacity. x Turkey is one of the top countries in Europe in terms of the number of intensive care unit (ICU) beds per capita. xi In the last decade, an ‘unreasonably’ high private sector investment in intensive care capacity has helped in this unprecedented health crisis, xii as the health sector has not been overwhelmed by the outbreak of the pandemic. xiii

Turkey has not experienced large number of deaths in the care institutions. On one hand, the early precautions and coordinated intervention in the nursing homes have prevented mass deaths in these institutions. On the other hand, Turkey does not have a high institutional capacity in LTC; only 0.4% of older people are living in the institutions. Therefore, measures that have been taken in the communities and by the families need further inquiry to understand the effects of COVID-19 on people who use LTC.

3. Impact of COVID-19 on long-term care users and staff so far

3.1. Number of positive cases in population and deaths

As of June 10, the total number of COVID-19 positive cases has reached 173,036. 4,746 COVID-19-caused deaths and 146,839 recovered patients have been registered. Furthermore, 2,451,700 tests have been conducted. xiv

3.2. Population level measures to contain spread of COVID-19

Turkey imposed flight bans first to the countries where the pandemic risks were high and then closed its borders and cancelled flights completely. As a quick response, on February 3, Turkey stopped all flights from China. xv On March 27, all overseas flights were terminated. xvi

On March 16, all primary, middle and high schools, day-care centres and universities were closed. xvii On March 23, all schools moved to distance education (till June 19) xviii and the universities moved to online education. The schools will reopen in September 2020. xix

By mid-March, all libraries and many businesses (such as, restaurants, cafes, bars, gyms, movie theatres, hairdressers, beauty salons, and shopping malls) were closed; xx nationwide ban came on prayer gatherings in mosques, including Friday prayers; xxi picnic areas, national parks, and ruins were closed for visits on the weekends. xxii Starting from 28–29 March, fishing at the shores, outdoor physical exercises in city and town centres were banned. xxiii On March 27, intercity travel bans were imposed and permissions were granted only for certain circumstances. xxiv
In February, all returnees from abroad were requested to self-quarantine for 14 days upon their arrival. Nursing home residents who had returned from abroad were quarantined for 14 days in flat-type social service institutions if it was not possible for them to stay with their families.\textsuperscript{xxv} In March, the pilgrims who returned from Umrah were quarantined in student dormitories;\textsuperscript{xxvi} all citizens who were transported by chartered flights from abroad spent 14 days under quarantine in student dorms that had been evacuated and reserved for the social isolation of the overseas arrivals.

Although a complete lockdown was not implemented in the country, as of March 22, a 7 days/24 hours curfew was imposed on citizens aged 65 and over.\textsuperscript{xxvii} As of April 3, the curfew was extended to persons younger than 20 years old.\textsuperscript{xxviii} Wearing masks in public places became compulsory.\textsuperscript{xxix} Since April 10, curfews that involve all age groups have been implemented over the weekends and official holidays. A four-day country-wide curfew over the official holiday (Eid break) for all age groups between May 23-26 was enforced.\textsuperscript{xxx}

As the daily cases were first reduced and then brought under control, a gradual normalization process was started in May.\textsuperscript{xxxi} implemented as a gradual easing of the restrictions throughout May, June, and July.\textsuperscript{xxxii} The curfew for the persons aged 65 and over and for children under 18 continued till the beginning of June; yet both children and older people were allowed to go out for a couple of hours on designated days and hours.\textsuperscript{xxxiii} The curfew for the older people and children ended on June 10.\textsuperscript{xxxiv} Older people are allowed to go outside between 10 am and 8 pm and children can go out anytime on the condition that they are accompanied by one adult member of their family.\textsuperscript{xxxv} The prolonged curfew imposed on senior citizens, which had been objected by the NGOs due to the negative effects of social isolation on the elderly, since March was over by mid-June.\textsuperscript{xxxvi}

