THE ROLE OF THE UNITED NATIONS AGENCIES IN PROVIDING HEALTHCARE FOR SYRIAN REFUGEES IN TURKEY (2011-2021)

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ABSTRACT

THE ROLE OF THE UNITED NATIONS AGENCIES IN PROVIDING HEALTHCARE FOR SYRIAN REFUGEES IN TURKEY (2011- 2021)

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Turkey, hosting more than three million registered Syrian refugees, have become the top-Syrian refugee hosting country in the world in the last decade following the outbreak of the Civil War in Syria started in 2011. As a response to pressures on its health sector which have implications for refugees' access to healthcare, Turkey realized significant changes in healthcare provision to overcome the pressures on its healthcare system and the difficulties refugees faced, and collaborated with international actors, including UN agencies. This thesis examines the role of three UN agencies, World Health Organization (WHO), United Nations Population Fund (UNFPA), and United Nations International Children's Emergency Fund (UNICEF) which took key roles in healthcare provision to refugees, on three different policy sectors. These policy sectors, respectively, are primary-level healthcare provision, sexual and reproductive healthcare provision to refugee women and immunization healthcare provision to refugee children. Based on findings from semi-structured interviews, comprehensive review of policy documents, international and national legal documents, and press coverage both in English and Turkish, this thesis investigates the nature of the policy change in Turkey's health sector after the Syrian migration crisis and the role of capacities and expertise of the UN agencies in the

process of this policy change. It further examines the impact of these policy capacities of the UN on the policy capacity of Turkey in three policy sectors and tries to clarify to what extent these policy capacities led policy learning in Turkey.

Keywords: United Nations, Syrian refugees, Turkey, healthcare provision, policy capacity

ÖZ

TÜRKİYE'DEKİ SURİYELİ MÜLTECİLERE SAĞLIK HİZMETİ SAĞLANMASINDA BİRLEŞMİŞ MİLLETLER KURULUŞLARININ ROLÜ (2011- 2021)

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Türkiye, 2011 yılında Suriye'de başlayan iç savaş sonrasında meydana gelen göç sonrasında üç milyondan fazla kayıtlı Suriyeli mülteciye ev sahipliği yaparak dünyanın en çok Suriyeli mülteciye ev sahipliği yapan ülkesi konumuna gelmiştir. Söz konusu göç, Türkiye'nin sağlık sistemi üzerinde etkiler yaratmış ve bu da mültecilerin sağlık hizmetlerine erişiminde bazı sorunlara sebep olmuştur. Türkiye, mültecilerin sağlık hizmetlerine tam erişimini sağlamak ve sağlık sistemini de bu göç krizine dayanıklı hale getirmek için sağlık hizmetlerinin sağlanması konusunda önemli değişiklikler yapmış ve bunu yaparken de içinde Birleşmiş Milletler kuruluşlarının da olduğu uluslararası aktörlerle iş birliği yapmıştır. Bu tez, mültecilere sağlık hizmeti sağlanmasında önemli roller üstlenen Dünya Sağlık Örgütü (WHO), Birleşmiş Milletler Nüfus Fonu (UNFPA) ve Birleşmiş Milletler Uluslararası Çocuklara Acil Yardım Fonu'nun (UNICEF) üç farklı politika sektörü üzerindeki etkisini incelemektedir. Bu politika sektörleri sırasıyla mültecilere birinci basamak sağlık hizmetleri sunumu, mülteci kadınlara cinsel sağlık ve üreme sağlığı hizmetleri sunumu ve mülteci çocuklara bağışıklama hizmetleri sunumudur. Bu tez, yarı yapılandırılmış mülakatlar, uluslararası ve ulusal politika belgeleri,

yasal metinler ve Türkçe ve İngilizce basın kaynaklarının kapsamlı taramasından elde edilen verilere dayanarak, Suriye’deki iç savaştan sonra başlayan göç krizinin etkisiyle Türkiye'nin sağlık sektöründe meydana gelen politika değişikliğinin niteliğini ve Birleşmiş Milletler kuruluşlarının kapasitelerinin ve uzmanlıklarının bu politika değişikliğindeki rolünü araştırmaktadır. Bu tez aynı zamanda Birleşmiş Milletler kuruluşlarının politika kapasitesinin söz konusu üç politika sektörü üzerinden Türkiye'nin politika kapasitesi üzerindeki etkilerini de incelemekte ve bu politika kapasitelerinin Türkiye'de politika öğrenimini ne ölçüde yönlendirdiğini açıklığa kavuşturmaya çalışmaktadır.

Anahtar Kelimeler: Birleşmiş Milletler, Suriyeli mülteciler, Türkiye, sağlık hizmeti sunumu, politika kapasitesi

To the cities of Kahramanmaraş, Adıyaman, Hatay, Gaziantep, Malatya, Adana, Osmaniye, Kilis, Şanlıurfa, Diyarbakır, and Elazığ…

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LIST OF ABBREVIATIONS

BPRM	: Bureau of Population, Refugees and Migration
CEDAW	: Convention on the Elimination of All Forms of Discrimination Against Women
DGECHO	: Directorate General for European Civil Protection and Humanitarian Aid Operations
ESSN	: Emergency Social Safety Net
EU	: European Union
FAO	: Food and Agriculture Organization of the United Nations
FRIT	: Facility for Refugees in Turkey
IFAD	: International Fund for Agricultural Development
ILO	: International Labour Organization
IOM	: International Organization for Migration
MHC	: Migrant Health Center
MISP	: Minimum Initial Service Package
NGO	: Non-governmental Organization
OECD	: Organisation for Economic Co-operation and Development
RHTC	: Refugee Health Training Center
SIHHAT	: Improving the Health Status of the Syrian Population under Temporary Protection and Related Services Provided by Turkish Authorities Project
UN	: United Nations
UNDP	: United Nations Development Programme
UNHCR	: United Nations High Commissioner for Refugees
UNIC	: United Nations Information Center
UNIDO	: United Nations Industrial Development Organization

UNICEF	: United Nations International Children's Emergency Fund
UNFPA	: United Nations Population Fund
UNWOMEN	: United Nations Entity for Gender Equality and the Empowerment of Women
WGSS	: Women and Girls Safe Spaces
WFP	: World Food Programme
WHO	: World Health Organization

CHAPTER 1

INTRODUCTION

The civil war in Syria started in March 2011 as civilian protests against the Syrian government, and it turned out to be a protracted civil war leading the biggest flow of the post-Second World War. 6, 9 million people became internally displaced, and 6, 8 million people sought refuge in another country, which meant that half of Syria's pre-war population became displaced. The neighboring countries of Syria were significantly affected by this migration flow. Turkey, Lebanon, and Jordan came to the point of hosting the 84 percent of Syrian asylum seekers. [1] Turkey, with 3,274,059 million registered Syrians[2], became the top refugee hosting country of this crisis and made several adjustments and amendments in its migration policy and national law to cope with pressures and uncertainties brought by mass flows since the very beginning of the crisis.

These adjustments included legislative and institutional reforms to build a responding national asylum system and a proper migration policy. These legislative and institutional changes resulted in policy changes in the affected policy sectors, among which the health sector was the most significant change occurred in. The Migrant Integration Policy Index 2020[3] evaluated the health sector in Turkey as the most successfully integrated policy area among all other policy areas of integration. Other integration areas assessed included other areas such as labor market mobility, and education. This policy change was significant in two ways. Firstly, it changed

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[1] "Why has the Syrian War Lasted 11 Years?," *BBC*, May 2022, available at https://www.bbc.com/news/world-middle-east-35806229 , accessed on 13 November 2022.

[2] "Syrian Regional Refugee Response- Registered Syrian Refugees," UNHCR, last updated on 5 October 2023, available at Situation Syria Regional Refugee Response (unhcr.org), accessed on 24 October 2023.

[3] "What is MIPEX?," Migration Integration Policy Index 2020, available at MIPEX 2020, accessed on 24 October 2023.

the methods or mode of service provision in Turkey through the introduction of new policy instruments and new policy tools. Some of these introduced policy instruments resulted in a radical shift in regular policy making. In contrast, some of these arrangements resulted in the continuation of the existing policy with slight variations from existing policies. Secondly, the policy change happened through collaboration between the Turkish government and several non-state actors, including the UN agencies.

The policy change in the healthcare system in Turkey was a decision to manage the uncertainties brought by migration crisis. This policy change involved several political interactions to manage these uncertainties. Political interactions are significant, and they may turn to a process of social learning expressed through policy.[4] The process of social learning expressing itself through policy, including the mechanisms of feedback exchange, the actors involved, and the policy instruments created, may eventually lead to policy changes. Within this framework, there is a relationship between policy learning and policy changes. However, most of the literature is ambiguous on how policy learning drives policy change, and the primary rationale of this ambiguity is that policy learning may only be among one of the reasons resulting in policy change.[5] This thesis examines the agency and role of UN agencies[6], as part of the broader UN System[7], which are important actors of these interactions feeding this policy learning through several capacities (resources and capabilities). To respond to the discussed concerns on policy learning, this thesis examines how the policy capacity of the UN agencies are developed and used, and

[4] Hugh Heclo, *Modern Social Politics in Britain and Sweden: From Relief to Income Maintenance* (New Haven and London: Yale University Press , 1974), 305- 306.

[5] Stéphane Moyson, Peter Scholten, and Christopher M. Weible, "Policy Learning and Policy Change: Theorizing Their Relations from Different Perspectives," *Policy and Society*, Vol: 36, No: 2 (2017): 165.

[6] UN agencies or UN technical agencies is an umbrella concept used in this research. It refers to the UN specialized agencies and technical funds of the UN System that took part in the refugee health governance in Turkey.

[7] The UN System, consisting of different international organizations such as the UN General Secretariat, the UN funds and programs (UNDP, UNFPA, UNICEF), and UN specialized agencies (World Health Organization and World Bank), is a complex international bureaucracy. A detailed chart of the UN System, in "The United Nations System," United Nations, available at https://www.un.int/sites/www.un.int/files/Permanent%20Missions/18-00159e_un_system_chart_17x11_4c_en_web_0.pdf, accessed on 20 December 2022.

eventually how these capacities lead a policy change by examining the policy capacities of the UN agencies in developing new policy models or supporting existing policy instruments in providing healthcare for Syrian refugees in Turkey. This empirical research aims to provide insights into the resources and capabilities while also providing further evidence on whether such a relationship between policy learning and policy change exists and if there are other factors contributing to policy change along with policy learning.

This thesis uses a comparative analysis through examining three different policy issues within the health sector, which are strengthening primary-level healthcare services, providing sexual and reproductive health services to Syrian refugee women, and providing immunization services to Syrian refugee children.

Within this context, the collaboration between the Turkish government and the UN technical agencies leading this change involved foundation of 187 Migrant Health Centres in 30 cities in Turkey[8], opening of seven Refugee Health Training Centres, training and employment of Syrian health professionals within these centers (in collaboration with World Health Organization (WHO));[9] foundation of the Women and Girl Safe Spaces and employment of Syrian female health mediators (in collaboration with United Nations Population Fund (UNFPA)); [10] conducting different thematic awareness-raising campaigns on issues of child nutrition and vaccination and running a nationwide vaccination campaign (in collaboration with the United Nations International Children's Emergency Fund (UNICEF))[11] as well as the provision of homecare services to Syrian refugees and the employment of health

[8] Please see "SIHHAT Project," SIHHAT, available at SIHHAT PROJESİ (sihhatproject.org), accessed on 17 December 2022.

[9] "Göçmen Sağlığı Eğitimleri Birimi Görev Tanımı," T.C. Sağlık Bakanlığı Halk Sağlığı Genel Müdürlüğü, available at Göçmen Sağlığı Eğitimleri Birimi Görev Tanımı (saglik.gov.tr), accessed on 17 December 2022.

[10] "UNFPA Turkey, Humanitarian Programme, the Women and Girl Safe Spaces," UNFPA Türkiye, available at Centers | Humanitarian Programme | UNFPA (unfpahumtr.org), accessed on 17 December 2022.

[11] UNICEF Turkey, "Humanitarian Situation Report No. 40- January- December 2020," (2020), available at UNICEF-Turkey-Humanitarian-Situation-Report-No.-40-(Syrian-Refugees-Response-)-January-December-2020.pdf accessed on 17 December 2022.

mediators for homecare service provision (in collaboration with WHO).[12] The Turkish Ministry of Health employed 4054 Syrian healthcare professionals and health system support personnel, including doctors, nurses, health mediators, and community support staff as part of this fundamental change.[13] Moreover, the Women and Girls Safe Spaces became operational in providing reproductive health services and advisory services to refugee women.

All these policy instruments belong to different policy issues within the health sector. Some of these sectors are more resistant to change, while policy change is much more facile in some of these sectors. Despite the challenges posed by nature and the politics in these policy sectors, some extent of policy occurred in each sector through policy learning. Within this framework, this study argues that different competencies or capabilities function in different ways in different policy sectors and, accordingly, result in different scales of change. Policy learning may lead to new policy instruments or result in a change in the settings of the existing policy instruments or tools. The process of learning is a complicated process encompassing all these issues. Through an exploration of the relationship between policy learning, policy change, and policy capacities, this research focuses on the agency of the UN technical agencies through an examination of the policy change that occurred in the healthcare system of Turkey in providing healthcare to Syrian refugees.

This study firstly aims to contribute to literature on the role of UN agencies on migration governance which is a significant issue of global politics. Studies on the UN System and specific UN institutions generally focus on decision-making bodies at UN secretariat level by focusing on the role the Secretariat plays on global migration. This study offers empirical evidence on the role of the UN System at the national level. Studies on national cases are rare, and there is a need to examine the role of the UN System on migration governance at the national level. The case of

[12] "Syrian Healthcare Workers Respond to the Health Needs of Refugees in Turkey," *World Health Organization Europe*, 11 March 2021, available at Syrian healthcare workers respond to the health needs of refugees in Turkey (who.int), accessed on 17 December 2022.

[13] European Commission, "Facility for Refugees in Turkey, Priority Area Brief, Health," No:2, October 2022 (Data Values- December 2021), available at Health_BN_Updated_30.11.2022.pdf (avrupa.info.tr), accessed on 16 March 2023.

Turkey on migration governance is a very significant case not only for being the top-refugee hosting country, but also for being an important example of cooperation with international organizations, including UN agencies, in responding to the pressures brought by migration. Within this framework, this case provides understandings into how to the agency of the UN agencies are developed to respond to policy problems as the country cooperated with international organizations extensively.

This study also offers evidence how policy change happened in healthcare provision towards Syrian refugees in Turkey. Within this framework, this research aims to answer the following questions: What was the nature of the policy change that occurred in the health sector of Turkey after the Syrian migration crisis? What kind of capacities and expertise did the UN agencies hold in the process of the policy change? How did these policy capacities of the UN affect policy capacity of the host state in three policy sectors, and how did these policy capacities lead policy learning in different policy sectors, including policy areas on the provision of primary-level healthcare services, the provision of sexual and reproductive health, and the provision of immunization services? The following part aims to present the research design of the thesis.

1.1. Research Design and Research Questions

The primary data of this research is collected through the semi-structured interviews conducted with the 19 respondents from state officials, the United Nations (UN) staff in Turkey, NGO representatives, and Turkish medical staff. A list of interviewees can be found in Appendix B. All interview data is transcribed word for word, reviewed, and analyzed. The key interviews were carried out by the Turkish Ministry of Health Officials (one working for the SIHHAT Project and one working in the Public Health Department, Directorate General for Migration Health), the UN officials (two officials from WHO, two officials from UNFPA and one official from UNICEF), eight non-governmental organization (NGO) representatives from key NGO stakeholders of UN refugee health programs, one representative from the Turkish Medical Association (Türk Tabipleri Birliği). Two additional interviews were conducted with medical doctors who had refugee patients and one pharmacist

working in a refugee-dense district of Ankara. The participants were based in different cities of Turkey where the UN programs were active, including Ankara, İstanbul, İzmir, Gaziantep, and Şanlıurfa.

Due to the COVID-19 pandemic, most interviews were conducted remotely using the Zoom conferencing tool. However, a few interviews were conducted face to face upon the special request of the interviewees. After receiving the interviewees' consent, all interviews except one Turkish Ministry of Health official, medical doctors, and the pharmacist were audio-recorded. Afterwards, the recordings were transcribed verbatim and were analyzed using thematic analysis. The approval of the Middle East Technical University Social Science Ethical Committee to conduct interviews with the respondents was received in November 2020 (Appendix A). Some of the interviewees were required to obtain the interview approval of their institutions. Additional documents (cv, cover letter, and forms) in addition to the approval document of the Middle East Technical University Social Sciences Ethical Committee Approval were provided to the management of those institutions that requested these documents for their internal procedures.

In addition to these interviews, various Turkish government reports (in Turkish), the EU (European Union), and the UN reports are reviewed, and a comprehensive press review both in English and Turkish is conducted to understand the mechanisms available in refugee health governance in Turkey. Moreover, a comprehensive review of international and national legislation is undertaken, along with a broad review of secondary sources, including books, journals, and websites, for the overall aims of the research. One of the challenges in data collection was the difficulties in accessing official data of the Turkish state, such as breakdown analysis of health spending on refugee health over the years and data such as the exact number of Syrians residing in Turkey, which is not clear due to unregulated entries at the beginning of the influx. Thus, some data gaps still need to be addressed. These difficulties stemmed from the need for more data collection exercises or lack of sharing the data concerning health spending devoted to refugee health during these years. These data gaps were tried to be compensated through comparative reading of international organizations' reports, academic research sources, and the statements of

the interviewees. Another challenge in data collection was the withdrawal of some previously available publications of international organizations from their website while this research was ongoing. Lastly, some interview invitations were rejected due to the busy schedules of the invitees. However, at least one participant from all the key institutions involved in the related refugee health programs accepted to participate.

To manage the collated information, the interview questions are grouped into four main categories. These categories are: 1) observations and experiences concerning policy change in the health sector, 2) Issues regarding the health of Syrian refugees and their access to the Turkish healthcare system, 3) overall technical contribution of the UN agencies, 4) recommendations and further observations for future integration especially with regards to the UN role. The data collected is analyzed under these themes. In addition to the semi-structured interviews conducted, the case study method is employed to investigate the role of UN technical expertise on different health policy issues. These three case studies aim to show how the policy sector influences government receptivity and how the capacities of the UN technical agencies affect the policy learning process. These cases are the WHO and its operations on the foundation of the Refugee Health Training Centres, employment of Syrian health professionals within the Migrant Health Centres, and employment of homecare staff within the scope of the Homecare Staff Project of WHO; UNFPA and employment of health mediators and programs on enhancing access to reproductive health services and mechanisms to fight gender-based violence through Women and Girls Safe Spaces; lastly UNICEF and its programs on awareness raising activities on vaccination and conduct of a nationwide vaccination campaign.

The case studies of the research are selected due to two main reasons. The first reason of the selection of three cases is to provide a comparative analysis to the role of three UN agencies (WHO, UNFPA and UNICEF) working on different health policy issues on healthcare provision to Syrian refugees. These three policy issues differ on two grounds: one is the demand for policy change on the policy issue (instrumentality), and the other is the problem pressures put on the relevant policy issue by the migration crisis. The primary role played by the UN technical agencies

in these specific areas is either solely technical in supporting state capacities or advocating some legal norms. Although all three UN entities have similar technical expertise but different mandate areas, their role in policy change varies. In this framework, three various policy issues are examined to understand the role of the UN agencies and how the capacities of the UN agencies affect policy change in analysis and in what ways. The second reason for the selection of the cases is the fact that WHO, UNFPA and UNICEF are the UN agencies which directly supported the healthcare provision during these years. The other UN agencies present in Turkey do not have refugee programs specifically focusing on healthcare provision.

The case of Turkey offers a lot in understanding the resources and capabilities of these organizations. Because Turkey, among all top Syrian refugee hosting countries (Lebanon, Jordan, and Egypt as other top Syrian refugee hosting countries), can be considered as the country, not only the most receptive one (in terms of numbers of refugees), but also the most cooperative one in accepting to transform healthcare provision to Syrian refugees. The underlying reasons of these policy choices will be discussed throughout the thesis. Turkey's migration cooperation with the EU during the years of the mass arrivals is one significant reason for choice and also this cooperation has significant implications for the policy capacities of the UN agencies. Within this framework, Turkey's relations with the EU will also be analyzed as this cooperation is significant in extending governance area and making the case of Turkey a unique example of cooperation on migration management.

Here, it is argued that policy change in the health sector of Turkey is an instrumental decision in which the host country aims to further its policy objectives and to manage the tensions in its healthcare system on different topics. In this framework, the policy change is instrumental, and the degree of the policy change is very much dependent upon the policy area the UN agency works in. One would thus expect more learning/ policy change in technical capacity programs than in programs on fighting gender-based violence since the actors seek to understand the world better to further their policy objectives. However, some resources and abilities of the actors can reinforce the policy learning even in the policy sectors that are not prone to change.

Within this framework, this thesis is organized into eight chapters. After this introductory chapter, the next chapter will present the analytical framework of the thesis. The third chapter reviews the legal status of Syrians in Turkey and analyzes the development of the health policy towards Syrians. The fourth chapter analyzes the role of UN technical agencies by international law and defines their role in the context of the health governance of Syrians in Turkey by examining the interplay between global, regional, and national politics. The fifth, sixth, and seventh chapters are the case studies of the research in which the role of different UN agencies in various topics are analyzed. These three chapters aim to provide insights into the role of UN technical agencies through understanding the nature of the policy change and the policy instruments enabling the change on the relevant subject. The final chapter is the conclusion.