Businesses like barbers, hairdressers, and beauty salons were allowed to reopen in May. They were required to comply with certain regulations, such as, accepting customers with masks and by appointment.\textsuperscript{xxxvii} Intercity travel restrictions were lifted, cafes and restaurants, beaches, national parks and gardens were reopened for visits on June 1. Day-care centres for children, libraries and youth centres were also reopened. Turkish Airlines resumed domestic flights on June 4\textsuperscript{xxxviii} and international flights on June 11.\textsuperscript{xxxix} People arriving on scheduled overseas flights go through medical checks and are monitored for 14 days at their homes.\textsuperscript{xl} The Ministry of Health stated that Turkey had completed the first stage of its struggle against COVID-19, and the country was moving into a ‘controlled social life’.\textsuperscript{xli}

### 3.3. Rates of infection and mortality among long-term care users and staff

No administrative data has been published; the information provided here relies on the public statements of the government officials provided in different platforms. As of May 7, there were 1,030 diagnosed COVID-19 cases in care institutions who had been admitted to hospitals.\textsuperscript{xlii} 60\% of these cases have been treated and discharged from hospitals.\textsuperscript{xliii} So far, the deaths of 150 older people have been reported in nursing homes.\textsuperscript{xlv} The deaths in nursing homes due to COVID-19 correspond to 4\% of all the deaths in Turkey.\textsuperscript{xlv} As of May 3, there are 7,428 health care workers
who tested positive for COVID-19. No data has been provided or shared so far concerning the infected staff of care homes.

4. Brief background to the long-term care system

Although Turkey has a relatively young population, aging is already a pressing issue in. People aged 65 and over constitute 9.1% of the population. Turkey has been a familialist welfare system where the family has been the main care-taker of older people. The Turkish Civil Code involves intergenerational obligations for family members to look after their dependents. There has been an expansion of long-term care services in the last two decades. This is partly due to the changing structure of the family (the care provider extended families are eroding) that cannot sustain relying on care by the family and the aging of the population in general.

There is no long-term care insurance system. The institutional framework for long-term care is composed of public and private nursing homes for people aged 60 or more who could look after themselves, care and rehabilitation centres for older and disabled people who need long-term care, day-care centres and home-based care services (health and social care) run by the municipalities, NGOs and private entities. In 2008, private entities were allowed to open nursing homes; since then there has been a rapidly growing social sector. Today the private nursing homes have outnumbered public homes. As of 2020, there are 426 nursing homes; of those, 179 are public and 247 are private entities; the privately run nursing homes constitute 58% of institutional care services whereas public nursing homes constitute 42%. Nevertheless, 61% of older people who receive institutional care reside in public nursing homes, whereas 39% reside in private ones. Only 0.4% of older people living in care homes. Apart from the large care institutions, the state has been opening community-based care facilities. These are houses with assigned staff that are run by the Ministry where 2 to 5 older people share a flat. There are a small number of flats (129) with a low capacity utilisation (122 people living in them). There are also care and rehabilitation centres run by the state and the private entities, day-care centres and a small number of community-based care centres (the house model) for people with disabilities. The state has a public-private partnership model where the state pays the centres a monthly sum per care user person that is equal to double the minimum wage. There are a small number of day-care centres established as part of the nursing homes which are provided in 30 institutions, serving 301 older people.

Home-based health care is provided by public and private hospitals. Home-based care is an emerging sector where small- and large-scale private entities (some own nursing homes) also provide home-based care services. The Municipalities also provide home-based social as well as health care services for 65+. Yet, there is no publicly available administrative data that demonstrates the capacity of the municipal care services for the elderly.

Palliative care is in its early stages of development. In 2010, the Palya-Turk Project was initiated by the Ministry of Health, and since then palliative care centres have been established in public and private hospitals. Generalized palliative provision is not integrated with the social care facilities.
In supporting family-based and home-based care, there are cash-for-care schemes and the social security premium incentives for the employers of domestic care workers. Cash-for-care is a means-tested cash transfer paid to the care provider who is usually a family member living in the same household and provides round-the-clock care seven days a week. To be eligible, a person must provide a medical report demonstrating a diagnosis of at least 50 percent disability. The care provider receives a monthly cash transfer approximately equivalent to the net minimum wage. Since 2007, the cash-for-care scheme has been the government’s main tool for supporting families with members who require care. The number of persons with LTC needs who benefit from the cash-for-care scheme was 523,068 as of February 2020, \(^{lvii}\) 32% of the beneficiaries of cash for care scheme are caring for older people. \(^{lviii}\) The social security premium incentives aimed at employers also cover the employers of domestic care workers; within the scope of the Law of Unemployment Insurance. \(^{lix}\) Social security premiums of domestic care workers could be funded by the Social Security Institutions for up to two years, if certain conditions are met. \(^{lx}\)

5. Long-term care policy and practice measures

5.1. Whole sector measures

Prior to the confirmation of the first COVID-19 case, Turkey had started the preparations for responding to the pandemic. In January, the Coronavirus Scientific Advisory Board (comprised of Chest Diseases, Infectious Diseases, Clinical Microbiology, Virology, Internal Medicine, and Intensive Care Medicine experts) was established. \(^{lxii}\) The Advisory Board has been developing medical guidelines for treatment as well as prevention measures to be followed by the population.

On March 20, the Ministry of Health declared all hospitals (including private and foundation hospitals with at least two specialists in infections, pulmonology, internal medicine, and clinical microbiology) as COVID-19 pandemic hospitals. \(^{lxiii}\) On April 14, the government decision announced the provision of health care services for all citizens (with or without social security) who tested positive for COVID-19 in all pandemic hospitals. \(^{lxiv}\) The free of charge treatment of COVID-19 patients includes provision of protective equipment, tests, medication or any other relevant material and supplies used in the treatment.

In the public and the private institutional care facilities, precautions have been taken in line with the two guidelines disseminated by the Ministry of Family, Labour and Social Services. The guidelines that came out on March 16 and April 16 have imposed strict prevention and protection measures on the care institutions and supported the management of the institutions in responding rapidly and in a coordinated manner. \(^{lxv}\)

On March 17, an online module was created to follow up on the supply shortages and stocks of the care institutions. \(^{lxvi}\) The institutions were provided with a supplementary allowance for medical devices and personal protective equipment (PPEs). \(^{lxvii}\) As of April 9, those residents who
live in the nursing homes, but are on leave during the pandemic were not charged any fees. Medical reports for the treatment and medication that required periodical approval by the relevant hospital committees were extended in order to prevent any travel to hospitals.

Day-care services at nursing homes and care and rehabilitation centres were suspended.

On April 16, a temporary article was added to the Law of Social Services. Due to the force majeure caused by the COVID-19 pandemic, the requirements of income tests and the medical reports (confirming severe disability) in order to receive free care and rehabilitation services (public or private) were suspended for the next three months (with possible extension up to one year). The requirement for means tests for admission of persons 60 or more in public nursing homes free of charge was also suspended; all older in need of care were allowed to stay in the care facilities irrespective of their income. During the pandemic, automatic renewal was granted to all medical reports (confirming severe disability) of the beneficiaries of cash-for-care schemes without any application.

5.2. Care coordination issues

5.2.1. Hospital discharges to residential and nursing homes

Nursing home residents discharged from hospitals are not immediately admitted to the nursing homes. Those who have family members, stay with their families in accordance with the social isolation guidelines. Residents who cannot go to their extended family homes are admitted to the social isolation units. These are units established to support residential care during the pandemic. Depending on the infrastructure availability, either newly built nursing homes without residents or care and rehabilitation centres were transformed into social isolation units. The social isolation facilities have their own staff whose spend their entire shifts at these facilities. These social isolation units are free of charge to all nursing home residents irrespective of their income.