CHAPTER 2

ANALYTICAL FRAMEWORK

This chapter aims to introduce the analytical framework and main concepts of the thesis to understand this subject policy change in the health sector occurred as a response to the migration crisis and to understand the capacity of the UN technical and specialized agencies in effecting the policy change for a better service provision to Syrian refugees. Through this analytical framework and the case studies analyzed in the next chapter, the subsequent chapters will explore the empirical data of the thesis to understand the fundamental agency of the UN technical agencies on the subject policy change. This thesis is interested in the policy learning process and how it leads to policy change in three sectors. Although policy learning literature is insightful to understand the change, this literature needs more insights into the UN technical agencies' abilities and resources in fostering and waving the policy learning process, as the main aim of this thesis is to understand in which capacities the UN technical agencies act as the actors of the policy change. To this aim, this thesis will also use the literature on policy capacity and policy learning literature for its potential to understand the agency of UN technical agencies.

Moreover, there will be two additional concepts employed to define specific policy environments and particular expertise of the UN technical agencies, which are policy sector and technical expertise. The policy sector is an essential analytical tool as the policy learning process is much related to the instrumentality of the policy sector and the problem pressures posed by the policy sector. Through this analytical framework, it is intended to analyze UN agencies' role in the policy transfer in the health sector of migration governance and the nature of the policy transfer in the health sector. Although governance literature is relevant to the scope and aims of the thesis and finds a place in the sub-titles of the research, there needs to be a focus on the analytical framework of the study, which requires other approaches. Within this

framework, governance literature is not directly the focus of the analytical framework and the usage of governance in this thesis does not rely on an extreme notion of governance such as "governance with minimal state action giving room more to market actors".[14] This thesis takes the migration governance in Turkey as an environment in which the Turkish state remains the leading actor and decision maker, but it adapts its policies and institutions through knowledge and experience exchange with other actors. Another non-central literature is the policy instrument studies. The studies of policy instruments mainly deal with the development of practical policy tools or toolkit designs and their effectiveness. [15] Understanding the effective policy designs or tools chosen for policy aims remains out of the aims of this thesis. The coming sections will present the analytical framework by explaining the works of literature briefly.

2.1. Policy Change as Policy Learning

The concept of policy change has a central place in the analytical framework of this research, as refugee health governance leads to a policy change in the health sector of Turkey. The policy transfer literature as an analytical framework offers important insights to understand policy changes, but it has limitations as well. Dolowitz and Marsh define the concept as "the process by which actors borrow policies developed in one setting to develop programs and policies within another".[16] Explaining policy change as a transfer from one setting to another still relies on a statist paradigm where state is treated as the only actor responsible of major changes and its actions are exempt from societal forces and the actions of other governmental or non-governmental actors. However, governance, as a mode of policy making marking today's political realities, requires going beyond the statist approach. There are various other concepts introduced to the policy change literature, such as lesson

[14] Roderick Arthur William Rhodes, "The New Governance: Governing without Government," *Political Studies*, Vol: 44, No:4 (1996): 653.

[15] Micheal Howlett, and Ishani Mukherjee, "The Importance of Policy Design: Effective Processes, Tools, And Outcomes," In *Routledge Handbook of Policy Design*, ed. Howlett and Mukherjee, (New York: Routledge, 2018): 6.

[16] David Dolowitz, and David Marsh, "Who Learns What from Whom: A Review of the Policy Transfer Literature," *Political Studies*, Vol: 44, No: 2 (1996):357.

learning[17] , lesson drawing[18], policy convergence[19] and policy diffusion[20]. All these new approaches to policy transfer have the potential to provide insights into different cases of policy transfer. [21]

Still, policy transfer as an analytical framework is quite limited especially in understanding the role of non- state actors. Because the policy transfer approaches to policy change as it is an unconscious process from an external actor towards the recipient state/ actor. However, the policy transfer is not always an unconscious or forced process in which the recipient state is a passive actor.[22] On contrary, the recipient state can take the decision of policy change and cooperate with the other actors relating to policy transfer process for its own policy goals. This insufficiency of this early literature on policy transfer to explain the realities of today, such as governance as a mode of politics, led numerous criticisms. [23] In this framework, understanding policy transfer cannot be achieved through a 'one fits all' approach. Instead, it requires a comprehensive analysis of individual cases in which the policy change takes place. Within this context, I will use Peter A. Hall's analytical framework on policymaking.[24] He treats the policy-making process as social policy learning.

Hall, while attempting to avoid the fallacies of the 'one fits all' approach in policymaking as social learning, states that a broad concept such as social learning

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[17] Emanuel Adler and Peter Haas, ed., "Knowledge, Power, and International Policy Coordination," *International Organization*, Vol:46. No: 1, (1992).

[18] Richard Rose, "What is Lesson-Drawing, " *Journal of Public Policy*, Vol:11, No: 1 (1991): 3.

[19] William D. Coleman, "Policy Convergence in Banking: A Comparative Study," *Political Studies*, Vol:42, No: 2, (1994):275.

[20] Giandomenico Majone,"Cross-National Sources of Regulatory Policy-making in Europe and the United States," J*ournal of Public Policy*, Vol: 11, No: 1 (1991): 94.

[21] Devrim Yurdaanık Eskiyerli, "Public Policy Making in Turkey: Policy Transfer, Bureaucratic Autonomy and Foreign Trade Companies in the 1980s and 1990s," (PhD diss., Middle East Technical University, 2013), 59-62.

[22] Eskiyerli, "Public Policy Making in Turkey: Policy Transfer, Bureaucratic Autonomy," 65.

[23] Oliver James and Martin Lodge, "The Limitations of Policy Transfer and Lesson Drawing for Public Policy Research," *Political Studies Review*, Vol: 1, No: 2 (2003), 190.

[24] Peter A. Hall, "Policy Paradigms, Social Learning, and the State: The Case of Economic Policy-making in Britain," *Comparative Politics*, Vol: 25, No: 3 (1993).

deserves more attention through examination of various contexts.[25] To this aim, Hall proposes a three-layered policy learning model for understanding policy changes, as either the actions of states or another actor that may influence policy-making result in different kinds of policy change. Hall calls first-order changes as policy change processes where only policy-making settings are changed, and second-order change is when there is a change in settings and policy instruments without any intention of changing the overall policy-making goals. Third-order changes, in Hall's explanatory framework, are radical changes where radical paradigm shifts occur in policymaking.[26] For him:

> The first and second order are normal policymaking, a process that adjusts policy without challenging the overall terms of a given policy paradigm. Third-order change, by contrast, is likely to reflect a very different approach, marked by the radical changes in the overarching terms of policy discourse associated with a "paradigm shift. [27]

This approach to policymaking, as social learning, acknowledges the role of experts and expert organizations in policymaking in technical areas where intensive knowledge leads the process. Within this framework, "social learning is a deliberate attempt to adjust the goals or techniques of policy in response to experience and new information."[28] However, there is an essential limitation of the empirical data of the research in fitting to Hall's analytical framework. The period covering the empirical data of the thesis is relatively very short between 2011 and 2021 for assessing the actual outcomes of the policy instruments developed. Although the policy instruments-initiated led to some extent of policy change and policy learning occurs accordingly, it is not certain that these instruments prevail under the uncertain fate of the temporary protection regime. Within this framework, Hall's policy learning conceptualization only allows for analyzing the outcomes of the cooperation between the host country and the UN technical agencies by looking at the policy instruments created without promising that it will be prevailing. The empirical data will enable

[25] Hall, "Policy Paradigms, Social Learning, and the State," 277.

[26] Hall, "Policy Paradigms, Social Learning, and the State," 279.

[27] Hall, "Policy Paradigms, Social Learning, and the State," 279.

[28] Hall, "Policy Paradigms, Social Learning, and the State," 278.

some understandings for a comparative study between the case studies but without a perfect fit with Hall's actual analytical tool.

This comparative approach is essential for the aim of this thesis. The three UN technical agencies (WHO, UNFPA, and UNICEF) function in different policy areas, which affect the role they take. Due to the differences in the policy implications of their mandate areas, the level of policy change varies, as well as the policy instruments used to attain specific goals. Although some activities of the UN agencies may lead to significant policy changes, some may only create weak policy initiatives without important policy outcomes. These different instruments are either complementary to each other or counterproductive. Such an approach not only enables an understanding of the different outcomes of the activities of the agencies but also provides insights into a policy process in which no other state dominates the receptive country; it recognizes other actors of the policy change. While the analytical framework provided by this conceptualization offers analytical tools into the policy learning process, it does not solely explain the agency of the UN technical agencies. As the UN technical agencies are assumed to be essential agents of policy change within the scope of this research, here comes another question: which abilities or resources do the UN agencies hold to affect the policy learning process? The following section will examine the literature on policy capacity to present this literature which will provide understanding to this question.

2.2. Policy Capacity

Much of the existing scholarship deals with policy capacity from a state perspective and engages with the concept of something belonging to the state. Within this approach to the concept, several definitions exist: "the administrative, political or state capacities to define strategic roadmaps for the use of the resources"[29] , ability to make sense of the environment for strategic decisions[30], abilities to analyze and

[29] Martin Painter, and Jon Pierre,"Unpacking Policy Capacity: Issues and Themes," in *Challenges to State Policy Capacity, Challenges to State Policy Capacity, Global Trends and Comparative Perspectives,* ed. Martin Painter and Jon PİerreCC (New York: Palgrave MacMillan, 2005): 6.

[30] Michael Howlett, and Evert Lindquist,"Policy Analysis and Governance: Analytical and Policy Styles in Canada," *Journal of Comparative Policy Analysis: Research and Practice*, Vol: 6, No: 3 (2004): 226.

assess the policy alternatives[31], managing knowledge and organizational learning to implement policy[32].[33] The more recent literature on the policy capacity generally defines the concept as "a set of skills, competencies, and resources across government agencies to design and pursue policy goals"[34]. However, within the new types of governance structures emerging in policymaking, more is needed to focus on the state's capacities to understand the policy-making processes, as there are many actors and agents involved in the process. Within this framework, this thesis acknowledges the role of non-state actors in policy-making processes. It assumes that these non-state organizations and institutions possess skills, competencies, and resources that might affect policy design and outcomes. It is one of the main aims of this analytical framework presented here to adapt the literature of policy capacity to study international organizations. Within this framework, this research requires a more practical analytical framework.

One of the most outstanding and practical analytical frameworks constructed to understand the policy capacities of actors is the one set out by Wu, Ramesh, and Howlett. In this analytical framework, Wu, Ramesh and Howlett engages with the concept of policy capacity by searching for an answer to the following question: “What constitutes policy capacity, and how existing and potential resources and skills can feed the policy capacity?". [35] Through this questioning, they propose a practical conceptual framework for defining and analyzing policy capacity.

Policy capacity, within this conceptual framework, can be understood as "the set of skills and resources- or competences and capabilities- necessary to perform policy functions, and accordingly can be categorized into three types: analytical, operational

[31] Herman Bakvis, "Country Report: Rebuilding Policy Capacity in the Era of the Fiscal Dividend: A Report from Canada," *Governance*, Vol: 13, No: 1 (2000): 71- 73.

[32] Wayne Parsons, "Not Just Steering but Weaving: Relevant Knowledge and the Craft of Building Policy Capacity and Coherence,"*Australian Journal of Public Administration*, Vol: 63, No:1 (2004): 45.

[33] X. Wu, M. Ramesh, and M. Howlett, "Policy Capacity: A Conceptual Framework for Understanding Policy Competences and Capabilities," *Policy and Society*, Vol: 34, No: 3–4 (2015): 165-166.

[34] Ishani Mukherjee, M. Kerem Çoban, and Azad Singh Bali, "Policy Capacities and Effective Policy Design: A Review," *Policy Sciences*, Vol: 54, No: 2 (2021): 247.

[35] Wu, Ramesh, and Howlett, “Policy Capacity: A Conceptual Framework,” 166.

and political and three levels: individual, organizational and systemic."[36] One advantage of this conceptual framework in understanding policy capacity is that it applies to all stages of policy making, including agenda setting, formulation, decision-making, implementation, and evaluation.[37] This research engages with the policy implementation phases and this analytical framework enable to look at how the resources and capabilities of UN agencies, called as policy capacity, are developed and implemented. Therefore, the conceptual framework enables an analysis of the policy capacity of non-state actors, including the UN technical agencies, as this framework focuses on abilities and resources. This framework is also invaluable for providing sound policy recommendations and assessing policy capacities for better policymaking. This discussion is related to a broader discussion of whether any hierarchy exists among different policy capacities.[38] Because there are various types of policy capacities according to this discussed analytical framework and Wu, Ramesh and Howlett classifies the policy capacities as analytical, operational, and political.

Although this framework provides an analysis on different levels, this research will only engage with organizational capacities (analytical, operational, and political). However, there might be other capacities at an individual (e.g., experts within the organizations) or systemic level (e.g., organization financial resources or research capacities). There might be references to these levels as well; but the focus of the research will be the analytical, operational, and political capacities at the organizational level. Analytical capacities ensure that the actions of the organizations are technically sound. Operational-level capacities provide the proper alignment of resources to enable policy actions in practice. And political level capacities help to obtain policy support for policy actions.[39]

The UN technical agencies are not political actors making political decisions, but rather technical actors founded to support capacities and capabilities in their

[36] Wu, Ramesh, and Howlett, "Policy Capacity: A Conceptual Framework," 166.

[37] Wu, Ramesh, and Howlett, "Policy Capacity: A Conceptual Framework," 167.

[38] Mukherjee, Çoban, and Bali, "Policy Capacities and Effective Policy Design," 245.

[39] Wu, Ramesh, and Howlett, "Policy Capacity: A Conceptual Framework," 168.

respective mandate areas. However, they might acquire political capacity through relations with other actors. In this framework, for example, relations with other actors plays a significant role here. Due to non-political but acquired policy capacities, they may execute advocacy roles as mandated by international law. By this nature, they act as a vital part of the response to global problems. Unlike political capacity, the operational and analytical capacities refer to the technical role of the UN technical agencies as underlined by international law. There is also a natural relationship between analytical and operational capacities and technical expertise. The UN agencies are technocratic agents that provide expertise and knowledge to the host countries as their clients. The expertise is provided in response to the client's requests, and on that note, it is by nature relational. To dig more into the agency and operational and analytical capacities of the UN technical agencies, I will differentiate between different types of technical expertise, which marks the analytical and operational capacities of the UN agencies. The next part elaborates on the concept of technical expertise, as it is a core concept within this research.

2.3. Technical Expertise

Technical expertise is an essential concept for understanding the role of international organizations and UN technical agencies. It also allows a taxonomy within the operational, analytical, and political policy capacities of the UN technical agencies. Moreover, technical expertise provides legitimization for actions. Boswell argues that "knowledge has a legitimizing function in governance which is a mode of technocratic policy making". [40] Technical knowledge is likewise the justification of the operational activities of the UN technical agencies, and more to the point, technical know- how increases the authority of these organizations. Many interviewees of the research, both from the UN and from the partners of the UN, highlighted that technical know-how is the core of the UN work. For example, a UNFPA representative said, "Our reason for establishment is technical expertise and providing technical know-how." [41] and one Turkish Ministry of Health official said

[40] Christina Boswell, *The Political Uses of Expert Knowledge: Immigration Policy and Social Research*.(Cambridge: Cambridge University Press, 2009), 7.

[41] Interview 5, UNFPA, Ankara, 5 August 2021.

that "technical expertise and technical capacity of the UN is what we benefit most while working with them. They have the experts and knowledge." [42]

By international law, UN technical agencies are not political actors, as will be discussed in the next chapter, however, they have important tasks in implementation of global political agenda. Within this framework, they are not political actors, but action actors with political capacities and they derive legitimacy from their outputs. UN agencies are action organizations that function on a performative basis and base their relations with the countries and stakeholders on a service provider-client framework. Within this framework, expertise is related to performance and expertise is something delivered at the request of someone else who wants it.[43] As experts, they "mediate between the production of knowledge and its application, defining and interpreting situations and setting priorities for action".[44] Migration and health governance are highly technocratic and require specialized knowledge. Governance of refugee health lies in the intersection of two technocratic policy issues, which are health and migration. UN agencies are technocratic bodies that bring technical knowledge and expertise to the governance schemes. In this nature, knowledge and expertise are significant for these organizations to both improve the quality of their work and to legitimize their actions as competent actors of refugee health governance.

Considering the empirical data of the thesis, four types of technical expertise are relevant to this thesis: outreach expertise, outsourcing expertise, empirical expertise, and coordination expertise. The outreach expertise refers to the activity of any organization to convey a message or aim to those people unaware of it.[45] It is an essential and commonly possessed type of expertise among the UN technical

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[42] Interview 2, The Turkish Ministry of Health, Ankara, 8 February 2021.

[43] Reiner Grundmann, "The Problem of Expertise in Knowledge Societies,"*Minerva*, Vol: 55, No:1 (2017): 26.

[44] Grundmann, "The Problem of Expertise in Knowledge Societies," 27.

[45] Andrew Karvonen, and Ralf Brand, "Expertise Specialized Knowledge in Environmental Politics and Sustainability" in *Routledge Handbook of Global Environmental Politics, ed. Paul G. Harris* (New York: Routledge, 2014), 221.

agencies, and it mainly aims to attain trust between the techno-scientific community and the public.

Outsourcing expertise refers to any technical knowledge or skill that supports a state function on a technical matter. The scope of outsourcing expertise is vast and diverse. It may be capacity development for state officials, organizing orientation training for health professionals, or conducting vaccination services. The important thing about outsourcing expertise is that it requires knowledge and skill on highly technocratic issues such as medicine or health administration. Empirical expertise refers to producing autocratical knowledge, which has an impact on its recipient. For UN agencies, this does not only involve knowledge production at the national level. UN technical agencies inherently have this empirical expertise since the reports and data collected and analyzed by them can affect national policies. Lastly, coordination expertise is another crucial expertise possessed by the UN agencies, and it refers to expertise bringing different actors together and organizing their work to attain specific policy goals. The table below gives some activities that represent the expertise mentioned above.

Table 2. 1. Taxonomy of Technical Expertise

Outreach Expertise	**Empirical Expertise**	**Outsourcing Expertise**	**Coordination Expertise**
Conducting awareness campaigns, Reaching out local populations.	Releasing publications, reports, conducting surveys, interviews, and focus group discussions.	Capacity development training for public officials or health professionals.	Coordination of meetings, providing platforms for communication.

2.4. Policy Sectors

The context or the environment within which policy making processes unfold takes a central place in the analytical framework of this research. I will call this context policy sector through this research. Understanding the conditions of the policy sector

and tracking what changes happened in the policy sector as an outcome of the policy instruments or tools initiated enables us to understand the consequences of these policy instruments/ tools. Employment of the policy sector approach, together with the policy learning literature discussed earlier, helps to understand the context, process, and outcome. Moreover, the policy sector itself is often a significant variable of the policy changes in most cases, and it is explanatory in understanding why some policy instruments in one sector result in substantial changes. In contrast, others in another sector do not result in such changes.

The literature on policy sectors has highlighted the possibility of differentiating topics within the same policy issues such as differentiating sexual and reproductive production from immunization healthcare provision. Freeman argues that "each sector poses its problems, constraints, and challenges". [46] There is also grand literature on linking the policy sector approach to policy effectiveness and policy design studies.[47] Within policy effectiveness and policy design studies, policy design space is the conditions that allow an effective policy design to occur or not to occur.[48] Here, the focus of the research remains on two issues. One is on the policy sector as being an instrumental environment for the policymakers for grand policy aims, and the other is on the problem pressures put forward by the policy sector. The first one underlines the host state's intentions and grand policies on the subject policy sector, while the other signifies the problems, challenges, and difficulties revealed by the policy sector. Within this framework, the first marks intentions, and the latter marks a much more dynamic area by underlying the forces necessitating the policy change.

By engaging in a discussion of the intention of the policy actors to engage in policy change in a specific policy sector, this research, therefore, aims to understand if the policy change is either driven by instrumentalism or problem-solving aims with less

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[46] Gary P. Freeman, "National Styles and Policy Sectors: Explaining Structured Variation," *Journal of Public Source,* Vol: 5, No: 4 (1985): 491.

[47] Mukherjee, Coban, and Bali, "Policy Capacities and Effective Policy Design," 250.

[48] Ishani Mukherjee, and Michael Howlett, "Gauging Effectiveness in Policy Design, First- and Second-Best Policy Design," in *Routledge Handbook of Policy Design*, ed. Michael Howlet and Ishani Mukherjee (New York: Routledg, 2018), 377.

intentional drives. Timing matters in defining and analyzing the policy sectors, as the standard approaches and methods of policy and challenges change over time in a specific policy sector. This argument emphasizes the assumption that the implications of the policy sectors on the policy outcome change over, which requires attention while analyzing the policy-making process. Within this framework, the thesis case studies will explore policy sectors and the historical context in the light of the empirical data. Within this framework, the thesis will use historical contextualization while analyzing the policy sectors. Considering the analytical framework discussed, the following chapter examines the development of health policy towards Syrian refugees in Turkey.

CHAPTER 3

THE DEVELOPMENT OF HEALTH POLICY TOWARDS SYRIANS IN TURKEY

Migration governance is based on international and national legislation. The international and national legislations define who a refugee is, what rights a refugee holds, and the extent of a refugee's access to the welfare system of the host countries. However, there are some contradicting issues between the Turkish national legislation and the international legislation, especially concerning the definition of who a refugee is. These contradicting issues create difficulties in explaining the legal status of Syrians, as national and international definitions differ.