5.3. Care homes (including supported living, residential and nursing homes, skilled nursing facilities)

5.3.1. Prevention of COVID-19 infections

Prior to the first case confirmed on March 11, in January, the staff training on the disease had started; the residents were provided with the necessary information on the protection measures.

In February, visits to nursing homes were restricted to the family members of the residents. The body temperatures of visitors were monitored. On March 14, all care institutions were closed to external visits. Gatherings within and among the institutions were prohibited.

On March 16, transfers/admissions to the care institutions, including the private ones were halted. Before the admission to institutions (in case of emergency situations), people are scanned
for symptoms of COVID-19 and are isolated in quarantine for 14 days at the institutions.\textsuperscript{lxix} Those residents who preferred to go to their families were allowed on the condition that they would not re-accepted to the institutions for 14 days.\textsuperscript{lxx}

Residents’ outside visits were restricted except for compelling reasons. Those residents who had left the institutions before 16 March 2020 were not re-admitted.\textsuperscript{lxxi} On April 12, admissions of emergency cases to the nursing homes was suspended until further notice. Instead, they were settled in public institution guesthouses which were reserved for the emergency cases within their provinces; if this is not possible, in designated hotels. Before their settlement, they were periodically controlled and informed about the disease, its transmission ways, and measures taken against it. Their sanitation, health, food, clothing, and other expenses are covered by Social Assistance Services of the Ministry of Family, Labour and Social Services. Suspect cases were immediately referred to health service units.

Health checks became more frequent. The body temperatures of residents were monitored frequently, those who had high temperatures were referred to the hospitals.\textsuperscript{lxxii}

At the beginning of the outbreak, the measures in the guidelines ensured that the staff were checked for the symptoms of high temperature and respiratory problems before being admitted to the nursing home for their shifts. Those who showed any symptoms were not admitted to the care institutions but referred to the health units. Since the early stages of the pandemic, staff and their family members were warned about social isolation rules that include relatives who had returned from abroad and in quarantine for 14 days; those who do not follow this rule were not admitted to the institutions. Staff who had transmission risk were asked to isolate themselves in quarantine for 14 days regardless of whether they showed any symptoms.\textsuperscript{lxxiii}

To prevent any transmission within the institutions by the staff, more strict measures were introduced on April 10. With the cooperation of the Ministry of Health, the staff started to be Polymerase Chain Reaction (PCR)-tested before they take up their shifts in nursing homes.\textsuperscript{lxxiv} On March 26, the staff in care institutions moved to working in shifts of 7, 10, or 15 consecutive days.

The staff who had contacted a confirmed COVID-19 case or had a suspected case in their home were asked to self-quarantine and the sick-leave process was made easier.\textsuperscript{lxxv} The staff who showed symptoms were monitored for 14 days following the emergence of the symptoms in self-isolation and the positive cases were referred to the hospital. The staff discharged from the hospital quarantined at least 14 days before restarting their shift.\textsuperscript{lxxvi}

Starting on April 12, wherever possible, all residents of the nursing homes were relocated into single rooms. All staff and residents were required to wear masks. Each staff member was assigned to a single floor, and mobility among the floors was suspended in order to prevent any rapid spread of the virus within the nursing home.
The nursing home residents who needed to go to hospitals for compelling reasons were accompanied by the nursing home staff. After their re-entrance to the nursing home, their rooms were converted into social isolation rooms and specific sanitary measures were taken. The staff providing services to each such resident were solely assigned that resident and were not changed. Wherever possible, the residents who received hospital treatment were gathered in a designated institution. If this was not possible, they were gathered in a separate wing that had a different entrance and exit.

Take-away food orders were suspended; mail/package delivery was minimized and sanitized upon acceptance. Purchase of unpackaged bread was stopped.

5.3.2. Controlling spread once infection is suspected or has entered a facility

The care institutions complied with the procedures included in the Guide for Monitoring of the Contacted (Temaslı Takip Rehberi) of the Ministry of Health.

The temperatures and respiratory problems of residents were monitored regularly. For those who had a high temperature or were suspected COVID-19 cases, the provincial health unit was informed and their transition to a pandemic hospital was completed. Until the transition of the patient to the hospital is completed, he/she was immediately isolated in a separate room, and staff in protective clothing were assigned to them.

As of April, the residents in the nursing homes started to be tested regularly, and the positive cases/suspected cases were transferred to the hospitals. After a suspect case was transferred to the hospital, the whole institution was quarantined with stable shift work. In a nursing home under quarantine, all services provided to the residents were provided in their rooms in accordance with the isolation regulations.

5.3.3. Managing staff availability and wellbeing

The staff availability was achieved with the tremendous effort put in by the staff, who took up the stable 14-day shifts, including live-in arrangements during the shifts. Starting March 26, staff moved to stable shifts for 7-10 days and then shift lengths were set at 14 days. The PCR tests were carried out for the staff at the start of their 14-day stable shifts. Once staff were admitted to the institutions, they moved to live-in shifts for 14 days. Single rooms with bathrooms were provided for live-in staff wherever possible.

Starting April 2020, any resignations of health and social care staff in the nursing homes were not accepted. All annual leave was cancelled except for emergency situations. Shifts were re-arranged by the management of the nursing homes concerning the administrative leave. When a member of staff contacted a positive case or there was a suspected case in their family environment, the necessary isolation procedures were implemented and the sick leave procedures were made easier. The guidelines recommend psychosocial support mechanisms
to the staff. Staff working in the social isolation institutions were selected from those who had no COVID-19 history.

5.3.4. Provision of health care and palliative care in care homes during COVID-19

There are no palliative care units integrated into the nursing homes. The health care staff of other institutions were not allowed to the nursing home, the suspected cases were transferred to a hospital in accordance with the isolation measures.

As of April 6, physicians based in the private nursing homes were authorized to prescribe medication. On April 7, physician needs of the care institutions were officially notified to the Directorate of Staff at the Ministry. According to the official statement, the number of physicians were going to be increased in the nursing homes.

5.4. Community-based care

Although a complete lockdown was not implemented in the country, a curfew measure was implemented for older citizens from March 22 to June 9. In such an age-based lockdown, in order to meet the basic needs of those persons living alone, the mobile social support teams (Vefa Sosyal Destek Grupları) were established in each province. These social support teams that are run under the Ministry of Family, Labour and Social Services have a mission to provide home-based care services to people aged 80 or older, they also meet the basic needs of persons with disabilities and older persons upon their phone calls to hotlines 112, 155 and 156. An easy-to-read guidebook was published by the Ministry of Family, Labour and Social Services that provided information about protection from the COVID-19 virus, available services for older people, and the psychosocial support hotlines of the Ministry of Health during the pandemic. This guidebook also included recommendations on psychological well-being, nutrition, exercising during the lockdown and suggestions for the carers.

In Turkey, home-based social care services (usually entangled with health care services) are predominantly provided by the municipalities and the NGOs. During the pandemic, the municipalities did not suspend their home-based care services and the measures are taken to maintain staff and beneficiary’s well-being. Istanbul Metropolitan Municipality carried on with its home-based care services with 68 mobile teams and provided care services to 5000 elderly, which constituted a significant increase in the demand for the local care services since March. Due to the pressing demands springing from the new requests from elderly who could not go to hospitals and hospitals that could not respond to general health care needs due to the outbreak, the Municipality was compelled to prioritize the most urgent cases.