Moreover, these issues result in various problems in clarifying the development of refugee health policy, as the health policies vary among different legal status holders. Within this framework, there is no unified health policy applied to refugees in Turkey due to the differentiation between the legal status of the foreigners seeking refuge in Turkey. The following sections aim to highlight and clarify these legal and conceptual issues regarding the legal status of Syrians and health policy development in Turkey.

3.1. Syrians in Turkey

Turkey is geographically located between the European continent, which is an important destination point for asylum seekers, and the regions where the most significant conflicts of the post-Second World War occur. The geographical location of Turkey made the country a traditional transition point for migrants and refugees who were making their way from different locations to European countries while seeking refuge from civil wars and other various structural inequalities that emerged as the outcome of the protracted conflicts. The recent past years were years of

economic development for Turkey which attracted economic migrants from Middle East and Asia and the Middle East in contra to its traditional role of being a transition country.[49] This change was primarily due to economic growth and increasing wealth Turkey experienced after 2000.[50] These were also the years when the EU (Euroepan Union) started to apply strict border management policies to prevent irregular arrivals. The common border policy starting with Schengen Agreement put uneven responsibilities on the member states.[51] Growing economy and the EU policies distracting new arrivals made Turkey a popular hub for regular migration.

Turkey developed a unified and structured migration law with the migration crisis occurred after the Syrian Civil War. Within this framework, its policies towards arrivals were ad-hoc based and not standardized. Some studies argue that Turkey applied different reception policies to different migration flows, and they were mostly based on seeking Turkish origin as a prerequisite for being accepted as a refugee. This ad- hoc nature for instance resulted in accepting the Turks coming Bulgaria as refugees in 1989 whereas not accepting the Kurds escaping from Saddam Hussein regime as refugees.[52] This ad-hoc approach was not only driven by nationalist rationales, and security concerns mostly dominated this ad-hoc status of the migration policy of Turkey. The security concerns led Turkey to sign international agreements with reservations.[53] This situation has a significant impact on the fact Turkey did not have unified approach in granting the status of refugee.

Turkey was a signatory to the 1951 Convention Relating to the Status of Refugees.[54] However, Turkey signed the Additional Protocol of the Convention dated 1967[55]

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[49] Seçil Paçacı Elitok, "Turkey's Migration Policy Revisited: (Dis)Continuities and Peculiarities," *Istituto Affari Internazionali*, Vol:18, No:16 (2018), 2, 10.

[50] Please see "Data- GNI (US$)- Türkiye," World Bank, available at GNI (current US$) - Turkiye | Data (worldbank.org), accessed on 11 March 2023.

[51] Vasilis Papageorgiou, "The Externalization of European Borders," *Center for International Strategic Analyses (KEDISA)*, Vol: 23 (2018): 3-7.

[52] Kemal Kirişçi, and Sema Karaca, "Hoşgörü ve Çelişkiler. 1989, 1991 ve 2011'de Türkiye'ye Yönelen Kitlesel Mülteci Akınları," in *Türkiye'nin Göç Tarihi 14. Yüzyıldan 21. Yüzyıla Türkiye'ye Göçler*, ed. M. Murat Erdoğan, and Ayhan Kaya (İstanbul: İstanbul Bilgi Üniversitesi, 2015), 298, 305.

[53] Elitok, "Turkey 's Migration Policy Revisited: (Dis)Continuities and Peculiarities," 6.

[54] UN General Assembly, Convention Relating to the Status of Refugees, adopted by Resolution 429 (V) 28 July 1951, entered into force 22 April 1954, available at refugees.pdf (ohchr.org).accessed on 26 January 2023.

with reservations about some provisions. The 1951 Convention on Refugees was a declaration for recognition of refugee status for the events occurring in Europe before 1951. Within this framework, the Convention has geographical and time restrictions in giving the refugee status, and accordingly, the Convention is not universal, as the Convention was created for European refugees fleeing the events of the Second World War.[56] The main aim of the 1967 Additional Protocol to the Convention was giving the Convention universal coverage through the elimination of geographical and timely restrictions.[57] Only a few states maintained geographical limitation, and Turkey was one of those countries holding the geographical limitation by putting reservation to the 1967 Protocol.

Turkey's reservation meant that without any historical limitation, only people fleeing from the events occurring in Europe could get refugee status in Turkey. People coming from out of Europe and seeking refuge in Turkey could only get the status of asylum seeker which marked an interim status before acquiring the status of a refugee.[58] Or any foreigner could obtain the status of migrant (*göçmen*) to get the right to remain in Turkey if they met the relevant criteria to be a migrant.[59] Migrants in Turkey are naturally the beneficiaries of the right to stay, work, and benefit from social and public services in Turkey. However, the migrant status was not applicable for the mass and sudden arrivals from Syria. Therefore, Syrians were not able to be named either refugees or migrants by Turkish national legislation. This ambiguity created a fundamental difference between national and international law.

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[55] UN General Assembly, Protocol Relating to the Status of Refugees, adopted by Resolution 2198 (XXI) on 16 December 1966, entered into force on 4 October 1967, available at https://www.ohchr.org/sites/default/files/protocolrefugees.pdf , accessed on 26 January 2023 .

[56] James C. Hathaway, *The Rights of Refugees Under International Law* (Cambridge: Cambridge University Press, 2005), 15, 95, 365.

[57] Hathaway, *The Rights of Refugees under International Law*, 111.

[58] "An asylum seeker is an individual who is seeking international protection. In countries with individualized procedures, an asylum seeker is someone whose claim has yet to be decided on by the country where they have submitted it. Not every asylum seeker will ultimately get the status of a refugee, but every recognized refugee is initially an asylum seeker", in "Master Glossary of Terms," *UNHCR*, available at UNHCR master glossary of terms | UNHCR , accessed on 25 January 2023.

[59] "Traditionally, the word 'migrant' has been used to designate people who move by choice rather than to escape conflict or persecution, usually across an international border." in "Emergency Handbook- Migrant Definition," UNHCR, (2019), 1, available at Migrant definition.pdf, accessed on 5 November 2023.

As per the International Refugee Convention, Syrians seeking protection in Turkey met all the criteria to become 'refugees'[60]. However, as Turkey maintained the geographical reservation after the 1964 Protocol, a terminological problem emerged concerning the status of Syrians in Turkey. Within this terminological ambiguity, the geographical limitation criteria define who a refugee is, and meeting the requirements of having Turkish descent or not, as well as having legal employment, define who a migrant is in Turkey. Within these definitions, Syrians who were escaping the war are neither categorized as refugees nor migrants under the Turkish national legal framework. This ambiguity creates a terminological contradiction between International Law and Turkish national law. While Turkey's geographical reservation to the 1951 Refugee Convention make terminological discrepancies, Turkey fulfilled its other obligations under the Convention Relating to the Status of Refugees (1951) and the Protocol Relating to Status of Refugees (1967). Among all the principles of the Convention and the Protocol, the principle of non-refoulment[61] requires a special attention.

Turkey's adherence to the principle of non-refoulement during the Syrian migration crisis was worth commenting, as the country, in contra to its reservations on giving the status of refugee to Syrians, applied the principle of non-refoulement principle with dedication. Within this framework, Turkey's first responses were quite in line with the non-refoulement principle of the 1951 Convention, and its policies towards allowing Syrians seeking protection in Turkey even went beyond the non-refoulement principle. Turkey adopted an open- door policy (*açık kapı politikası)* at the beginning of the crisis in accepting the Syrians seeking refuge in Turkey and continued it for years.[62] The open-door policy refers here to the entrance policies of Turkey, allowing Syrians into Turkey with a fast but not well-regulated registration

[60] A refugee, according to the Convention, "is a person who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion," in UN General Assembly, Convention Relating to the Status of Refugees (1951), accessed on 17 December 2022.

[61] "Non- refoulement is a core principle of international human rights and refugee law that prohibits States from returning individuals in any manner." in "Master Glossary of Terms," UNHCR, available at UNHCR master glossary of terms | UNHCR , on 17 December 2022.

[62] "Başbakan Davutoğlu: Açık Kapı Politikası Devam Edecek," *NTV*, 19 April 2016 available at https://www.ntv.com.tr/turkiye/kapilarimiz-acik-kalacak,Dzl1xuWeHkm_eiQOHur0NQ, accessed on 4 March 2023.

process. The initial open-door policy of Turkey showed that the authorities did not expect such a long and massive flow, which would eventually leave almost 13 million people displaced internally and externally. At the very beginning, Turkey perceived this policy to be an opportunity to foster its soft power to become a powerful regional actor and to become an essential player at the international level. [63] In the beginning, this policy indeed contributed to Turkey's emerging soft power image. As a result of the open-door policy, Turkey ranked 20th in Monocle's first-ever Soft Power Index[64] conducted in 2012. However, as the conflicts intensified, Turkey reached a point where this policy could not be sustained further, and its rising soft power image did not continue with its policies. The 2017- 2018 Monocle's Soft Power Index Turkey did not rank among the first 25 soft powers of the world.[65]

As the war in Syria escalated over the years and the number of Syrian asylum seekers went beyond expectations, the open-door policy of Turkey started to create internal tensions. It also caused criticism in the Turkish public and media.[66] The Turkish government used a political discourse referring to the collective memory of the Turkish state by calling Turkish society a charitable polity to mitigate the internal tensions.[67] This discourse was also supported by religious and historical references, for example, referring to the Ansar spirit. This discourse underlined the support of the people of al-Madinah to Prophet Mohammad and his supporters.[68] This discourse of the government was underlying the temporariness of Syrians' stay in Turkey, as the Ansar spirit was about protecting and supporting the guests during the exile from

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[63] Kemal Kirişçi, "Can Turkey Salvage its Soft Power Image Ahead of the World Humanitarian Summit?," *Brookings*, 16 May 2016, available at Can Turkey salvage its soft power image ahead of the World Humanitarian Summit? | Brookings, accessed on 22 January 2023.

[64] "Soft Power Survey, 2012," *Monocle*, 14 March 2012, available at Soft Power Survey - 2012 - Film | Monocle, accessed on 5 November 2023.

[65] "Soft Power Survey, 2017- 2018," *Monocle*, 28 December 2017, available at https://monocle.com/film/affairs/soft-power-survey-2017-18/ , accessed on 5 December 2023.

[66] M. Murat Erdogan, "Türkiye'deki Suriyeliler: Toplumsal Kabul ve Uyum Araştırması," *Hacettepe Üniversitesi Göç ve Siyaset Araştırmaları Merkezi*, (2014): 64, available at tc3bcrkiyedeki-suriyeliler-rapor.pdf (wordpress.com), accessed on 5 November 2023.

[67] Umut Korkut, "Pragmatism, Moral Responsibility or Policy Change: The Syrian Refugee Crisis and Selective Humanitarianism in the Turkish Refugee Regime," *Comparative Migration Studies*, Vol:4, No:1 (2016): 3.

[68] Korkut, "Pragmatism, Moral Responsibility or Policy Change,"13.

Makkah. In this framework, this discourse was deeming Syrians as guests[69] of Turkey who were escaping from brutality and Turkish people as their Ansar brothers and sisters who were sheltering them.[70] However, as the tension over the Syrian border escalated, and the numbers went far beyond initial expectations over a few years, the government changed the discourse toward the possible return of the Syrians, which was also far from a way of covering the realities of the protracted war.[71] This was also the period when the uncertainty in the legal status of Syrians started to create significant difficulties in refugees' access to social and public services.

The ad-hoc and uncertain approach of Turkey continued until 2014, when the Turkish government started to announce some institutional and legal arrangements to clarify the status of Syrians in Turkey. By the Law on Foreigners and International Protection (Uluslararası Koruma ve Yabancılar Kanunu, Law No: 6458)[72], legislated by the Parliament and entered into force on 11 April 2014, Turkey adopted the status of temporary protection (*geçici koruma*) to define the legal status of Syrians.[73] This law also regulated the rights of the Syrians and the services they could benefit from. The temporary protection status was a status used by the EU to manage the mass influx after the dissolution of Yugoslavia and the bloody conflicts in Kosova in the 1990s.[74] The Law on Foreigners and International Protection became a milestone for

[69] "Erdoğan: 200 Bine Yakın Suriyeli Kardeşimizi Misafir Ediyoruz," *T24*, 1 December 2012, available at Erdoğan: 200 bine yakın Suriyeli kardeşimizi misafir ediyoruz (t24.com.tr) ,accessed on 29 October 2023.

[70] Korkut, "Pragmatism, Moral Responsibility or Policy Change," 13.

[71] Susan Beth Rottmann, "Integration Policies, Practices and Experiences- Turkey Country Report, 2020," *Respond Project,* Paper 2020/50, (2020): 21.

[72] Yabancılar ve Uluslararası Koruma Kanunu, Law No: 6458, Resmi Gazete Date: 11 April 2013, No: 28615, Section 4, Article 91-1, available at 1.5.6458.pdf (mevzuat.gov.tr) , accessed on 26 November 2022.

[73] According to the Law on Foreigners and International Protection, "temporary protection can be provided for foreigners who have been forced to leave their country, cannot return to the country that they have left, and have arrived at or crossed the borders of Turkey in a mass influx situation seeking immediate and temporary protection", in Yabancılar ve Uluslararası Koruma Kanunu (Law No: 6458) Section 4, Article 91-1.

[74] Council Directive on Minimum Standards for Giving Temporary Protection in the Event of a Mass Influx of Displaced Persons and on Measures Promoting A Balance of Efforts Between Member States in Receiving Such Persons, Official Journal of European Union Date: 7 August 2001, Number:

Turkish migration and asylum policy, as it was the first ever primary source of law regulating asylum and migration issues. This law clarified the status of refugee in Turkish law and regulated the other categories to give international protection to foreigners. [75] Secondly, the law founded the Directorate General for Migration Management (Göç İdaresi Genel Müdürlüğü). Within this context, the temporary protection regime applied only to Syrians. It excluded other nationalities coming out of Europe, such as the Afghan and Iraqi refugees who sought refuge in Turkey during these years. These issues continue to create dualities in migration management.

The Law on Foreigners and International Protection marked another era in the migration and asylum policy of Turkey. Turkey shifted its policy on migration policy from an ad hoc nature towards a more standardized way. The Law on Foreigners and International Protection regulated full access to social and public services for Syrians under temporary protection. The temporary protection regime also gave Syrians the right to work in Turkey. Although Syrians were not granted international protection as a refugee, they were granted temporary protection, which gave them a similar coverage of international protection to the status of refugees with only one significant difference. That difference lies in the uncertainty (in terms of time and scope) of the temporary protection status. While temporary protection status defined the rights and liabilities of Syrian refugees, the uncertainty in their future persisted, as the latest election propaganda discourse of most political parties in Turkey showed. For example, one of the candidates running for the Turkish Presidency in the Presidency elections held on 14 May 2023 based its entire political propaganda radically on the definite return of Syrians canceling their temporary protection status[76] and the same discourse is underlined in the propaganda of most of the opposition parties in Turkey.

L212/12, available at eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32001L0055, accessed on 17 March 2023.

[75] Elitok, "Turkey 's Migration Policy Revisited: (Dis)Continuities and Peculiarities,"6.

[76]"Ata İttifakı' Bir Eksikle İlan Edildi: Zafer İnananların Olacak," *Gazete Duvar*, 13 March 2023, available at 'Ata İttifakı' bir eksikle ilan edildi: Zafer inananların olacak (gazeteduvar.com.tr), accessed on 15 April 2023.

This uncertainty in the future of the Syrians in Turkey and the unconformity of the Law on Turkish Foreigners and International Protection with the international law led to difficulties for the migration cooperation between the Turkish state and international actors. This resulted in some discourse differences and practical challenges in the joint actions of the Turkish state and international actors. There were examples where several collaborative works and publications between the international organizations (the EU or the UN) and the Turkish public authorities named Syrians as "refugees". [77] Therefore, the ambiguity in practice continues. Acknowledging the haziness in naming the status of Syrians in Turkey, this research uses both the category of refugee and calls the Syrians in Turkey as Syrian refugees before temporary protection is granted. It also uses the phrase of Syrians under temporary protection while referring to Syrian refugees in Turkey. All these categories refer to the same legal category throughout this research. The next section discusses the health policy towards Syrians in Turkey.

3.2. The Development of the Health Policy and Syrians

Turkey hosts 3,274,059 million registered Syrians under temporary protection[78], and this makes the country the top Syrian refugee-hosting country. In addition to temporary protection holders, Turkey hosts 344,000 registered asylum seekers from different nationalities[79] Registered Syrian refugees can access social services, such as health care, education, social assistance, and translation, under a temporary protection regime. However, the status of the non-Syrian and non-European people is neither clarified as a refugee in Turkey nor a temporary protection holder. Within this conceptual complexity, it will only be possible to mention one standardized refugee health policy applied to temporary protection beneficiaries. The refugee health policy, within the context of this thesis, refers to the refugee health policy

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[77]For example, Türkiye Büyük Millet Meclisi İnsan Haklarını İnceleme Komisyonu Mülteci Hakları Alt Komisyonu "Göç ve Uyum Raporu," (2018), available at goc_ve_uyum_raporu.pdf (tbmm.gov.tr), accessed on 18 March 2023.

[78] "Syrian Regional Refugee Response, Registered Syrian Refugees," UNHCR, last updated on 5 October 2023, available at Situation Syria Regional Refugee Response (unhcr.org), , accessed on 24 October 2023.

[79] "Turkey, Populations," UNHCR available at Türkiye | Global Focus (unhcr.org), accessed on 30 October 2023.

development relevant to temporary protection holders. The rights and the extent of service provision granted to other nationalities are not within the scope of this research. It is noteworthy here that this duality in migration management towards different legal categories is criticized for being an impediment in ensuring the right to health for all by many civil society actors. For example, the Turkish Medical Association Representative interviewed stated this point by calling this situation one of the most critical impediments to ensuring a right-based approach in health service provision to people seeking refuge in Turkey. [80]

The discussed unclear status of Syrians in Turkey and the unregulated registration process of arrivals up to the adoption of the temporary protection regime in 2014 affected the access of the Syrian refugees to the welfare system. The uncertainty in their stay and the increasing number of arrivals had implications for healthcare access. The interviewee from the Turkish Medical Association, who was also medical doctor stated that the unclarity in the legal status of Syrians created a fear of deportation among Syrian refugees, and this led to hesitation to apply for healthcare services unless it was a life-threatening emergency.[81] Several other interviewees repeated the fact that not having a legal status was a significant impediment for Syrians in Turkey in accessing healthcare services. According to the Turkish Medical Association report dated 2014[82], the registration process, which remained idle at the very beginning of the crisis, created an essential challenge for the health access of Syrians, as the unregistered Syrians could only apply to healthcare facilities in emergencies. During this time, the mobile health facilities were meeting the health needs of the non-camp refugees primarily due to difficulties in access to Turkish healthcare facilities.

While this period was marked by several difficulties and uncertainty in healthcare access, a significant part of the Syrian refugees was suffering from different chronic diseases, which intensified during and after the migration, as chronic diseases require

[80] Interview 16, The Turkish Medical Association, Ankara, 9 January 2021.

[81] Interview 16, The Turkish Medical Association, Ankara, 9 January 2021.

[82] Türk Tabipleri Birliği, *Suriyeli Sığınmacılar ve Sağlık Hizmetleri Raporu* (Ankara: Türk Tabipleri Birliği Yayınları, 2014), 31, available at https://ttb.org.tr/kutuphane/siginmacirpr.pdf?ysclid=lfpfpbidc2314012336, accessed on 26 March 2023.

regular treatment with full access to healthcare facilities. According to the WHO survey data of 2019, the 15.2 percent of respondents living in Turkey aged 18– 69 years were reported having chronic diseases, with the 10.2 percent among those were between 18–29 years old and the 56.6 percent among those were aged 60– 69 years. The most common chronic diseases among refugees were hypertension (3.7percent), psychiatric disorders (2.8 percent), diabetes (2.6 percent), asthma (2.6 percent) and cardiac disease (2.5 percent). [83]

Moreover, a significant part of the refugees had specific health needs. For instance, according to the Turkish Population and Health Research (Syrians Sample) 2018 Report, the 46 percent of the Syrians in Turkey were women.[84] 38.8 percent of these refuge women were at reproductive age (15- 49) and had specific needs for sexual and reproductive health service provision and additional protection measures against issues such as gender-based violence or early or forced marriages (for women in Turkey it was 60.6 percent).[85] The proportion of Syrian women who were married before 18 is 44.8 percent (for women in Turkey it was 14.7 percent), before 15 is 9.2 percent (for women in Turkey it was 2 percent).[86] Therefore, these women at reproductive health age had specific needs for reproductive health, such as family planning, or needed additional services to be protected or to overcome the health outcomes of harmful practices such as early or forced marriages. The emergency paradigm shaping the healthcare provision at this stage was not able to cover these needs as it mostly focused on treating individuals harmed by the conflict situations.

There were also structural problems affecting the access of the Syrian refugees to the Turkish healthcare system. These were mostly related to language and cultural

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[83]Daniele Mipatrani, Mehmet Balcılar, Matteo Dembech, Toker Ergüder, and Pavel Uslu, *Survey on the Health Status, Services Utilization and Determinants of Health of the Syrian Refugee Population in Turkey* (Ankara: World Health Organization, 2019): 32.

[84] "Geçici Koruma- Yıllara Göre Geçici Koruma Kapsamındaki Suriyelilerin Yaş ve Cinsiyete Göre Dağılımı," Türkiye Cumhuriyeti İç İşleri Bakanlığı Göç İdaresi Başkanlığı, data updated on 8 December 2022, available at https://www.goc.gov.tr/gecici-koruma5638 , accessed on 22 December 2022.

[85] Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey Syrian Migrant Sample* (Ankara: Elma Teknik Basım Matbaacılık, 2019), xv.

[86] Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey Syrian Migrant Sample*, xv.

barriers that impeded their access. The existing issues and problems in the Turkish healthcare system also intensified with the migration crisis and put additional pressures that will be discussed. Moreover, the refugees were also vulnerable in meeting all health needs as their full integration into labor markets was not achieved in Turkey at that time, and they faced various challenges in accessing the Turkish labor market. Several studies show that having a decent job and meeting a level of life standard are among the determinants of health status. In countries such as Turkey following neoliberal paths in the healthcare service provision, the financial situation has a direct impact on the health status of people. The neoliberal reforms followed by Turkey started through the Health Transition Program of 2003, which decreased the state's role and increased the role of private actors in healthcare service provision, requires special attention here, as it affected the health access of Syrians on many aspects.

The subject Health Transition Program of 2003 marked a significant change in Turkey's healthcare system. The program changed state-governed, financed, and provided health service provision towards a mode in which private actors became responsible for healthcare management through privatization, marketization, commercialization, and economization acts.[87] The impact of the Health Transition Program was significant in two ways. Firstly, it changed the financing structure of the healthcare system, which was part of a broader healthcare transformation being run in many countries towards a market-oriented mode with the support of financial institutions such as the World Bank[88]. The second important implication of the transition was its impact on changing the mode of healthcare service provision through the introduction of family medicine and the Family Health Centers in 2005. Which also changed the working conditions of the physicians.[89] The family

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[87] Volkan Yılmaz, *The Politics of Healthcare Reform in Turkey* (Cham, Palgrave McMillan, 2017), 30.

[88] Meltem Çiçeklioğlu, Zeliha Aslı Öcek, Meral Türk, and Şafak Taner, "The Influence of a Market-Oriented Primary Care Reform on Family Physicians' Working Conditions: A Qualitative Study in Turkey," *European Journal of General Practice*, Vol: 21, No: 2 (2015): 1.

[89] Tuba I. Ağartan, "Health Workforce Policy and Turkey's Health Care Reform," *Health Policy*, Vol: 119, No: 12 (2015): 1625; Zeynep Güldem Ökem, and Mehmet Çakar, "What have Health Care Reforms Achieved in Turkey? An Appraisal of the Health Transformation Programme," *Health Policy*, Vol: 119, No: 9 (2015): 1155.

physicians in this system were former state-salaried civil service employees who became contracted employees in the centers later.[90]

The impact of the change on the financing structure was shifting the role of the patients from the natural beneficiary of state-financed social services towards service recipients of health services who will pay for the services and medication unless individuals under no social security institutions prove that they are not able to afford health services or medications and receive a Green Card accordingly.[91] The impact of the Family Health Center model in service provision was various, such as its impact on the working conditions of family physicians [92] and on the outreach of immunization services. [93] Several studies show that the new system created difficulties for individuals who needed to pay for services and medication, and this put a burden on people with low incomes in Turkey.[94] Refugees, mostly employed in the informal labour market, are among the financially disadvantaged groups. Syrians acquired the right to work six months after having the temporary identity cards, per the Regulation on Provision of Work Permits for People under temporary protection.[95] Studies also show that even after they were legally allowed to work in the Turkish labor market, Syrians mainly continued to be employed in the informal labor market.[96] This was due to the inadequate language skills of Syrians in Turkish and the limits put forward by the Law on International Workforce on the

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[90] Çiçeklioğlu, Öcek, Türk, and Tanel, "The Influence of a Market-Oriented Primary Care Reform," 2.

[91]Ödeme Gücü Olmayan Vatandaşların Tedavi Giderlerinin Yeşil Kart Verilerek Devlet Tarafından Karşılanması Hakkında Kanun, Law No: 3816, Resmi Gazete: Date: 3.7.1992, No: 21273, available at yesilkartkanundoc.doc (live.com) ,accessed on 6 December 2023.

[92]Çiçeklioğlu, Öcek, Türk, and Tanel, "The Influence of a Market-Oriented Primary Care Reform," 3.

[93] Muzaffer Eskiocak, and Bahar Marangoz, *Türkiye'de Bağışıklama Hizmetlerinin Durumu*, (Ankara, Türk Tabipleri Birliği Yayınları, June 2021), 20.

[94]The negative impact of the Health Transition Program on people with low incomes was also criticized by civil society actors, such as the following press statement of the Ankara Medical Association; "Yoksulluk bir Halk Sağlığı Sorunudur," *Ankara Tabip Odası*, 2022, Ankara Tabip Odası, available at https://ato.org.tr/announcement/show/526 , accessed on 29 January 2023.

[95]Geçici Koruma Sağlanan Yabancıların Çalışma İzinlerine Dair Yönetmelik, Law No: 6575, Resmi Gazete Date :15 January 2016 No: 29594, available at 3.5.20168375.pdf (mevzuat.gov.tr), accessed on 20.December 2022.

[96]Asiye Şahin Emir, "Türkiye'de Geçici Koruma Statüsünde Olan Kişilerin Çalışma Hakkı," *Dokuz Eylül Üniversitesi Sosyal Bilimler Enstitüsü Dergisi,* Vol: 23, Special Issue (2021): 34.

employment of Syrians vis a vis the employment of Turkish citizens.[97] Moreover, there was also evidence that there was a tendency among Turkish employers to benefit from Syrians as a source of a "cheap labor force".[98] by employing them mostly in the informal labor market. Therefore, despite having acquired the right to work with temporary protection status, Syrians continued to have difficulties in accessing the labor market and accessing to have a decent income as a result, and this also put significant barriers to their access to healthcare services. They became vulnerable in meeting healthcare costs due to the not satisfying employment conditions.

Up to the Prime Ministry Disaster and Emergency Management Presidency (Afet ve Acil Durum Yönetim Başkanlığı, AFAD) Circular (2013-8) [99], there was not a specific law or law regarding the healthcare access of refugees registered and living outside of the camps (non-camp urban refugees). With the 2013- 8 Circular, the Governorships (Valilik) in the registration city became responsible for the costs of healthcare provided to Syrians. The review of the reports does not show any prior legislation up to this Circular regulating healthcare access and the issues of charging the related costs of health services. However, the interviews conducted for this research[100] show that Syrian refugees were generally not being costed, as they were generally applying for emergency services, and most of the Syrians up to 2013 were living in the temporary accommodation centers founded on the border cities of Turkey.[101] There were healthcare services in these accommodations as well as the

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[97] Uluslararası İşgücü Kanunu, Law No :6735, Resmi Gazete Date: 13 August 2016, No: 29800, available at 8049 (mevzuat.gov.tr) **,** accessed on 17 March 2023.

[98] "Patronlar İstiyor, Suriyeli Göçmenler Ucuz İşgücü Olarak Kullanılıyor," *Sol*, 24 December 2014, available at https://haber.sol.org.tr/emek-sermaye/patronlar-istiyor-suriyeli-gocmenler-ucuz-isgucu-olarak-kullaniliyor-103817, accessed on 28 March 2023.

[99] Türkiye Cumhuriyeti Başbakanlık, Afet ve Acil Durum Yönetimi Başkanlığı, Suriyeli Misafirlerin Sağlık ve Diğer Hizmetleri Hakkında Genelge, Circular No: 2013/8, Date: 8 September 2013, available at Suriyeli_Misafirlerin_Saglik_ve_Diger_Hizmetleri_Hakkinda_Genelge_20138.pdf (afad.gov.tr)
accessed on 30 October 2023.

[100] Interview 3, World Health Organization, Ankara, 10 February 2021.; Interview 7, UNICEF, Ankara, 15 January 2021.

[101] Türkiye Cumhuriyeti Başbakanlık Afet ve Acil Durum Yönetimi Başkanlığı, "Türkiye'deki Suriyeli Sığınmacılar, 2013 Saha Araştırması Sonuçları," (2013): 16, available at 1a-Turkiye_deki_Suriyeli_Siginmacilar_2013_1.pdf (afad.gov.tr), accessed on 27 November 2022.

mobile health clinics in the border which will be discussed in more detail in the coming sections. Therefore, up to this Circular, healthcare services were not defined as being free, at least through legislation, and access of Syrian refugees to the Turkish labor market was quite limited up to the Regulation on Provision of Work Permits for People under temporary protection.

With the Temporary Protection Directive, the AFAD became responsible for the costs of the healthcare services provided to Syrian refugees and the AFAD Circular (2015- 8) further regulated procedures and principles. [102] Most of the legal difficulties are solved with the Temporary Protection Directive and the AFAD 2015-8 Circular, as the Directive and this Circular defined the responsible institutions for the costs and general principles for Syrians' access to health services and medications free of charge. However, some difficulties remained in practice, such as the registration process taking up to three months. [103]

Moreover, Syrians were facing difficulties in accessing healthcare services due to the conditions created by migration and their vulnerabilities stemming from being a refugee. It is also worth noting here that refugees were already disadvantaged in accessing primary-level healthcare services due to language barriers and their lack of information on the Turkish healthcare system.[104] Therefore, the structural difficulties in accessing the labor markets and healthcare services and their vulnerabilities caused by migration were putting significant pressure on the health status of Syrians in Turkey. In addition to the systemic and cultural barriers to healthcare access, the public reaction to Syrian refugees was also not so positive at these times, with a dominant discourse blaming Syrians for causing long queues in Turkish health facilities.

[102] Türkiye Cumhuriyeti Başbakanlık, Afet ve Acil Durum Yönetimi Başkanlığı, Geçici Koruma altındaki Yabancılara İlişkin Sağlık Hizmetlerinin Yürütülmesi Hakkında Genelge, Circular No: 2015/8, Date:12 October 2015, available at 2015_8_Gecici_Koruma_altindaki_Yabancilara_Iliskin_Saglik_Hizmetlerinin_Yurutulmesi.pdf (afad.gov.tr), accessed on 30 October 2023.

[103] Türk Tabipleri Birliği, *Suriyeli Sığınmacılar ve Sağlık Hizmetleri Raporu*, 51.

[104] Ayman Saleh, Serdar Aydın, and Orhan Koçak, "A Comparative Study of Syrian Refugees in Turkey, Lebanon, and Jordan: Healthcare Access and Delivery," *OPUS International Journal of Society Researches*, Vol: 8, No: 14 (2018): 450.

According to a recently published study in 2020, Syrian refugees were living in poor accommodation facilities with difficulties in accessing clean water with poor sanitation, and hygiene conditions, especially in big cities like İzmir, İstanbul, and Şanlıurfa.[105] The refugees lacked financial resources to accommodate themselves in proper housing and they faced maltreatment cases by their landlords[106]. Therefore, the difficulties in accessing adequate housing and clean environment affected the social determinants of refugee health in Turkey. The field research conducted by the Turkish Medical Association also shows that the Syrians interviewed and visited within the scope this research were living in poor accommodations.[107] Another study found that the 12 percent of the refugee population in Istanbul is food insecure, the 24 percent of children under five suffer from chronic under-nutrition.[108] Considering that having proper housing and means of subsistence is a critical factor in ensuring the right to health, there is a need for specific policies to enhance Syrians' access to healthcare facilities, providing sufficient accommodation facilities, food, and water resources.

Turkey offered limited Temporary Accommodation Centres run by the Disaster and Emergency Management Presidency. However, these Centers were falling short of meeting the needs of Syrians, whose numbers have been increasing over the years. While growing numbers were creating tensions and pressures, some significant international funds were announced by the EU due to the Readmission Agreement signed by the EU and Turkey in 2014. [109] The availability of new funds from international donors and the increasing tensions and pressures discussed made Turkey consider new policies. The Turkish government, at this point, started to

[105] Ayhan Kaya, *Global Migration: Consequences and Responses in Global Migration: Consequences and Responses, Reception, Turkey Country Report, Respond Working Papers, Paper 2020/ 37* (İstanbul: Bilgi Yayınları, 2020): 55.

[106] Kaya, *Global Migration: Consequences and Responses*, 55.

[107]Türk Tabipleri Birliği, *Suriyeli Sığınmacılar ve Sağlık Hizmetleri Raporu*, 42.

[108]Kaya, *Global Migration: Consequences and Responses*, 55.

[109] Agreement between the European Union and the Republic of Turkey on the Readmission of Persons Residing without Authorization, Official Journal of the European Union, Date: 7 May 2014, No: L134/3, available at https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A22014A0507%2801%29&qid=1693815199982 , accessed on 4 September 2023.

introduce some policy initiatives to make healthcare services more accessible for Syrian refugees, whose numbers in Turkey were expeditiously increasing. Within this context, the development of refugee health policy regarding the Syrian migration crisis can be grouped into three phases.

The period between 2011 and 2013 was a phase in which both Turkey and the international community approached the situation as an emergency, which can be called the 'reception phase'. The reception phase was when significant policy change was not realized, and temporary solutions were introduced to enable Syrians' access to Turkish public health services. The necessary legal and institutional amendments were initiated in the 'institutionalization phase' between 2013- 2016 to create policy instruments and new institutions to respond to emerging needs. The developed policies started to be implemented after 2016, which may be called the 'implementation phase'. Table 3.1. shows these three critical phases in developing a proper refugee health policy Syrians in Turkey. The following sections will analyze the reception and institutionalization phases. The implementation phase will be explored through the three case studies of this thesis.

Table 3. 1. Phases of the Policy Change in the Health Sector of Turkey.

Phases	Features of the Phases
Reception Phase (2011- 2013)	Lack of grand law on migration politics, Lack of secure and continuous international fund, Uncertainty in the legal status of Syrians, Irregular entries and lack of systematic registration, No specific acknowledgement of the need for new solutions.
Institutionalization Phase (2013- 2016)	Law on Foreigners and International Protection (2013), Agreement between the European Union and the Republic of Turkey on the Readmission of Persons Residing without Authorization and provision of the international funds devoted to health sector (2014)[110], Regular contacts between state and international actors, Acknowledgement of the need towards a policy change in the health sector to integrate Syrians into Turkish healthcare system, Introduction of new policy institutions, instruments and policy initiatives for the policy change.
Implementation Phase (2016- 2021)	Implementation of the newly introduced policy institutions/ instrument and initiatives, First positive/negative outcomes.

[110] Agreement between the European Union and the Republic of Turkey on the Readmission of Persons Residing (2014).

3.2.1. The Reception Phase

The reception phase here refers to the period between the first arrivals of the Syrian refugees between 2011 and 2013. It marks the period before the Turkish authorities acknowledged the need for a policy change in the health sector. Accordingly, the reception phase was when no legal or institutional step was taken to solve the policy problem. Still, the need for a legal or institutional change was realized by the authorities. In the policy transfer literature, Evans calls such initial phases as the "recognition", where the need for a policy transfer is accepted.[111] The emergency paradigm shaped the mode of health service provision in the reception phase of the migration crisis. The initial responses were not planned for a situation that would take years. The very first arrivals required emergency treatment due to the harmful effects of the ongoing war. At this time, such injuries were treated by mobile health services sent to the borders by the Turkish Ministry of Health and by voluntary health facilities founded by civil society organizations. In response to the unexpected and underregulated arrivals of Syrian refugees, various temporary voluntary health facilities were established in southeastern Turkey by national and international civil society organizations during the reception phase. As one of the interviewees of this thesis stated, Turkey, as a country that was traditionally not used to receiving humanitarian assistance in humanitarian situations through cooperating with civil society organizations, accepted the deployment of civil society organizations at the borders for the first time.[112]

The research conducted by Asylum and Migration Research Center (İltica ve Göç Araştırmaları Merkezi- IGAM) in 2013 lists the civil society organizations that founded these voluntary health facilities and the services they provided.[113] According to this report, the civil society organizations that provided these services

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[111] Mark Evans and Jonathan Davies, "Understanding Policy Transfer: A Multi-Level, Multi-Disciplinary Perspective," *Public Administration*, Vol: 77, No:2 (1998): 378.

[112] *In*terview 7, UNICEF, Ankara, 15 January 2021.

[113] İltica ve Göç Araştırmaları Merkezi, *Sivil Toplum Örgütlerinin Türkiye'deki Suriyeli Mülteciler için Yaptıkları Çalışmalar ile İlgili Rapor* (Ankara: Anıl Matbaa, 2013), 17, 35, available at https://igamder.org/uploads/belgeler/IGAMSuriyeSTK2013.pdf , accessed on 26 March 2023.

were International Blue Crescent (Uluslararası Mavi Hilal)[114], Malteser International[115], and International Medical Corps (Uluslararası Sağlık Çalışanları)[116]. The project records of these non-governmental organizations and the research conducted by IGAM in 2013 show that these organizations provided medical services to the refugees in the emergency period in container hospitals or mobile clinics, as the capacities of state hospitals of Turkey located in some of the southeastern cities of Turkey such as Kilis fell out of capacity during the mass influx.[117] Apart from the voluntary health facilities providing mobile health services to Syrian refugees, registered Syrians were granted access to healthcare facilities. Still, generally, through emergency services, they could buy medicine by paying 20 percent of the price.[118] The lack of legal regulations and unpreparedness due to the emergency conditions within this framework enabled the civil society organizations to receive roles in health service provision.

According to the Disaster and Emergency Management Presidency report released in 2013, most of the Syrians crossing the Syrian borders were from the first groups settled in the districts of Hatay (Yayladağı, Altınözü), which was the closest city of Turkey to the Syrian territory.[119] The first Temporary Accommodation Center

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[114]"International Blue Crescent is an organization initiated by a group of businessmen. It aims to provide input in improving the lives of the people suffering, especially the most disadvantaged section of the world population" in "About Us- Who We Are," *International Blue Crescent*, available at https://www.ibc.org.tr/TR/main , accessed on 26 March 2023.

[115] "Malteser International is a worldwide humanitarian relief agency of the Sovereign Order of Malta. The Sovereign Order of Malta is a Catholic religious order that had previously a military and noble nature, and now its work focuses on providing humanitarian assistance" , in "Who We Are," *Malteser International,* available at Malteser International | Health and Dignity for People in Need (Malteser-international.org), accessed on 5 November 2023.

[116]"International Medical Corps is an international NGO that aims to provide emergency medical and related services to those affected by conflict disasters and diseases", in " A First Responder Since 1984," *International Medical Corps*, available at https://internationalmedicalcorps.org/ , accessed on 26 March 2023.

[117] İltica ve Göç Araştırmaları Merkezi, *Sivil Toplum Örgütlerinin Türkiye'deki Suriyeli Mülteciler*, 33.

[118] İltica ve Göç Araştırmaları Merkezi, *Sivil Toplum Örgütlerinin Türkiye'deki Suriyeli Mülteciler*, 11.

[119]Türkiye Cumhuriyeti Başbakanlık Afet ve Acil Durum Yönetimi Başkanlığı, "Türkiye'deki Suriyeli Sığınmacılar," 24, available at 1a-Turkiye_deki_Suriyeli_Siginmacilar_2013_1.pdf (afad.gov.tr), accessed on 16 March 2023.

(Geçici Barınma Merkezi) was founded in Altınözü, Hatay, as a tent city on 10 June 2011 and then turned into a container city on 3 October 2016.[120] The foundation of Temporary Accommodation Centers had a significant impact on the access of Syrian refugees to healthcare services, and significant differences emerged in ease of access between camp and non-camp urban refugees who sought accommodation in different cities outside of these centers. However, the Temporary Accommodations Centers became out of capacity as the number of arrivals increased. The transformation of tent cities to container cities reflected the increasing need for more extensive accommodation facilities due to the increasing number of arrivals from 2011 to 2016. Within this context, between 2011 and 2015, most of the refugees were accommodated in Temporary Accommodation Centers, serving as tent cities in the southeastern cities of Turkey, and health facilities were located within these centers.

By the end of 2015, 20 Temporary Accommodation Centers in total were founded in ten southeastern Turkey, and these cities were Adana, Adıyaman, Hatay, Gaziantep, Kahramanmaraş, Kilis, Malatya, Mardin, Osmaniye and Şanlıurfa.[121] Temporary Accommodation Centers were designed as tent cities, and then they were transferred to container cities that accommodated all the necessary facilities required for communal life.

The Temporary Accommodation Centers and the container cities had healthcare facilities within, and therefore, the access of the camp refugees was relatively easier compared to non-camp urban refugees. The below photograph of a Boynuyoğun Temporary Accommodation Centre Health Facility (Figure 3.1.) was taken for ethnographic research conducted in the Temporary Accommodation Centres.[122]

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[120] "Dünyaya Örnek Bir Barınma Merkezi, Altınözü Boynuyoğun Geçici Barınma Merkezi," Türkiye Cumhuriyeti Altınözü Kaymakamlığı, 17 September 2018, available at Dünyaya Örnek Bir Barınma Merkezi, Altınözü Boynuyoğun Geçici Barınma Merkezi (altinozu.gov.tr), accessed on 28 November 2022.

[121] Türkiye Cumhuriyeti İçişleri Bakanlığı Afet ve Acil Durum Yönetimi Başkanlığı, "Geçici Barınma Merkezleri," 8 October 2018, 1, available at https://www.afad.gov.tr/kurumlar/afad.gov.tr/2374/files/08_10_2018_Suriye_GBM_Bilgi_Notu_.pdf, accessed on 28 November 2022.

[122] Mehmet Fansa, "Türkiye'deki Bir Geçici Barınma Merkezinde Suriyeli Çocukların Yaşamı: İlkokul Eğitimi Üzerine Etnografik Bir Çalışma," (PhD diss, Eskişehir Anadolu Üniversitesi, 2021), 177.