In maintaining staff well-being, the frequency of home visits was decreased as much as possible and non-urgent visits were postponed. The social care services such as bathing and home cleaning were done every 15 days instead of every week.
Measures were taken for the safety of the staff; protective suits, filtering facepiece (FFP3) masks, and visor masks were made available to the staff and the equipment was changed after each visit. During the visits, the travel story and any contact with suspected cases were inquired. If a suspected case was confirmed in the near environment of the elderly, the care workers postponed home visits as much as possible. Municipalities have started providing psychotherapy services through hotlines since the onset of the outbreak.

Provincial municipalities like Beşiktaş in Istanbul, did not suspend home-based health care services apart from the home-based physiotherapy and some non-urgent care services. Staff is enforced to wear protective suits, masks, and gloves during the home visits. The psychotherapy services were started to be carried out online. The Directorate of Social Assistance continued with the delivery of meals to people 65+ in need. The demand for the distribution of food increased during the outbreak. Psychosocial support services are also maintained through the phone calls.

Other metropolitan and provincial municipalities (İzmir Metropolitan, Büyükçekmece Municipality in Istanbul, Odunpazarı Municipality in Eskişehir, Şişli Municipality in Istanbul, Tuzla Municipality in Istanbul, Muratpaşa Municipality in Antalya, Kars Metropolitan) have continued with their home-based care services.

5.5. Impact on people with intellectual disabilities and measures to support them

The curfew for the children and youth under the age of 20 was not applied to children with autism, mental retardation, or down syndrome. They were allowed to go outside by complying with the regulations.

5.6. Impact on people living with dementia and measures to support them and their carers

According to the observations of the Turkish Alzheimer Association, persons living with dementia have been negatively affected by the age-based lockdown measures. Distress has increased among the Alzheimer patients who do not fully understand the context of the pandemic; they got more vulnerable as they have been isolated from the daily visits and outdoor walks.

The day-care centres that serve Alzheimer patients were shut down until June 15 to safeguard the safety of the service users. As day-care services were not operating, more burden has been put on the carers. The Alzheimer Association had been providing home-based care training to the unpaid carers of persons living with dementia, which also had to be suspended since the outbreak of the pandemic. Nursing homes for Alzheimer patients run by NGOs in Mersin and Eskişehir follow the prevention and protection measures of Ministry of Family, Labour and Social Services; they have no registered COVID-19 cases. The day-care centres of the facilities are temporally shut down.
There are psychosocial support services provided through the hotlines of the Ministry of Health. NGOs’ online as well as over the phone counselling services have been continuing. Through social media channels, the NGOs inform and support the carers of persons living with dementia. They receive questions from carers via phone and e-mail and they respond to those questions with the help of specialists through online talks whose records are later released on social media. The Izmir branch of the association launched the Digital Grandchild (Dijital Torun) project with the participation of the young volunteers holding online gatherings with persons who have Alzheimer’s disease.

6. Lessons learnt so far

In a country where the institutional long-term care services serve a small percentage of the elderly, the pandemic showed the importance of community-based and home-based care services.

6.1. Short-term calls for action

The support mechanisms for elderly who have lived under lockdown for about 2.5 months need to be prioritized. The home-based care services which also include psychosocial support should be expanded in order to cover a wide range of elderly population who have been locked down in their homes since March 22.

6.2. Longer term policy implications

The capacity of LTC in Turkey is limited, yet it is an emerging social and health policy area. As the population is aging, the demand on the long-term care sector will increase. The COVID-19 responses have demonstrated the importance of the early measures that were taken at the institutional level. Yet, it also showed the importance of coordinated action among the sectors of the LTC. There are many emerging actors in the LTC in Turkey whose sustainable coordination holds great importance.

The importance of the care work both in the institutions and the community became more visible. The essential care workers’ working conditions should be among the LTC priorities.

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Kuruluşlarımıza yönelik koronavirüs bilgilendirme rehberi – II (The informative guide on coronavirus for our institutions – II).  
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Infomation was provided by the Municipality staff, 4 June 2020


Based on the telephone interview with the representative of the Turkish Alzheimer association.

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