Figure 3. 1. Boynuyoğun Temporary Accommodation Centre Health Facility. [123]

According to the Disaster and Emergency Management Presidency report dated 2013, the total number of registered Syrian asylum seekers in 2015 in Turkey was 550,000, and 200,000 Syrians were residing in the 20 Temporary Accommodation Centers founded in the ten cities of Turkey. [124] The remaining 350,000 Syrians lived out of the Temporary Accommodation Centers across Turkey. This Disaster and Emergency Management Presidency report was the first report assessing the demographic features and the needs of Syrians in Turkey. It is worth noting here that there are some inconsistent figures regarding the numbers of Syrians in this report. This inconsistency was probably due to the uncertainty in the numbers of Syrians living out of the Temporary Accommodation Centers. The reception phase was marked by unregulated entries to Turkey and a lack of registration unless Syrians voluntarily registered themselves with the governorate (*valilik*) of the city they settled in. At that time, only the 45 percent of non-camp urban refugees were registered with the Disaster and Emergency Management Presidency, and only the 20 percent had a residency permit to stay in Turkey. Most of the Syrians residing out of the Temporary Accommodation Centers were living in the southeastern cities of Turkey up to 2013. The Turkish Medical Association Report dated 2014 reports that there were even registration problems within Temporary Accommodation Centres.[125]

[123]Fansa, "Türkiye'deki Bir Geçici Barınma Merkezinde," 177.

[124]Türkiye Cumhuriyeti Başbakanlık Afet ve Acil Durum Yönetimi Başkanlığı, "Türkiye'deki Suriyeli Sığınmacılar,"12.

[125] Türk Tabipleri Birliği, *Suriyeli Sığınmacılar ve Sağlık Hizmetleri Raporu*, 33.

Regardless of the uncertainty surrounding the numbers of unregistered Syrians, according to the UNHCR data released in 2022, the number of registered Syrians in Turkey on 15 October 2012 was only 9,500, and the numbers increased to 560,129 by the end of 2013 (Figure 3.2.).[126]

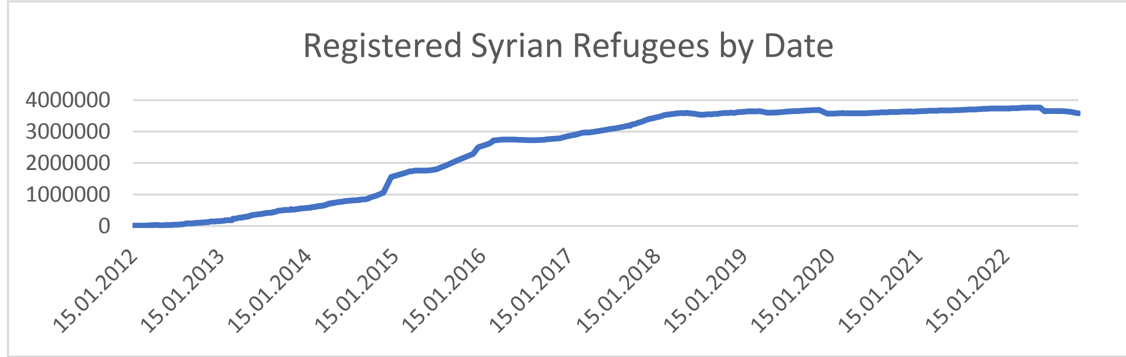

Figure 3. 2. UNHCR Data on Registered Syrian Refugees by Date.[127]

According to the Disaster and Emergency Management Presidency data of 2013, more than 90 percent of the Syrians residing in the Temporary Accommodation Centers used health services available in the camps, and around 60 percent of those in the Temporary Accommodation Centers who ever used the healthcare services stated that they were satisfied or very satisfied with the services they received. However, only around 60 percent of registered non-camp urban Syrian refugees were using the healthcare services in Turkey.[128] As stated earlier, the Turkish Medical Association representative interviewed for this research stated that the non-camp urban Syrian refugees had a fear of deportation if they applied for public service or were simply unaware of the registration procedures due to the uncertainties in their legal status.[129]

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[126] "Data Registered Syrian Refugees by Date," UNHCR, available at https://data.unhcr.org/en/situations/syria, accessed on 1 December 2022.

[127] "Data Registered Syrian Refugees by Date", UNHCR, available at https://data.unhcr.org/en/situations/syria, accessed on 1 December 2022.

[128] Türkiye Cumhuriyeti Başbakanlık Afet ve Acil Durum Yönetimi Başkanlığı, "Türkiye'deki Suriyeli Sığınmacılar,"38.

[129] Interview 16, The Turkish Medical Association, Ankara, 9 January 2021.

Further, it should be mentioned that the unregistered non-camp urban Syrian refugees were only legally entitled to use healthcare services with charge up to the discussed Disaster and Emergency Management Presidency Circular released in 2013. The lack of a population census due to the problems in registration had a direct impact on the health status of the Syrians, such as lack of information on accommodation conditions, nutrition, and risk groups (newborns, children, people with chronic diseases, etc.).[130] This data demonstrates that neither the registration procedures nor the policies related to the access of Syrian refugees to healthcare services were defined precisely. In this framework, the uncertainty in the status of Syrians also shaped the health service provision policy towards them. Amidst this uncertainty in health service provision, people with chronic diseases and children at the age of vaccination had difficulties in reaching treatment and vaccination.

The 53 percent of the Syrians in the Temporary Accommodation Centers and the 49 percent of the non-camp urban Syrian refugees were children aged between 0- 18 years old. Another figure in the Disaster and Emergency Management Presidency report is that the 24 percent of children residing in the Temporary Accommodation Centers and the 45 percent of the children living out of the camps were not vaccinated against polio; the 33 percent of children residing in the Temporary Accommodation Centers and the 41 percent of the children living in out of the Temporary Accommodation Centers were not vaccinated against measles. It is stated in this official Disaster and Emergency Management Presidency report that the low vaccination rate among Syrian children was a serious health threat to the children of the local population as well.[131] Moreover, almost the 8 percent of Syrians living in and out of the Temporary Accommodation Centers were suffering from at least one chronic disease. During the reception phase, the numbers of Syrians remained manageable, and the unregulated registration and emergency service provision methods met the needs of the Syrians. A statement given by one of the interviewees, who is a Turkish Ministry of Health official, summarizes the general status of health service provision for Syrian refugees at the reception phase:

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[130]Türk Tabipleri Birliği, *Suriyeli Sığınmacılar ve Sağlık Hizmetleri Raporu*, 36.

[131] Türkiye Cumhuriyeti, Başbakanlık Afet ve Acil Durum Yönetimi Başkanlığı, "Türkiye'deki Suriyeli Sığınmacılar,"9.

> The period between 2011 and 2015 was an acute emergency period. Different agencies of the state observed that there was indeed a need for permanent solutions instead of temporary solutions. By the end of 2015, there were unstandardized health facilities run by different civil society organizations across the southeastern cities of Turkey, and various donors funded them in the same city. They provided unstandardized health services in other cities where the refugees were most populated. There was a need for more sophisticated and permanent solutions.[132]

As the total numbers reached over 500,000 by the end of 2013 and the individual arrivals turned into mass arrivals, Turkey started to consider institutional and legal initiatives to regularize the arrivals of these refugees and control their registration.

3.2.2. The Institutionalization Phase

The institutionalization phase within the framework of this thesis refers to series of periods defined in Evans and Davies' framework when the authorities started to search for new policy options, contact and interact with different actors, and make the necessary evaluations.[133] This phase was marked by the adoption of a grand law on migration, which also defined the legal status of Syrians and the introduction of international funds. The institutionalization phase in the migration management of Turkey started in 2014 with the acknowledgment of the Law on Foreigners and International Protection. This law also established the Directorate General for Migration Management as a General Directorate.[134] and this was a significant step for Turkish migration policy, as it marked a radical shift from ad-hoc policymaking on migration issues towards a more standardized way of policymaking in migration matters. The Law on Foreigners and International Protection regulated the access of Syrians to the healthcare system, and it defined general frameworks of liabilities of Syrian refugees under the law and their access to healthcare services.

The Law on Social Security and General Health Insurance (*Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu*) numbered 5510 dated 2006 is the primary law

[132]Interview 1, the Turkish Ministry of Health, Ankara, 15 February 2021.

[133]Evans, and Davies, "Understanding Policy Transfer: A Multi-Level," 377- 379.

[134]The status of the Directorate General has been changed to Presidency with the Cumhurbaşkanlığı Kararnamesi, Decision Number: 85, Resmi Gazete Date: 29 October 2021, Date: 31643, available at 20211029-35.pdf (resmigazete.gov.tr), accessed 12 December 2023.

defining the liabilities and rights of Syrians under temporary protection.[135] As per Article 89 of the Law on Foreigners and International Protection, all foreigners in Turkey, including the temporary protection status holders, are required to be registered with the General Health Insurance (*Genel Sağlık Sigortası*), which was created to finance health services provided to all individuals in Turkey. The General Health Insurance System is based on collecting premiums from the receiver of health services in proportion to their income level.[136] The Article 89 of the law emphasized the obligation to be registered under the General Health Insurance System but granted the exemption of paying the premiums to the temporary protection holders.[137]

The Temporary Protection Regulation (*Geçici Koruma Yönetmeliği*) with the subject regulation defined the status of the people who could not afford medical insurance and the conditions of benefiting from the healthcare services by people who did not have financial resources to afford the healthcare services.[138] As per Article 89, these people who could not afford to pay the premiums were subject to the provisions of the Social Security and Universal Medical Insurance Law, which also defined the exemption of registering with the General Health Insurance Law. Payments of the premiums for those required to pay to benefit from the universal medical insurance were allocated to the budget of the Directorate General for Migration Management. The premiums of those unable to afford medical or healthcare services started to be paid by the Directorate General for Migration Management. Those who could afford the medications and healthcare services required to contribute proportionally to their financial means as per Article 89 of the Law on Foreigners and International Protection. For temporary protection beneficiaries, both for those paying the premiums or for those benefiting from the Directorate General for Migration Management budget, holding a Temporary Protection Identity Card with an ID

[135]Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu, Law No: 5510, Resmi Gazete Date: 16 June 2006, No: 26200, available at Mevzuat Bilgi Sistemi, accessed on 26 January 2023.

[136]Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu, (Law No: 5510).

[137]Yabancılar ve Uluslararası Koruma Kanunu, Law No: 6458, Resmi Gazete Date: 11 April 2013, No: 28615, Article 89-a, available at 1.5.6458.pdf (mevzuat.gov.tr), accessed on 26 November 2022.

[138]Geçici Koruma Yönetmeliği, Law No: 6203, Resmi Gazete Date: 22 October 2014, No: 29153, available at 21.5.20146883.pdf (mevzuat.gov.tr), accessed on 18 March 2023.

number starting with 99 was an essential prerequisite to enjoy the rights and benefits fully[139] Healthcare services and medications free of charge with the prerequisite of having the ID card was also ensured with the 2013 Circular numbered 2013/ 8[140] and later with the Law on Foreigners and International Protection.

Up to 2019, Syrians under temporary protection were exempted from paying premiums and the costs of the medicine in Turkey. As per the amendment brought by the Presidency Degree numbered 1851 published on the Official Gazette numbered 30989 dated 25 December 2019, the international protection applicants and temporary protection holders were also held responsible for paying contribution fees in line with their income level as applicable to Turkish citizens, and they were no longer free of charge. [141] The prior exemption given to temporary protection holders on paying the premiums for healthcare services and medications meant that Turkey devoted an essential budget to the health of Syrian refugees. For example, as of 2019, the number of Turkish citizens who were exempt from paying the premiums and had the right to hold a Green Card (*Yeşil Kart*).[142] The number Green Card holders was 8,638,000, according to the 2019 Social Security Institution data.[143] Registered number of Syrian who were mostly exempt from paying the premiums was almost 40 percent of the Green Card holders under no protection of security institutions in Turkey. Turkey's generosity in devoting a significant budget to exempting Syrians who could not afford healthcare services and medication costs can be understood by this simple comparison.

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[139] Türkiye Cumhuriyeti Sağlık Bakanlığı, Geçici Koruma Altına Alınanlara Verilecek Sağlık Hizmetlerine Dair Esaslar Hakkında Yönerge, Directive No: 39942531, Article 5 ,available at https://dosyasb.saglik.gov.tr/Eklenti/1376,saglik-bakanligi-gecici-koruma-yonergesi-25032015pdf.pdf?0 , accessed on 24 October 2020.

[140]Türkiye Cumhuriyeti Başbakanlık, Afet ve Acil Durum Yönetimi Başkanlığı, Suriyeli Misafirlerin Sağlık ve Diğer Hizmetleri Hakkında Genelge, Circular No: 2013/8, Date: 8 September 2013, available at Suriyeli_Misafirlerin_Saglik_ve_Diger_Hizmetleri_Hakkinda_Genelge_20138.pdf (afad.gov.tr), accessed on 5 November 2023.

[141]Geçici Koruma Yönetmeliği (Law No: 6203).

[142]Ödeme Gücü Olmayan Vatandaşların Tedavi Giderlerinin Yeşil Kart Verilerek Devlet Tarafından Karşılanması Hakkında Kanun, Law No: 3816, Resmi Gazete Date: 3 July 1992, No: 21273, available at yesilkartkanundoc.doc (live.com), accessed on 18 March 2023.

[143]"Yeşil Kartlı sayısı 8 milyon 628 bine ulaştı," *T24,* 24 September 2019, available at Yeşil Kartlı sayısı 8 milyon 628 bine ulaştı (t24.com.tr), accessed on 18 March 2023.

With reference to Article 88, international protection holders were not granted more rights and benefits than those given to Turkish Citizens[144] We may argue that Syrians benefited from the same rights granted to Turkish citizens with Green Cards who were exempted from paying the premiums and medication costs up to the 2019 Presidency Decree. With all these provisions, Syrians had acquired a similar coverage of health access to Turkish citizens. The Directorate General for Migration Management budget mostly covered the costs of healthcare services and medications, as most of the Syrians could not afford the healthcare and medication costs due to the legal and migration-related impediments to accessing the labor markets.

The Temporary Protection Directive (*Geçici Koruma Yönetmeliği*) involved several provisions regarding the health entitlement of the people under temporary protection.[145] The Directive was released to define the actions to be carried out for the reception, to regulate the stay, rights, and obligations, the exit procedures from Turkey, measures to be taken to prevent mass influx, cooperation and coordination among national and international institutions and organizations, determination of the duties and mandate of the central and provincial institutions and organizations for the management of the migration. As per the Temporary Protection Regulation, temporary protection beneficiaries have the right to remain in Turkey (Article 25) and full access to primary, secondary, and third-level healthcare services (Article 27). However, the health service costs provided in the second and third phases were limited not to exceed the price in the health application communiqué (*Sağlık Uygulama Tebliği*) determined by the Presidency of the Social Security Institution for general health insurers, (Article 27)[146]. As per the same article, specially designed health centers were allowed to carry out healthcare services.

The scope of the healthcare services to be provided to temporary protection beneficiaries was further elaborated in different Circulars released after the Temporary Protection Regulations, such as Circular No. 29153, dated 22 October

[144]Yabancılar ve Uluslararası Koruma Kanunu, Law No: 6458, Resmi Gazete Date: 11 April 2013, No: 28615, Article 88, available at 1.5.6458.pdf (mevzuat.gov.tr) , accessed on 26 November 2022.

[145]Geçici Koruma Yönetmeliği (Law No: 6203).

[146]Geçici Koruma Yönetmeliği (Law No: 6203).

2014 on “Health Services Provided for Foreigners under Temporary Protection”[147]. According to this Circular, temporary protection holders were only allowed to apply to primary healthcare services, and transfers to secondary and third health care services were under a doctor’s decision. With this Circular, the temporary protection holders were only allowed to receive the mentioned healthcare services in their city of registration. This limitation on benefiting from the health facilities only in the city of registration, unless it was an emergency, was stated to be creating difficulties and challenges for Syrians by the Turkish Medical Association Representative who was interviewed for this thesis. [148]Although this clause created restrictions on access, those under temporary protection could benefit from all types of preventives, curative, and emergency health services at primary, secondary, and tertiary levels free of charge in the city of registration. After 2019, they continued to benefit from healthcare services and medication while paying the premiums in case of employment.

The foundation of the Directorate General for Migration Management was one of the most significant institutional amendments taken at this phase. The Law on Foreigners and International Protection established the Directorate General for Migration Management and defined the duties and authorities of the Directorate General. The Directorate General was mainly responsible for implementing policies and strategies related to migration, ensuring coordination between institutions and organizations related to these issues, managing foreigners’ entrance, their stay in Turkey, their departure from Turkey, issues of deportation, issues related to victims of human trafficking, temporary protection, and other categories of international protection.[149] The establishment of the Directorate General first and foremost regulated the registration procedures of the Syrians, which had implications for the access of Syrians under temporary protection to healthcare services in Turkey. With the

[147] Türkiye Cumhuriyeti Sağlık Bakanlığı, Geçici Koruma Altına Alınanlara Verilecek Sağlık Hizmetlerine Dair Esaslar Hakkında Yönerge, Directive No: 39942531, available at https://dosyasb.saglik.gov.tr/Eklenti/1376,saglik-bakanligi-gecici-koruma-yonergesi-25032015pdf.pdf?0, accessed on 24 October 2020.

[148]Interview 16, The Turkish Medical Association, Ankara, 9 January 2021.

[149] “Başkanlık,” Türkiye Cumhuriyeti İçişleri Bakanlığı Göç İdaresi Başkanlığı available at https://www.goc.gov.tr/baskanligin-gorevleri, accessed on 11 December 2022.

Presidential Decree No. 85 published in the Official Gazette dated 29 October 2021 and numbered 31643, the status of the General Directorate was changed to the Presidency.[150]

Secondly, Syrians under temporary protection were given identity cards numbered with a starting number of 99, and this standardized the health service provision to people under temporary protection. It was as simple as saying that anyone with a temporary protection card numbered starting with 99 had the right to access all levels of healthcare services (primary, secondary, and tertiary) as any Turkish citizen. The law allowed Syrians under temporary protection to benefit from health service provision. Saying this does not mean there are no challenges and difficulties for the Syrians under temporary protection to access healthcare service provision in Turkey after the whole regulation in the legislation.

There were persisting challenges and difficulties preventing people under temporary protection from fully benefiting from the available services, such as language barriers, health illiteracy, and lack of information that could not be prevented by only taking legal amendments to the national legislation. Acknowledgment of the Law on Foreigners and International Protection, along with several other regulations regarding health service provision, were only marking the beginning of the policy change that would happen. Through all these legal and institutional changes, Turkey completed a set of institutional and legal steps to regulate the access of Syrians under temporary protection to the existing welfare systems in Turkey. These amendments also regulated the health sector. Moreover, these changes affected the work of non-state actors as the law also regulated the cooperation framework between Turkey and non-state actors.

Within this context, the Turkish law allowed full access of refugees to primary and secondary-level healthcare services. Having access to healthcare services is an essential component of the fulfillment of health rights as acknowledged by WHO. [151]

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[150] Cumhurbaşkanlığı Kararnamesi, Decision Number: 85, Resmi Gazete Date: 29 October 2021, Date: 31643, available at 20211029-35.pdf (resmigazete.gov.tr), accessed 12 December 2023.

[151]"Core Components of Health Right," World Health Organization, available at Human rights (who. int), accessed on 18 March 2023.

The above numbers and data show that Turkey devoted a significant budget to financing the health needs of the Syrians who were vulnerable to funding the costs of their health needs. However, having access is only one component of health rights as acknowledged by WHO, and realizing the health right also requires the elimination of external threats by taking the necessary measures. Eliminating external threats requires providing necessary conditions, adequate food, and access to clean water. It includes vaccination measures against diseases as well. Fulfilling health rights also requires a legal background for the confidentiality of medical records, choosing a physician, refusing treatment, etc. Within this context, ensuring full access to healthcare services is significant for fulfilling the health right, but more was needed.

Within this framework, Turkish law only provides a commitment to providing accommodation and financial allowances, and temporary protection holders were fully responsible for securing housing if they were not accommodated in Temporary Accommodation Centres. As with the allowance of the temporary protection holders to the Turkish Labour market with Law numbered 6575, Syrians were provided access to the means of subsistence. [152] This change was a critical step in the integration process. It was directly related to full access to the healthcare system in terms of financing the health costs, which paved the way for enabling the Syrians under temporary protection to have the necessary means to finance the essential conditions of a healthy life such as clean water, adequate accommodation opportunities, and nutrition. Although challenges and difficulties remained, Turkey provided the legal arrangements to define the scope and mode of health service provision to Syrians by enacting one primary law and various circulars complementing it. At around the same time, with the adoption of the Law on Foreigners and International Protection, Turkey signed the Bilateral Agreement with the EU, which triggered the development of several policy instruments that created the policy change in the health sector in Turkey. The next chapter analyzes the role of UN agencies in refugee health by international law and analyzes their role in the national context.

[152] Geçici Koruma Sağlanan Yabancıların Çalışma İzinlerine Dair Yönetmelik, Law No: 6575, Resmi Gazete Date :15 January 2016 No: 29594, available at 3.5.20168375.pdf (mevzuat.gov.tr), accessed on 20.December 2022.

CHAPTER 4

THE UN AGENCIES AND REFUGEE HEALTH GOVERNANCE

The previous chapters analyzed the refugee health policy development in Turkey and clarified the complexity of explaining the legal status of Syrians in Turkey. The uncertainty in the legal status of Syrians caused by Turkey's geographical limitation to the 1951 Convention Relating to the Status of Refugees and Turkey's ad-hoc migration policy up to the Law on Foreigners and International Protection created a delay in the development of health policy toward Syrians. As argued earlier, Refugee health development policy there refers to the refugee health policy development only regarding the health policy applied to Syrians under temporary protection. Other nationals have different health coverage and means to access healthcare services in Turkey. As the above discussion regarding Turkey's migration policy shows, Turkey still needs a proper refugee policy applicable to non-European and non- Syrian people seeking refuge in its territories.

The temporary protection regime underlines a service provision-focused approach rather than a right-based one, and it sets the whole framework for regulating full-access to healthcare services to Syrians in cooperation with specific UN technical agencies. The UN agencies, within the framework of this thesis, refers to both UN specialized agencies, UN funds and UN programs. The UN specialized agencies (such as the World Bank, and WHO) are independent international organizations and they are funded either by voluntary or assessed contributions of the UN member states and they hold legal personality in international law.[153] The UN funds and

[153]"The United Nations System comprises many funds, programs, and specialized agencies, each with a working area, leadership, and budget. The programs and funds finance their operations through voluntary and assessed contributions. The Specialized Agencies are independent international organizations funded by voluntary and assessed contributions. The UN coordinates its work with these separate UN System entities, which cooperate with the Organization to help it achieve its goals", in "The UN System," United Nations, , available at https://www.un.org/en/about-us/un-system., accessed on 19 December 2022.

programs (UNDP, UNICEF, UNFPA) are founded by various resolutions of the UN General Assembly and they are mostly funded by voluntary contributions of the member states and they all have a governing body reviewing their activities.[154] All these agencies have different mandate areas delegated by international law instruments, and the states signing their founding agreements endorse their mandate on the subject area.

Turkey was among the first signatory countries to the founding agreements of the UN technical agencies and started to cooperate with these agencies soon after their foundation on country basis.[155] Therefore, Turkey's recognition of the UN agencies and acknowledgment of working with them on technical matters has a history of more than 70 years. The United Nations presence in Turkey is coordinated through the Resident Coordinator (RC) system. The UN Country Team (UNCT) comprises the various specialized agencies, funds, and programs. FAO, ILO, UNDP, UNFPA, UNHCR, UNICEF, UNIDO, WFP, IOM, UNDSS, WHO, UNWOMEN, UNIDO, and IFAD maintain offices in Turkey, and there are also non-resident UN agencies represented. [156]

Refugee health governance, by nature, does not lie solely in the mandate areas of one of these UN agencies; rather, it lies in the intersection of migration governance and health governance. Neither the UN funds and programs (UNFPA and UNICEF) nor the UN specialized agencies (WHO and World Bank) have direct mandates related to refugee health. Therefore, it is a complex matter of analysis, and this policy area lies

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[154] "UN Funds, Programmes and Other Entities," available at https://research.un.org/en/docs/unsystem/fundsprogs., accessed on 25 March 2023.

[155] Turkey's cooperation with UNICEF started in 1951, in "Ne Yapıyoruz," UNICEF Türkiye, available at Ne yapıyoruz | UNICEF Türkiye, accessed on 24 November 2023; Turkey's cooperation with UNFPA started in 1971 with UNFPA, in "Türkiye'de UNFPA," UNFPA Türkiye, available at UNFPA Türkiye | Hakkımızda, accessed on 24 November 2023, "UNFPA was created in 1967 as a trust fund, and then established as a subsidiary of the General Assembly in its own right in 1969" in Rachel Sullivan Robinson, "UNFPA in Context: An Institutional History- Background Paper Prepared for the
Center for Global Development Working Group on UNFPA's Leaderships Transition" (October, 2010), available at UNFPA-in-Context.pdf (cgdev.org), accessed on 24 November 2023; The WHO Country Office in Turkey was established in 1959 in "About WHO in Türkiye", WHO Türkiye, available at About us (who.int), accessed on 24 November 2023.

[156] United Nations Türkiye, "2021 Results Report, United Nations Country Team In Türkiye," 1, available at 2021_UNCT_ResultsRreport_Final_0.pdf, accessed on 17 November 2023.

in the mandate area of various UN technical agencies. Understanding the role of the UN technical agencies in the governance of refugees requires understanding what 'refugee health' means in international law, and it requires understanding how the mandate area of the UN technical agencies requires the involvement of these technical agencies on matters of refugee health as delegated by the international law. This chapter is devoted to examining the agency of the UN technical agencies in refugee health by first investigating their role in international law and then in the national context of Turkey. The following part of this chapter (4.1) aims to analyze the role of the UN technical agencies as defined by international law and analyzes the core principles that identify the responsibilities of UN technical agencies in refugee health. The part 4.2 examines the UN technical agencies by examining the interplay between national and regional politics to understand its role in the health governance of Syrians in Turkey and lastly this section introduces the discussion of UN agencies' role in the subject policy change.

4.1. The UN Agencies and Refugee Health

There are two fundamental principles of international law framing the mandate the UN System in refugee health; one is UN's role on overseeing that international protection is provided to all refugees worldwide[157], and the other is ensuring the right to health is ensured for all as foreseen by the Constitution of the World Health Organization[158]. "The WHO Constitution is a multilateral agreement in front of Public International Law, binding upon States that are party to the Constitution".[159]

[157]"The protection that is accorded by the international community to individuals or groups who are outside their own country, who are unable to return because they would be at risk there, and whose own country is unable or unwilling to protect them", in " Master Glossary of Terms," UNHCR, , available at UNHCR master glossary of terms | UNHCR, accessed on 23 November 2023; for a comprehensive analysis of international protection in international law please see Volker Türk, and Frances Nicholson, "Refugee Protection in International Law: An Overall Perspective" , in Refugee Protection in International Law, UNHCR's Globlal Consultations on International Protection, ed. Erika Feller, Volker Türk, and Frances Nicholson (Cambridge: Cambridge University Press, 2009).

[158]UN General Assembly, The Constitution of the World Health Organization, adopted by Resolution A/RES/131 on 22 July 1946, entered into force on 7 April 1948, available at constitution-en.pdf (who.int), accessed on 24 November 2023.

[159] International Organization for Migration, *Migration, and the Right to Health: A Review of International Law*, No. 19, edited by Paola Pace (Geneva: International Migration Law Series, 2009), 8.

These two principles define and legitimize the mandate of the UN technical agencies and accordingly inform the work and operations of these agencies.

These two principles and the relevant legal documents codifying these principles regulate the rights of the refugees (refugee rights regime), the responsibilities of the host states, and the role of non-state actors in providing international protection and the right to health. The Convention and Protocol Relating to the Status of Refugees[160] and other related documents, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[161], Convention on the Rights of the Child[162], and the Constitution of the World Health Organization are some of these documents these two principles are codified in. Each of these legal documents delegates the UN System and the relevant UN entity's responsibilities in supporting the state's capacities to extend health services to refugees and different sub-groups among refugees (refugee women, refugee children, and refugees with disabilities) who might have challenges and impediments in accessing the available healthcare systems. These international legal documents define the responsibilities of the UN technical and specialized agencies, including UNHCR, WHO, UNDP, UNFPA, and UNICEF, on the matters of migration management and underline the state responsibilities for ensuring the right to health for all and provision of international protection for refugees.

Within this context, the role of the UN technical agencies is either based on a technical role or an advocacy role defined and framed by these legal documents. This differentiation between the technical and advocacy roles is essential, as undertaking a technical role (WHO) or an advocacy role (UNFPA and UNICEF) has significant implications for the agency of the UN technical agencies in the policy change. The

[160]UN General Assembly, Convention Relating to the Status of Refugees, adopted by Resolution 429 (V) 28 July 1951, entered into force 22 April 1954, available at refugees.pdf (ohchr.org)., accessed on 12 November 2023.

[161]UN General Assembly, Convention on the Elimination of All Forms of Discrimination against Women, adopted by Resolution 34/180 on 18 December 1979, entered into force 3 September 1981, available at CEDAW 29th Session 30 June to 25 July 2003, accessed on 12 November 2023.

[162]UN General Assembly, Convention on the Rights of the Child, adopted by Resolution 44/25 on 20 November 1989, entered into force 2 September 1990, available at the file (unicef.org), accessed on 12 November 2023.

following sections analyze the primary international documents regulating, focusing on international protection and the right to health principles.

4.1.1. International Protection

The principle of international protection is the core of the 1951 Convention and the 1966 Protocol Relating to the Status of Refugees. Protecting refugees from refoulement, which is the principle of non- refoulement, is one of the most fundamental principles of refugee rights. [163] The 1951 Convention and the 1966 Protocol Relating to the Status of Refugees are also the primary legal documents that define who a refugee is.[164] Moreover, the refugee regime and the 1951 Convention is about protecting refugees from refoulement and providing the refugees with safe solutions, which may become voluntary repatriation, third-country resettlement, or integration.[165] Adoption of the 195 Convention Relating to Status of Refugees is a milestone in emerging refugee rights law. However, at the very beginning, the version of the Convention signed in 1951 did not have universal coverage. Because this version mainly aimed to respond to the needs of European refugees after the Second World War, and this is why the 1951 Convention specifically regulated economic rights such as administrative help, identity documentation, freedom of religion, property, and artistic rights, education as well as taxation. This focus on economic rights reflected the Convention's focus on protection needs of European refugees of the Second World War.[166] Within this framework, the codified refugee rights in the 1951 Convention firstly aimed to provide international protection to those escaping from the events occurred in Europe and secondly, these codified rights addressed the needs of European refugees.

The 1951 Convention Relating to the Status of Refugees has another important aspect. This international document delegates UNHCR among all the UN entities

[163]UN General Assembly, Convention Relating to the Status of Refugees, (1951), Article 33.

[164]A refugee, according to the Convention, is "the person unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion", in UN General Assembly, Convention Relating to the Status of Refugees (1951), Article 1.

[165]Hathaway, *The Rights of Refugees Under International Law*, 913.

[166] Hathaway, *The Rights of Refugees Under International Law*, 9-12.

with the mandate of promoting and supervising the implementation of the 1951 Convention to provide refugees with the necessary international protection.[167] Therefore, UNHCR is the foremost organization responsible for collaborating with state institutions to provide international protection to refugees, ensuring the fulfillment of non-refoulement, and supporting states on the settlement/ resettlement process when necessary. UNHCR executes an important interpretative function for the 1951 Convention through its Executive Committee. Although the committee's decisions are not binding, UNHCR and the UN System have significant authority on matters related to the refugees.[168] The international protection and the related mandate of UNHCR are the core of the UN's authority on forced migration. However, how refugee protection is understood and delivered is complex and varies from country to country.[169]

Within this context, the states hold the right to define the legal system and to define how international protection is delivered at national level. It may not always be possible to deliver all human rights to refugees to its full purposes, as this requires full integration of these codified rights into the social and political regulations.[170] For example, in case of Turkey, international protection is delivered through different categories protection depending upon the nationality. For example, Syrians hold the status of temporary protection. Although, this category provides the Syrian refugees an extent of international protection, the temporariness underlines this category of international protection. The international protection provided by temporary protection emphasized the service provision rather than the rights of the temporary protection holders. Within this framework, the temporary protection, as a category of international protection, is heavily based on a service provision approach. Moreover, how the services are delivered and how the rights are used by refugees is very much

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[167] Tom Clark, "Rights Based Refuge, the Potential of the 1951 Convention and the Need for Authoritative Interpretation," *International Journal of Refugee Law*, Vol:16, No:4 (2004), 593.

[168] Goodwin-Gill, Guy S., and Jane McAdam, *The Refugee in International Law* (New York, Oxford University Press, 1996), in Clark, "Rights-Based Refuge," 588.

[169] Çetin Çelik, and Holly White, "Forced Migration and Protection: Turkey's Domestic Responses to the Syrian Refugees," *European Review*, Vol: 30, No: 3 (2021), 354.

[170] J. Olaf Kleist, "The History of Refugee Protection: Conceptual and Methodological Challenges," *Journal of Refugee Studies*, Vol: 30, No: 2 (2017), 165.

shaped by regional politics which creates bottlenecks in the complete execution of refugee protection at certain points. For example, the events of Turkey's opening of its border in late February 2020, and the mass movement of Syrian refugees into European border gates to pass to Europe is an example of the regional arrangements triggered by political considerations can turn into refugee law violations.

The opening of the doors was the reaction of the Turkish government to the EU after the deaths of 33 Turkish troops in airstrike due to intensifying Russian and Syrian operations. After the killings, Turkey sought the EU's support to mitigate the conflicts and financial support for the 3,274,059 million registered Syrians in Turkey without a positive result. Turkey afterward announced the opening of Turkey's borders for those refugees who would like to cross to Europe.[171] The escalating tension between Turkey and the EU ended with the aggressive use of gas, water cannons, and rubber ballots by the Greek police, and according to Prime Minister Erdoğan's statement, resulted in injuries and death.[172] The below photograph shows how the events created unpleasant situation for the refugees trying to pass to Europe (Figure 4.1.).

Figure 4. 1. New York Times, 1 March 2020[173]

[171]Matina Stevis-Gridneff and Carlotta Gall, "Erdogan Says, 'We Opened the Doors,' and Clashes Erupt as Migrants Head for Europe," *New York Times*, 1 March 2020, available at https://www.nytimes.com/2020/02/29/world/europe/turkey-migrants-eu.html , accessed on 26 February 2023.

[172]Helena Smith, "Erdoğan Likens Greek border Crackdown to Nazi Atrocities,"*Guardian*, 11 March 2020, available online at https://www.theguardian.com/world/2020/mar/11/erdogan-compares-greek-border-crackdown-to-nazi-atrocities, accessed on 14 November 2020.

[173]Gridness and Gall, "We Opened the Doors".

The reaction of the EU to the attempts of the refugees to cross the EU border was interpreted as a breach of the International Refugee Law by several authorities and scholars. UNHCR made the following statement upon the act of the Greek authorities on the asylum seekers and refugees:

> Neither the 1951 Convention Relating to the Status of Refugees nor EU refugee law provides any legal basis for the suspension of the reception of asylum applications. Article 78(3) of the Treaty of the Functioning of the EU (TFEU) has been evoked by the Greek Government in this regard, however this provision allows for provisional measures to be adopted by the Council, on a proposal from the Commission and in consultation with the European Parliament, in the event that one or more Member States are confronted by an emergency situation characterized by a sudden inflow of third country nationals while it cannot suspend the internationally recognized right to seek asylum and the principle of non-refoulement that are also emphasized in EU law. Persons entering irregularly on the territory of a State should also not be punished if they present themselves without delay to the authorities to seek asylum.[174]

These events represent how international protection, as the core of refugee law, can be breached by political considerations. These happening also show that how non-refoulement processes and its supervision by UNHCR can be breached by politics. Within this framework, such events show that the authority of the UN on international protection may be damaged by politics. This event was a significant example of how refugee protection is vulnerable to politics. Some political arrangements between Turkey and the EU pulled some criticisms for being an impediment to the full realization of international protection. The Agreement between the European Union and the Republic of Turkey signed in 2014[175] received significant scholarly and political reaction. The Readmission Agreement foresees the return of each refugee crossing illegally to European borders being sent back Turkey and the reception of one refugee waiting for resettlement instead of this return. The agreement was called a 'one-out, one-in deal' by some scholars due to these provisions mentioned.[176] The Readmission Agreement also included prospects for

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[174]"Press Releases: Statement on the Situation at the Turkey-EU Border," UNHCR, 2 March 2020, available online at https://www.unhcr.org/news/press/2020/3/5e5d08ad4/unhcr-statement-situation-turkey-eu-border.html, accessed on 14 November, 2020.

[175]Agreement between the European Union and the Republic of Turkey on the Readmission of Persons Residing (2014).

[176]Seçil Paçacı Elitok, "Three Years on: An Evaluation of the EU-Turkey Refugee Deal," *Mirekoç Working Papers*, No:3 (2019): 3.

reforming the current Customs Unions and visa liberalization for Turkey. More importantly, this Agreement defined the roadmap of the EU Facility for Refugees in Turkey (FRIT) which will be discussed in detail in the coming part of this chapter.

The Readmission Agreements are common practices for the EU migration and asylum policy, and the EU signed similar agreements with other countries. Molinari argues that "the Readmission Agreements prevent individuals not only crossing territories but also accessing legal systems giving them certain rights and protections".[177] Within this framework, the Readmission Agreement between the European Union and the Republic of Turkey first and foremost contradicted with the core principles of the 1951 Refugee Convention among which the non- refoulement was a core principle. Moreover, the prospects of the Readmission Agreement such as visa liberalization have not been achieved so far. Although the EU reported some progresses on visa liberalization in the following years of agreements, the progress reports underlined a need for further alignment on the matters of corruption, cooperation on criminal matters and anti- terrorism for Turkey.[178]

The parties of the Readmission Agreement responded to the above- discussed criticism received with a humanitarian discourse justifying the Agreement on its clauses of preventing irregular migration across the Aegean Sea and deaths over the seas and coasts.[179] Several EU reports emphasized the decreases in numbers of the irregular crossings (161 people annually at the end of 2019 and 1794 prior the Agreement).[180] However, some studies argued that the decrease in numbers was mostly related to refugees' changing routes to transit to Europe rather than giving

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[177] Caterina Molinari, "The EU Readmission Policy to the Test of Subsidiarity and Institutional Balance: Framing the Exercise of a Peculiar Shared Competence," *European Papers - A Journal on Law and Integration*, Vol: 7, No: 1 (2022): 170.

[178] European Commission, "Commission Staff Working Document Turkey 2018 Report," SWD (2018) 153 final, Strasbourg (2018):4-7, 49, available online at [20180417-turkey-report.pdf (ab.gov.tr)](), accessed on 19 November 2023.

[179] "EU, Turkey Sign Readmission Agreement," *Sofia Globe*, 16 December 2013, available at EU, Turkey sign readmission agreement – The Sofia Globe, accessed on 23 December 2023.

[180] European Commission, "Commission Staff Working Document Turkey 2020 Report," SWD(2020), 355 Final, Brussels (2020): 48, available online at https://www.ab.gov.tr/siteimages/trkiye_raporustrateji_belgesi_2020/turkey_report_2020.pdf, accessed on 15 November 2020.

up.[181] Nonetheless, the Readmission Agreement had direct impact on international protection and caused repercussions for the overall role of the UN System regarding its supervision functions over that every refugees is protected against refoulement. UNHCR was excluded from its mandate on ensuring international protection and finding a solution for their situation at the case discussed above.[182] The case between the EU and Turkey was a common global problem that required global solutions and burden-sharing among the international actors. Overall, the deal brought the issues of a global migration crisis and the solutions that need to be handled at the global level to the regional level and caused repercussions at the core of UN responsibility in migration management. The other core aspect of refugee health is the right to health, which is part of the fundamental human rights.

The 1951 Convention did not regulate and elaborate the right to health for refugees, and UNHCR does not have a mandate regarding refugee health per se. The right to health is part of the broad international human rights law and involves a justice paradigm, which means that refugees are naturally part of the international human rights law. There is neither an international legal document nor an international institution advocating the health rights of refugees per se.

To this fact, some studies address a need to consider the principle of international protection and overall international human rights law to define the general framework of refugee health.[183] These critics are primarily due to the Convention's emphasis on the economic rights of refugees. This section reviewed how the international protection is codified by international law and how it is enforced at national law. There is a need for an elaboration of internation human rights law to understand and analyze the general framework of health rights of refugees and how these rights regime define the role of UN in protecting right to health. The following section will analyze the right to health and refugee's health rights within this principle, as well as the mandate of the UN technical agencies to ensure the right to health for all.

[181]Elitok, "Three Years on," 4.

[182]Elitok, "Three Years on," 8.

[183]Clark, "Rights-based Refugee," 606.

4.1.2. Right to Health

The Universal Declaration of Human Rights[184] and the International Covenant on Economic, Social, and Cultural Rights[185], are the primary international documents codifying the right to health for all. The other related documents are the International Covenant on Civil and Political Rights[186] and the World Health Organization Constitution[187]. These documents draw the general framework on the right to health. By international law, the health right of refugees, by definition, does not differ from the right to health for everyone as defined in international human rights law. The UN Committee on Economic, Social and Cultural Rights openly stated the below view:

> States parties have a joint and individual responsibility, in accordance with the Charter of the United Nations and relevant resolutions of the United Nations General Assembly and of the World Health Assembly, to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons… Each State should provide international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population.[188]

In this sense, The UN Committee on Economic, Social and Cultural Rights elaborates a further extent of medical aid in times of emergencies to refugees, while recognizing the health rights of refugees should be considered within the principle of

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[184]UN General Assembly, Universal Declaration of Human Rights, adopted by Resolution 217 A (III) on 10 December 1948, available at udhr.pdf (un.org), accessed 13 November 2023.

[185]UN General Assembly, International Covenant on Economic, Social and Cultural Rights, adopted by Resolution 2200A (XXI) on 16 December 196, entered into force 3 January 1976, available at International Covenant on Economic, Social and Cultural Rights | OHCHR., accessed on13 November 2023.

[186] UN General Assembly, International Covenant on Civil and Political Rights, adopted by Resolution 2200A (XXI) on 16 December 1966, entered into force on 23 March 1976, available at https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights , accessed 13 November 2023.

[187]UN General Assembly, The Constitution of the World Health Organization, (1946).

[188]UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights), adopted by Decision E/C.12/2000/4 on 11 August 2000, Article 40, available at docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1AVC1NkPsgUedPlF1vfPMJ2c7ey6PAz2qaojTzDJmC0y%2B9t%2BsAtGDNzdEqA6SuP2r0w%2F6sVBGTpvTSCbiOr4XVFTqhQY65auTFbQRPWNDxL, accessed on 24 November 2023.

the right to health for all, and this view approach it as a fundamental human right. The primary provisions in these documents codifying the right to health are the Universal Declaration of Human Rights,[189] and the Article 12 of the International Covenant on Economic, Social, and Cultural Rights. In addition to the international human rights law, international labor law, and some specific legal documents, such as the Convention on the Rights of the Child[190] and the Convention on the Elimination of All Forms of Discrimination against Women[191] have some provisions on the right to health.

Article 25.1 of the Universal Declaration of Human Rights indicates that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family including (but not limited to) food, clothing, housing and medical care and necessary social service."[192] The Article 12 of the International Covenant on Economic, Social, and Cultural Rights affirms the right to health as a human right and indicates that "every human being is entitled to the enjoyment of the highest attainable standard of physical and mental health."[193] These two definitions referring to health as human rights differ from the WHO constitution, which defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[194] WHO's health definition is extensively a medical definition and does not address any socio- economic or socio-cultural issue that may have an impact on health of individuals. In response to WHO's technical health definition, the General Comment on the Article 12 of the Covenant on Economic, Social and Cultural Rights states that:

> Health is not only about the provision of healthcare, and it encompasses the social determinants of health such as food and nutrition, housing, access to safe and potable

[189]UN General Assembly, Universal Declaration of Human Rights, (1948).

[190]UN General Assembly, Convention on the Rights of the Child (1989).

[191]UN General Assembly, Convention on the Elimination of All Forms of Discrimination against Women (1979).

[192] UN General Assembly (1948), Universal Declaration of Human Rights, Article 25(1), in International Organization for Migration, *Migration and the Right to Health*, 26.

[193]UN Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000): 1.

[194]UN General Assembly, The Constitution of the World Health Organization, (1946): 1.

> water and adequate sanitation, safe and healthy working conditions, and a healthy environment.[195]

The extent of the health definition emphasizing socio- economic underpinnings of health is wider than the technical medical definition, and it requires further steps to be taken rather than providing healthcare. This kind of definition is coherent with the technical role given to WHO within the UN system on health matters. However, this definition overlooks many issues that is hazardous to human life such as environmental problems, lack of hygiene water resources. Within this context, there are two approaches to health: one is a right-based approach, and the other one is healthcare-based. The first one requires protection measures by states for the fulfillment of the right and provision of "available, accessible, acceptable and quality healthcare".[196]

However, even the International Covenant on Economic, Social and Cultural Rights acknowledges that states may not always meet the whole social determinants of health, and some determinants of health are related to personal lifestyles and habits of individuals. Within this context, the fulfillment of the right to health is an ideal that states must adhere to provide the highest standards possible. Some of these international legal instruments define and delegate some responsibilities to the UN entities for supporting state capacities to protect this fundamental human right. The Covenant also acknowledges that states' capacities may not always be sufficient to take all these actions to secure the right to health for all, including the refugees, and the Covenant underlines the fact that full realization is closely related to state capacity and available resources and underlies the importance of the necessity of international cooperation when needed. As discussed earlier, refugee protection gives international organizations, especially UN agencies and entities, some responsibility to ensure that every refugee is provided international protection. Considering the above discussion, refugee health requires cooperating with international organizations with expertise in health when the state capacities need support. The institution that holds a certain extent of authority regarding health is naturally World Health Organization. However, the socio- economic definition of health calls involvement of different other actors on socio- economic determinants of health.

[195]UN Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000): 2.

[196]UN Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000): 3-5.

The Article 12 of the International Covenant on Economic, Social, and Cultural Rights assigns a key role to WHO for the fulfillment of the right to the highest attainable standard of health.[197] As per the Article 12, the parties of the WHO Constitution avail themselves to follow the technical advice and health programs developed by WHO to realize the right to health for everyone entirely. Moreover, they acknowledge the necessity of conducting national health strategy and policies in line with the technical advice of WHO depending on their national capacity. Moreover, they accept the advisory services of WHO in data collection, disaggregation, and the development of the right to health indicators and benchmarks.[198] In this legal framework, WHO has a pivotal function to achieve the goal of the right to health for everyone.

As discussed earlier, the definition of the right to health involves not only medical care but also refers to socio- economic determinants of health, such as safe and clean water, food, sanitation, healthy occupational and environmental conditions, and access to health-related education and information, sexual and reproductive health and it also addresses several other human rights accordingly. The complex and comprehensive nature of the right to health requires the participation of different international actors to support the national health capacity of the states where the state capacity is insufficient to meet the needs. In line with the Covenant, WHO, the International Labour Organization, the United Nations Development Programme, UNICEF, the United Nations Population Fund, the World Bank, the World Trade Organization, and other relevant bodies within the United Nations System. They are therefore called to cooperate effectively with state parties. Moreover, financial institutions are also held responsible for protecting the right to health in their programming, lending strategies and agreements by the Article 12 of the International Covenant on Economic, Social, and Cultural Rights. [199]

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[197]UN Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000) in International Organization for Migration, *Migration and the Right to Health*, 8.

[198]UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, (2000), Article 63- 64, in International Organization for Migration, *Migration and the Right to Health*, 76.

[199] UN Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000), Article 63- 64, in International Organization for Migration, *Migration and the Right to Health*, 76.

Therefore, the comprehensive nature of the right to health requires the expertise of relevant UN bodies and gives them responsibility in line with the international instruments and technical and institutional capacities. Moreover, the advocated definition of health addressing the socio-economic indicators of health requires intervention and contribution of several UN agencies for supporting state capacities, even when they not have a direct mandate in health, such as UNDP or UN Women. In this framework, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social, and Cultural Rights are the general ones to define the right to health and state responsibilities and the obligations of the international actors within the UN System. However, migration is a more complex and dynamic issue, and the category of refugees includes different groups. Therefore, various instruments of the international human rights law refer to the specific rights of multiple groups among refugees. In this sense, for example, Article 24 of the Convention on the Rights of the Child recognizes the child's right to enjoy the highest attainable standard of health facilities for treating illness and rehabilitation of health. [200] Likewise, the Article 12 of the International Covenant on Economic, Social, and Cultural Rights calls for states to eliminate discrimination against women in health care. Different specific Human Rights Instruments refer to various groups and aim to prevent other inequalities (women, children, people with disabilities, etc.) among different groups that may come up.[201]

The UN bodies also advocate the right to health and monitor the violations that occur at national levels through the Human Rights Treaty Bodies. However, violations of the law instruments may occur, as the ultimate decisions are very much dependent on state's ultimate decision. Within this framework, refugees around the world are vulnerable to the violations of the right to health. These violations may be due to insufficient resources of the host countries, the inadequacy in national legislations and national strategies, insufficient international cooperation, or simply the state's unwillingness to realize the right to health or lack of international support. In this sense, national legislation may involve provisions confronting International Law, and

[200] UN General Assembly, Convention on the Rights of the Child (1989), Article 24.

[201] International Organization for Migration, *Migration and the Right to Health*, 23.

these confrontations may leave some questions about to what extent governments allow refugees to access healthcare systems. These confrontations may result in deviations in the authority of the UN system in ensuring the right to health for all and provision of international protection for all refugees. Moreover, political dimensions shape the governance of refugee health and politics may result in difficulties realizing the right to health. Within the framework of the complex technical nature of health, various organizations may take on different responsibilities.

The World Health Organization, among all these agencies, is the most technical one supporting state capacities to extend health coverage for all. UNFPA and UNICEF are more advocacy organizations; the first one advocates the rights regarding sexual and reproductive health, whereas UNICEF advocates children's health rights as part of universal children's rights. After examining the role of UN technical agencies on refugee health, the following section moves to investigate the role of UN technical agencies in the Turkish context with a focus on the role of the accession process of Turkey to the EU and to the process of migration crisis which the Readmission Agreement between the EU and Turkey marks. The governance environment emerged with the adoption of the national legislation and the signing of the Readmission Agreement which provided funds for the refugee health programs is important, as these amendments and arrangements provided different capacities for the UN technical agencies to act in the field as required by international law.

4.2. The UN Agencies and the EU in the Development of Healthcare Provision to Syrian Refugees

As discussed earlier, Turkey's healthcare system went through important changes since the launch of 2003 Health Transition Program. During this transformation, Turkey cooperated with World Bank extensively in transforming primary level healthcare facilities (Health Centers (*sağlık ocakları*) to Family Health Centers (aile sağlığı merkezleri). [202] Within this framework, World Bank is an important international actor in Turkey's healthcare transformation. However, this thesis does

[202] İpek Özkal Sayan, and Aziz Küçük, "Türkiye'de Kamu Personeli İstihdamında Dönüşüm: Sağlık Bakanlığı Örneği," *Ankara Üniversitesi SBF Dergisi*, Vol: 67, No:1 (2012): 183.

not focus on this significant actor, as the main international donor of refugee health programs undertaken after the Readmission Agreement of 2014 in Turkey is the EU. Moreover, the accession process of Turkey to the EU started in 1999 had also significant impact on expanding governance environment during the last 30 years. Moreover, these processes made a significant impact in the changing migration policy of Turkey. Within this framework, Turkey's relations with the EU both before and after the Syrian War had a significant impact on the emerging migration governance environment in Turkey.

In line with the research aims of this thesis, this chapter of the thesis is devoted to understanding the impact of the relations between the EU and Turkey in providing and/ or strengthening the policy capacities of the UN agencies. The financial and political resources provided by the EU opened new paths and limitations for the agency of the UN technical agencies and had significant impact on the capacities of these organizations. Firstly, 9.2 billion Euros were given under the Instrument for Pre-Accession Assistance[203], then 6 billion Euros given under the EU Facility for Refugees in Turkey[204] and additional 3 billion Euros funding in 2021-2023 to support refugees[205]have implications for the agency of the UN technical agencies. This part examines this governance environment with a focus on the EU- Turkey relations in relation to its impact on the UN technical agencies.

In line with this, the following section examines this issue in the accession process and the second section of this part focuses on the EU Turkey cooperation during the migration crisis. The aim of these sections is to contextualize EU- Turkey relations to understand how the UN agencies equip themselves with the resources provided during these two separate periods.

[203]"Katılım Öncesi Yardım Aracı (Instrument for Pre-Accession Assistance- IPA) Nedir?," Instrument for Pre- Accession, available at https://ipa.gov.tr/ipa-nedir/, accessed on 19 February 2023.

[204] "EU Support to Refugees in Türkiye," European Commission, available at EU Support to Refugees in Türkiye (europa.eu), accessed on 14 November 2023.

[205] European Commission, "Seventh Annual Report of the Facility for Refugees in Turkey," COM(2023) 543 final, Brussels (2023): 6, available at COM_2023_543_F1_COMMUNICATION_FROM_COMMISSION_TO_INST_EN_V3_P1_2696289.PDF (europa.eu), accessed on 17 November 2023.

4.2.1. The UN Agencies and the Accession Process

Turkey's intensifying cooperation with the UN technical agencies on different policy issues including migration matters dates to the beginning of 2000s and can be argued to have started with Turkey's candidacy to the EU in 1999 Helsinki European Council which provided Turkey with access to EU funding, and benefits from the EU programs and participation in the EU agencies. [206] The relations with the EU and Turkey were, in fact, older than Turkey's candidacy process and dated back to early years of the foundation of the European Economic Community. The Ankara Agreement between the European Economic Community and Turkey in 1964 had a special place as it marked the beginning of the cooperation between Turkey and the EU on cooperation for labor politics. [207] The relations continued with ups and downs during these years and Turkey's first attempt to become a member of European Economic Community ended up with rejection in 1989. The EU became an important actor for Turkey after 1999 Helsinki European Council where Turkey became a candidate for the EU membership.[208] The following long- lasting accession process led important changes in Turkey's policy making processes where Turkey tried to align its policies with the EU rules and policies on various issues of the Chapters of the Acquis Communautaire[209] . During this process, the EU also became a major donor for projects/ programs implemented for the alignment of domestic policies with the EU policies and standards on the related policy areas. The accession process also marked the increasing involvement of the civil society organizations in the policy implementation process.

The EU, being a political supranational political union, is not a traditional technical organization with the technical capacity on project/ program implementation.

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[206]Andrea Ott, "EU-Turkey Cooperation in Migration Matters: A Game Changer in a Multi-Layered Relationship?," in *Bilateral Relations in the Mediterranean: Prospects for Migration Issues*, ed. by F. Ippolito, G. Borzoni, and F. Casolari (Chelthenham: Edward Elgar Publishing, 2020): 189.

[207]EU-Turkey Association Agreement (the Ankara Agreement), signed on 12 Eylül 1963, entered into force on 1 December 1964, available at EU texts | Documents | D-TR | Delegations | European Parliament (europa.eu), accessed on 18 February 2023.

[208]Ott, "EU-Turkey Cooperation in Migration Matters,"186- 187.

[209]"List of EU Acquis by Negotiation Chapters," Republic of Türkiye, Ministry of Foreign Affairs, DG for EU Affairs, available at List of EU Acquis by Negotiation Chapters (ab.gov.tr), accessed on 18 March 2023.

Although the EU acted as a major donor and policy partner during Turkey's candidacy process, it never acted as a technical actor in the respective policy areas that the alignment required amendments and reforms. Turkey collaborated with other technical external actors such as the UN technical agencies (UNDP, UNICEF, UNFPA) and UN specialized agencies (WHO, FAO). Therefore, the progress of Turkey's relations with the EU in line with Turkey's candidacy process provided resources for the work of the UN technical agencies on different policy areas. This is not a situation specifically applied to the EU funding in Turkey, but this is the general steps followed by the candidate countries to the EU. The EU dispersed the Instrument for Pre-Accession to technical implementing agencies such as the UN technical agencies. Therefore, Turkey's relations with the EU and its alignment policies with the EU rules and policies paved the way for more active cooperation with non- state actors including the UN agencies, as some issues regarding the alignment were technical issues such the issues of free movement of goods, people and services, agriculture, taxation, social policy and employment and border policies.

In terms of migration policy development, opening of the 24th Chapter of the Acquis on Justice and Home Affairs of the EU[210] and Turkey's political and institutional amendments for alignment played a key role in the development of the migration policy which was discussed to be driven by security concerns of the country during the 1990s. During continuing candidacy, Turkey took many more steps to align its migration and asylum policy with Chapter 24, Justice, Freedom, and Security of the EU Acquis Communautaire such as the foundation of the Asylum Migration Bureau and Border Management Bureau (Sınır Yönetimi, Dış İlişkiler ve Proje Daire Başkanlığı) formed under the Ministry of Interior and Committee Against Irregular Migration in 2018 in line with the EU procedures. The foundation of the Directorate General for Migration Management in 2014 and the Migration Policies Board (Göç Kurulu) established to support the Directorate General for providing regular advice on migration management and migration policy and Turkey's cooperation with the academia and rights- based civil society organizations were only the latest steps

[210] All the key steps taken into alignment with the EU Acquis on Justice, Freedom and Security can be found in Progress Database available at "EU Measure Layout - List of EU Acquis by Negotiation Chapters," Republic of Türkiye, Ministry of Foreign Affairs, DG for EU Affairs, available at List of EU Acquis by Negotiation Chapters (ab.gov.tr), accessed on 18 March 2023.

taken in the migration management policies.[211] All these developments led Turkey to develop a migration policy in cooperation with non- state actors.

Within this framework, Turkey's introduction of the Law on Foreigners and International Protection was only a last step in the long-term reforms being taken in Turkey with regards to the migration and asylum policies. As mentioned, this law was a fundamental legal framework that defined the scope of the health service to Syrian refugees (not limited to access to healthcare services), however, the discussion regarding the need to make a law on migration in Turkey started long before the Syrian migration crisis. It was first drafted following the National Action Plan prepared by Turkey in 2005 without turning to a fundamental migration law. Turkey invited the NGOs and academics and allowed them as participants in the decision- taking process.[212] The adoption of such a grand law became possible with only after Turkey's experience of mass migration flows from Syria. This new law regulated the different categories of irregular and regular migration as discussed earlier. This new law shifted Turkey's long-lasting migration and asylum approach dominated by its security concerns to a policy welcoming refugee out of Europe which needs to be understood in Turkey's attempt to become a powerful regional actor and acting international actor.

The war in Syria and the mass influx of Syrians to Turkey had undeniably an accelerating impact in policy- making process in Turkey on issues related to migration. Considering all these with the introduction of the Law on Foreigners and International Protection, Turkey adhered itself to solve migration and asylum related issues with a single immigration administration and by a single law rather than approaching the issue on a case by case and ad- hoc manner. The national asylum and migration policy took a step from a flexible approach to a long-term perspective in the light of these changes. The next section moves to discuss the period after the civil war started which is called as a migration crisis in this thesis.

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[211]Seçil Paçacı Elitok, "Turkish Migration Policy over the Last Decade: A Gradual Shift towards Better Management and Good Governance," *Turkish Policy Quarterly*, Vol: 12, No: 1 (2013): 168.

[212]Elitok, "Turkish Migration Policy," 167.

4.2.2. The UN Agencies and the Syrian Migration Crisis

The events of 2011 and following mass human movements created a migration crisis. The term of crisis here does not solely underline the mass numbers, but it underlines the crisis it resulted in the lives of the people seeking refuge in other countries, and the crisis it created in the governance, reception, and welfare systems of the receiving countries. Sahin Mencütek, et- al defines the crisis "as an extraordinary event leading to increased but temporal instability and uncertainty in the pre-existing status quo or perceived normality."[213] Turkey's collaboration with the non-state actors was partially related to manage the temporal instability and uncertainty in its governance, reception, and welfare systems.

Firstly, Turkey's primary response to the first arrivals to the southeastern borders and the health needs emerged became a turning point for Turkey's approach on working with international actors in cases of humanitarian emergencies. Turkey's approach to emergencies was long dominated by a statist paradigm prior to the civil war and the country preferred to respond to emergencies on its own resources, as this was the case for catastrophic magnitude 7.6 Gölcük Earthquake happened on 17 August 1999. Turkey only started to work with some civil society organizations such as the Search and Rescue Association (Arama Kurtarma Derneği- AKUT) to respond to the earthquake which resulted in 17,480 deaths and 43,953 injuries.[214] The international support received for this case was also on an ad-hoc manner. One of the interviewees from UNICEF stated that Turkey was traditionally not so much prone to work with civil society in situations of emergency prior to 2011, as the country was approaching emergency management as a matter of sovereignty that refers to the approach in which sovereign is expected to handle emergency situations on its own resources.[215]

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[213] Zeynep Şahin‑Mençütek, Soner Barthoma, N. Ela Gökalp‑Aras and Anna Triandafyllidou, "A Crisis Mode in Migration Governance: Comparative and Analytical Insights," *Comparative Migration Studies* Vol: 10, No: 12 (2022): 2.

[214] Turkish Grand National Parliament, "Parliamentary Research Commission Report, The Parliamentary Investigation Research Commission Established for the Purpose of Determining the Measures to be Taken in Earthquake Management by Researching the Earthquake Risks" (2010), available at tanseldurak-549-(1-176):Mizanpaj 1.qxd (tbmm.gov.tr), accessed on 18 February 2023.

[215] Interview 7, UNICEF, Ankara, 15 January 2021.

This approach changed profoundly with the migration crisis started in 2011, as Turkey accepted to work with national/ international civil society actors in founding the voluntary health facilities at the very beginning of the crisis, and later, it extended this collaboration to UN technical bodies and international non-governmental organizations in the health sector with more extended projects. The Turkish Red Crescent representative interviewee, who was working in a senior management position at the organization, gave the below statement which shows how the migration crisis made an impact on Turkey's policy on humanitarian diplomacy:

> In the last 11 years Turkey developed a culture to work with international organizations and humanitarian actors. There is almost every day at least one coordination meeting that is taking place with the Turkish state institutions and international actors. Turkey's humanitarian assistance capacity developed significantly during these years. Several units are founded to cooperate with these organizations within the Turkish Republic Disaster and Emergency Management Presidency, Directorate General for Migration Management, and the relevant ministries including Ministry of Interior, Ministry of Family and Social Services. All of these constituted the developing humanitarian culture in Turkey. [216]

As a continuation of Turkey's changing approach to collaboration on humanitarian matters, the Turkish state and Turkish public as well showed a welcoming approach to the United Nations' human appeal, worth of 1 billion US dollars to the devastating earthquakes happened on 6 February 2023, in the southeastern cities of Turkey. [217] The interest of the public on the UN's human appeal is mostly related to country's previous experience in cooperating with the UN actors to respond to the emergency needs of the Syrians. Turkey's bilateral negotiations with the EU at the acute phase of the migration crisis also contributed to Turkey's changing approach. Turkey collaborated not only with the UN agencies whom the Turkish institutions had the prior experience to work with, but Turkey also collaborated with local/ national and international civil society organizations in the foundation of the voluntary health facilities and health service provision in these facilities.

The year of 2014 was a milestone year both for the role of non- state actors in migration and migrant health management in Turkey due to the acceptance of the

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[216]Interview 14, Turkish Red Crescent, Ankara, 26 January 2021.

[217]"UN Issues Call for $1 Billion to Help Millions of People in Türkiye Affected by Devastating Quakes," United Nations Türkiye, 16 February 2023, available at UN issues call for $1 billion to help millions of people in Türkiye affected by devastating quakes | United Nations in Türkiye, accessed on 18 March 2023.

Law on Foreigners and International Protection as well as the Readmission Agreement between the EU and Turkey as discussed earlier.[218] The Agreement changed the nature of the cooperation between the EU and Turkey. Although Turkey's candidacy to the EU was discussed to have led some institutional and legal changes in Turkish migration politics, this is not to say that the EU applied the clauses on the so-called changes on total humane causes. Justice and home affairs of the EU has been long criticized by linking the external dimension with the internal and abolishing the internal border controls and whereas strengthening the external border controls. There is a significant literature looking at this process, which is broadly referred as externalization of the EU's migration politics and this literature analyses different country cases for externalization politics of the EU.[219] The externalization politics also shaped the internal migration policy of Turkey which increasingly became a very popular hub for migration flows of the last 20 years.

The EU implemented the migration management policies with the externalization logic through different practices such as the Readmission Agreements, and Strategic Partnerships. Militarization of the borders was also another tool adopted by the EU to manage the irregular migration. In this context, Turkey was always an important third country due to its geographical location as a transit point for the irregular migration flows to the Europe. The tragic events of the Arab Spring and mass movements only increased the strategic role of Turkey for the increasing the migration flows at the borders of the EU. As response, the EU and Turkey started to discuss similar arrangements for border management. Finally, the Readmission Agreement between the EU and Turkey, was finally signed and published on the Official Journal of the EU on 7 May 2014.[220] The Readmission Agreement was so

[218] Agreement between the European Union and the Republic of Turkey on the Readmission of Persons Residing without Authorization, Official Journal of the European Union Date: 7 May 2014, Number: L134/3, available at https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A22014A0507%2801%29&qid=1693815199982, accessed on 4 September 2023.

[219] For example Saime Özçürümez, and Nazlı Şenses, "Europeanization and Turkey: Studying Irregular Migration Policy," *Journal of Balkan and Near Eastern Studies, Vol:* 13, No: 2 (2011).; Maribel Casas-Cortes, Sebastian Cobarrubias, and John Pickles, "Riding Routes and Itinerant Borders: Autonomy of Migration and Border Externalization," *Antipode, Vol:* 47, No: 4 (2015): 894–914; Inka Stock, Ayşen Üstübici, and Susanne U. Schultz, "Externalization at Work: Responses to Migration Policies from the Global South," *Comparative Migration Studies*, Vol: 7, No: 1 (2019).

[220] Agreement Between the European Union and the Republic of Turkey (2014).

significant for the UN technical agencies as well, as the financial and political resources provided different capacities for the UN technical agencies.

With this Agreement, the EU committed itself to provide humanitarian aid which was stated as 6 billion Euros that would be paid to Turkey in two parts and 300 million Euros was solely devoted to the health sector under this Agreement.[221] A significant portion of the refugee health programs implemented by the UN agencies in Turkey are funded by the EU Facility for Syrian Refugees in Turkey (FRIT). The EU set the Facility for Syrian Refugees in Turkey (FRIT) in 2015 to respond to the European Council call for the additional funding for supporting Syrian refugees in Turkey. In addition to humanitarian assistance given, the FRIT focuses on education, migration management, health, municipal infrastructure, and socio-economic support. The total budget of 6 billion Euros (with reference to first and second tranche of the facility) was contracted to be completed by mid-2025 and additional funding of 1.6 billion Euros is given to some projects under the FRIT as a special measure towards COVID- 19 pandemic. [222] For 2020, the EU allocated an additional 50 million Euros in humanitarian assistance to continue protection and health projects in Turkey as part of this special measure.[223] The EU Facility for Syrian Refugees in Turkey represent the biggest source of international funding in refugee health governance.

The FRIT funds devoted to health sector is majorly on the funding of SIHHAT Project (300 million Euros in 2016, and 210 million Euros given in 2020) for the foundation of the 187 Migrant Health Centers and three Extended Migrant Health Centers (190 in total) in 30 provinces of Turkey.[224] The FRIT funds were far below the actual costs spent on the health sector integration of Syrian refugees, however the

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[221] "EU Support to Refugees in Türkiye, " European Commission, available at EU Support to Refugees in Türkiye (europa.eu), accessed on 14 November 2023.

[222] European Commission, "Seventh Annual Report of the Facility for Refugees in Turkey," 2, 5.

[223] "Commission Continues Humanitarian Support for Refugees in Turkey," *European Commission*, available at Turkey: Commission continues humanitarian support refugees (europa.eu) , accessed on 18 September 2023.

[224] European Commission, "Seventh Annual Report of the Facility for Refugees in Turkey,"10.

FRIT's role on extending the policy making on migration management to the involvement of non- state actors is important. The EU is an important and influential actor. The following statement of the Turkish Ministry of Health shows that it was influential actor. "The Turkish state and the EU took the decisions collaboratively. The overall agreed scheme was collaboratively decided between two through bilateral negotiations."[225]

The EU funds were important resources for many refugee health programs undertaken. The main targeted outputs of the FRIT actions in the health sector were supporting primary and secondary healthcare facilities (construction and operationalization), and to improve the healthcare staffing in the refugee- dense cities of Turkey as well as increasing level of refugees' awareness and knowledge relating to health seeking behavior.[226] Within this framework, the FRIT is an important funding source for the refugee health programs of the UN technical agencies in Turkey. For example, the below analysis of the funding of the WHO Refugee Program (Figure 4.2.) shows how the EU is a significant donor for its actions.

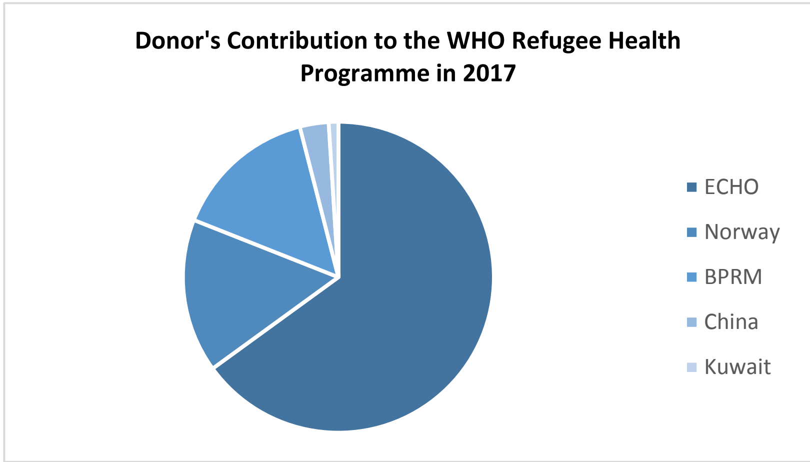

Figure 4. 2. Donor Contribution to the WHO Refugee Health Programme in 2017.[227]

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[225] Interview 1, The Turkish Ministry of Health, Ankara, 15 February 2021.

[226] European Commission, "EU Support to Refugees in Türkiye, The Facility Results Framework Monitoring Report- Results Achievement Progress (as of 31 December, 2022)," No:11 (June 2023): 6, available online at fda8f1c2-4605-48c8-9dec-78be59ee922c_en (europa.eu), accessed on 18 November 2023.

[227] World Health Organization, "Health Emergency Response to the Crisis in the Syrian Arab Republic, Annual Report 2017" (2018): 35.

The EU is a major donor to UNFPA interventions as well. However, it has also limitations. The humanitarian assistance of the EU by 2020 came to a critical point with completion of several flagship projects. Although the EU mobilized additional fundings, the future of the EU contribution is yet not crystal- clear. This is also another uncertainty for the future of Syrians in Turkey along with the temporary protection regime. Yet, the EU fundings can be discussed to have provided an environment for the UN technical agencies to provide technical expertise to the refugee health programs. Within this framework, the FRIT funds and other sources of the EU funds were the major international contribution to the migration crisis, yet the financial support was far of covering the actual amount to cover the health needs of Syrians in Turkey over the past 13 years.[228]

Just to give an understanding on the real numbers of the refugee health finance, Germany, the most refugee welcoming country of the EU, devoted 40 billion Euros for the integration of 1.1 million Syrians for only one year. Considering this, we can argue that the EU's financial assistance to the refugee crisis is far below the actual need. Some press sources criticized the EU contribution for using Turkey as a "cheap hotel for refugees".[229] Still, comparing the support with the total 9.2 billion Euros of three phases of the Instrument for the Pre- Accession which was given for the full accession process shows that the funds were an important donor contribution.[230] Even though health costs were much higher than the EU contribution, we can say that its political implications are significant in terms of institutionalizing refugee health governance in Turkey. An evaluation report prepared by an Ireland based consultancy company and published by the European Commission also emphasized the EU grants remain much below what was spent by the host state. However, this report also states that its impact on integration in the health sector is quite significant.

[228] It is worth to note here that there were also contributions from different governments including Germany, Japan, and South Korea. However, the major funder of the policy transfer in Turkey was the EU.

[229] Ayhan Kaya, *Mülteci Krizi Ekseninde Türkiye-AB İşbirliği: Fırsatlar ve Zorluklar* (İstanbul: İktisadi Kalkınma Vakfı Yayınları, 2016), 17.

[230] For a discussion of the cost of the integration of Syrians in Turkey please see Mustafa Kutlay and Öznur Akçalı, "Mülteci Krizi ve Türkiye-AB İlişkilerinde Eksen Kayması Riski Künye Mülteci Krizi ve Türkiye-AB İlişkilerinde Eksen Kayması Riski," *Uluslararası Stratejik Araştırmalar Kurumu*, Analiz No: 29 (2015): 3.

[231] A Turkish Ministry of Health official interviewed for this research also stated that these funds "were very important in terms of structuring the health service provision to Syrians under temporary protection". [232]

Up to the FRIT, Turkey was covering all the financial costs of health service provision to Syrians under temporary protection without demanding any charge of fee from Syrians (officially starting with the Disaster and Emergency Management Presidency Circular numbered 2013/ 7 dated 2013). Even after the funds were dispersed, Turkey remained as the major funder of the health service provision and the medicine costs of the Syrians under temporary protection all over these years from the very beginning. Yet the Bilateral Agreement contributed to the resilience of the public services and public institutions of Turkey. In this framework, the Agreement made an impact on enhancing institutionalization of the health service provision. The Turkish Ministry of Health official gave the below statements confirming the impact of the EU funds on structuring the healthcare provision.

> The EU's contribution to health sector is relatively a small contribution, when considered the total operational cost of the health service provision to Syrians under temporary protection. It is a contribution of 300 million Euros, however, if we could see the breakdown analysis of Turkey's spending, we would probably see that Turkey's annual expense for medicine to Syrians under temporary protection would be around 300 million Euros without mentioning the expenses on primary level healthcare services or secondary healthcare service which included the expenses on operations and hospital bed fees. However, undeniably it is a significant foreign contribution. If SIHHAT was not an EU funded project, there would not be an extending Migrant Health Center network all over Turkey. There are 177 Migrant Health Centers in the 29 cities of Turkey and there are almost 3500 Syrian healthcare professionals and healthcare workers employed by the Turkish Ministry of Health in these centers.[233].

As mentioned by the Turkish Ministry of Health official, the funds allocated to health sector remains relatively low compared with the financial resources allocated

[231]European Commission, "Strategic Mid-term Evaluation of the Facility for Refugees in Turkey, 2016-2019/2020, Final Report," Volume II: Sector Report on Health (2021): 53, available at Vol II - Sector Report - Health.pdf (europa.eu) , accessed on 19 November 2023.

[232]Interview 2, The Turkish Ministry of Health Ankara, 8 February 2021.

[233]Interview 1, the Turkish Ministry of Health, Ankara, 15 February 2021. The numbers given here differs from the actual latest numbers of the Migrant Health Centers, as this interview was taken in 2021.

by Turkey to health spendings for Syrians under temporary protection over the course of EU's support. The actual numbers of the spendings on health sector for refugees by the Turkish state remain unknown. One of the biggest challenges in the data collection of this research was indeed the fact that the breakdown of the Turkey's spending on refugee health governance was not available to public. However, some supportive data found so far is beneficial understanding the financial pressure put on the host state's shoulders. For instance, a data stated by one of the pharmacists[234] working in one of the most Syrian population dense districts of Ankara support the above statement of the Turkish Ministry of Health official. And this shows that only one pharmacy in this district sent an invoice of 8,200 TRY to the Provincial Immigration Authority (İl Göç İdaresi) for September 2022. This district accommodates only 0.1 percent of the overall registered Syrian population in Turkey, and there are 10 pharmacies in this district. Considering that there are around 26,000 pharmacies in Turkey in 2019[235], one might predict how this number would increase if all the medicine costs spent for Syrians under temporary protection for 10 years, were calculated.

The Readmission Agreement did not only bring financial resources to the refugee health programs implemented by the UN agencies. There were also other important developments in the Turkish migration policy following the agreement. For example, Turkey founded the Presidency of Migration Health Department (Göç Sağlığı Dairesi Başkanlığı) in 2015 as part of the General Directorate of Public Health (Halk Sağlığı Genel Müdürlüğü) under the Turkish Ministry of Health with the aim of managing the changes in the healthcare provision to refugees. This was an important part of the institutionalization phase in the health sector. This institutional change also shows Turkey's will to manage the new available funds in a more structured way. Within this framework, the Readmission Agreement opened a new chapter in the refugee health policy of Turkey. Next part discusses the institutional changes and the policy instruments developed that constitute the policy change.

[234]Interview 19, Pharmacist, Ankara, 4 October 2022.

[235]Türkiye Eczacılar Birliği, "Eczanelerde Ekonomik ve Finansal Durum Araştırması," (2019): 1, available at Türk Eczacıları Birliği - Anasayfa (teb.org.tr). accessed 18 December 2022.

4.3. Policy Implementation Phase and Policy Instruments

Turkey in collaboration with international actors realized various change through introducing new policy instruments to ensure better access for Syrian refugees to healthcare services. Among all these policy instruments introduced to strengthen primary and secondary care health facilities and enhancing healthcare access the most outstanding instruments was the Improving the Health Status of the Syrian Population Under Temporary Protection and Related Services Provided by Turkish Authorities Project [236], also known as SIHHAT Project[237]. This project was delivered via a direct grant of 300 million Euros to the Turkish Ministry of Health, launched and signed on 1 December 2016 and it was the most significant international contribution to the health sector. As might be seen in Figure 4.3. below, the project also holds the biggest share of the whole EU funds devoted to the health sector. The second biggest share belongs to the construction of two hospitals in Hatay and Kilis, followed by two projects implemented by WHO and UNFPA which will be discussed in more detail in the case studies.

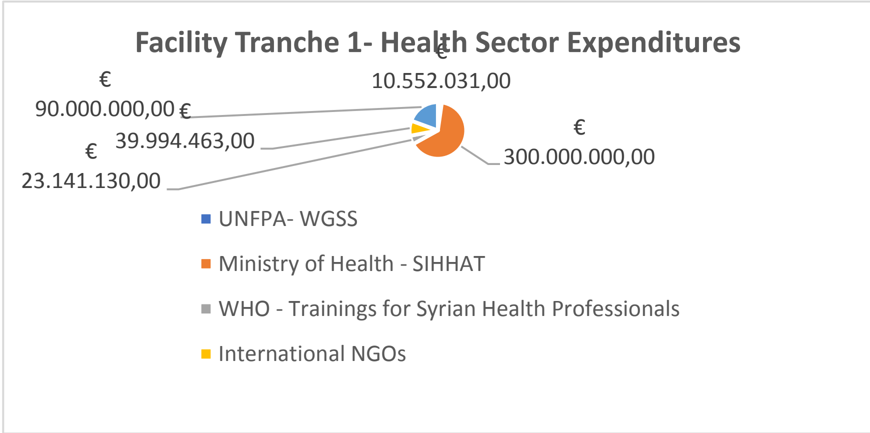

Figure 4. 3. Financial Analysis of the EU Funds on Health Sector. [238]

[236] "SIHHAT (Contract no. IPA/2016/378-641) – is a Facility Tranche I, IPA-funded, EUR 300m grant to the Turkish Ministry of Health, under direct management by the Delegation of the European Union to Türkiye, which started in December 2016 and is foreseen to be closed in January 2021 (following a 2-month extension in response to COVID-19). It will be followed by a similar direct grant under Facility Tranche II).", in European Commission, "Strategic Mid-term Evaluation of the Facility," 16.

[237] "SIHHAT,"Sıhhat Project, available at SIHHAT PROJESİ (sihhatproject.org), accessed on 13 March 2023.; Sıhhat is originally an Arabic word which means "health" in Turkish and Arabic and it is understandable by both Turkish and Arabic speakers.

[238] European Commission, "Strategic Mid-term Evaluation of the Facility," 20.

The SIHHAT project was very important as it marked an important policy change occurred in the Turkish healthcare system. WHO and UNFPA provided important technical outputs to it. UNICEF's immunization campaign was also related to this project. 187 Migrant Health Centers and three Extended Migrant Health Centers were founded in the 30 refugee- dense cities of Turkey within the scope of the SIHHAT Project with the aim to provide capacity support to Turkish healthcare system and to support Syrian refugees to overcome the technical (capacity of the Turkish healthcare system) and practical challenges (language barriers, etc.) to the healthcare services.[239]

Migrant Health Centers were originally planned supportive units to Family Health Centers (Aile Sağlığı Merkezleri) and Public Health Centers (Toplum Sağlığı Merkezleri) of Turkey for providing primary level healthcare to Syrian refugees. More importantly, Migrant Health Centers provided employment opportunity for Syrian health professionals who received orientation trainings for providing healthcare to their nationals in the Refugee Health Training Centers. The foundation of the 187 Migrant Health Centers in the 30 refugee- dense cities of Turkey, and employment of 4000 Syrian health professional was the core of the policy change occurred in the Turkish healthcare system.[240] The Turkish government collaborated with WHO and the non- governmental organizations for organizing the orientation of the Syrian health professionals and collaborated with UNFPA for the foundation of the Women and Girls Safe Spaces which turned to Women Health Advisory Units within the Migrant Health Centers later. The foundation of Women, Girls Safe Spaces (WGSS), as well as employment and training of health mediators recruited in the Women and Girls Safe Spaces and all the awareness raising activities regarding reproductive health and mechanisms to prevent gender- based violence was the main policy initiatives introduced through the technical capacity provided by UNFPA and its implementing partners.

In this network of primary level healthcare centers, there are also Extended Migrant Health Centres in which some specialized Syrian doctors on gynecology, internal

[239] European Commission, "Seventh Annual Report of the Facility for Refugees in Turkey," 10.

[240] Ceren Ark Yıldırım, Ayşegül Komsuoğlu, and İnanç Özekmekçi, "The Transformation of the Primary Health Care System for Syrian Refugees in Turkey," *Asian and Pacific Migration Journal*, Vol: 28, No: 1 (2019): 90-91.

diseases, and pediatrics are employed to provide healthcare to Syrian refugees. The Turkish Ministry of Health and WHO collaboration focused on the foundation of the Refugee Health Training Centers (*Mülteci Sağlığı Eğitimi Merkezleri*) and the orientation trainings given to Syrian healthcare professionals in which they received practical training working with their Turkish peers and theoretical trainings organized by WHO and the University of Health Sciences (*Sağlık Bilimleri Üniversitesi*). These centers dispersed to seven cities of Turkey can be seen in the Figure 4.4. below.

Figure 4. 4. Distribution of Syrians across Turkey and the Location of Refugee Health Training Centers.[241]

These policy initiatives discussed were all introduced in collaboration with the UN technical agencies. Initiation of each policy instruments became feasible only after the provision of the major migration law (Law on Foreigners and International Protection) and provision of financial resources (the Readmission Agreement of 2014). Therefore, these two important steps, which was closely related were very much defining in policy- making process. The below table (Table 4.1.) shows comparatively the developments in migration and asylum policies of Turkey and the introduction of the new policy instruments which led to the policy change in the healthcare system. The below also shows the related UN technical agency involved in the development of the related policy instruments.

[241] A Smart Map based on the Presidency of Migration Management data on the Registered Syrian Refugees, For the subject data please see Presidency of Migration Management, "Geçici Koruma Kapsamındaki Suriyelilerin İllere Göre Dağılımı, Geçici Koruma," Türkiye Cumhuriyeti İç İşleri Bakanlığı Göç İdaresi Başkanlığı, available at GEÇİCİ KORUMA (goc.gov.tr), accessed on 22 June 2022.

Table 4. 1. Policies on Migration and Refugee Health and the UN Actions in Turkey (2011- 2021).

	Development in Migration and Asylum Policies of Turkey	**Date**	**Policy Instrument**
Reception Phase (2011- 2013)	First Arrivals to Turkey (29 April 2011) [242]	29-Apr-11	No Specific Policy Instruments- Ad hoc Policy Solutions
	Active Open Door Policy [243]	from the beginning of the crisis	
	Foundation of Altınözü Boynuyoğun Temporary Accomodation Center (first Temporary Accomodation Center)-(10 June 2011)[244]	10-Jun-11	
Institutionalisation Phase (2013- 2016)	The Law on Foreigners and Temporary Protection (11 April 2013)[245]	11-Apr-13	Change in Legislation and Receipt of International Funds
	First Disaster and Emergency Management Presidency Circular regulating healthcare service provision to Syrian refugees (Circular 2013-8)[246]	08-Sep-13	
	Agreement between the European Union and the Republic of Turkey on the Readmission of Persons Residing without Authorization (7 May 2014)[247]	07-May-14	
	Foundation of the Directorate General of Migration Management under the Ministry of Interior with the Law on Foreigners and International Protection (7 May 2014) [248]	07-May-14	
	Temporary Protection Directive (22 October 2014) [249]	22-Oct-14	

[242]"Türkiye 2011'den bu yana 2.1 Milyon Suriyeli Mülteciye 8 Milyar Dolar Harcadı," *Hürriyet*, 29 October 2015, available at Türkiye 2011'den bu yana 2.1 milyon Suriyeli mülteciye 8 milyar dolar harcadı - Son Dakika Ekonomi Haberleri (hurriyet.com.tr), accessed on 11 February 2024.

[243]Turkish Ministry of Foreign Affairs, "Dışişleri Bakanı Davutoğlu "BM Güvenlik Konseyi'ni Daha fazla Geç Kalmadan İnsani Duruma Çözüm Bulacak Güçlü Bir Karar Almaya Çağırıyorum", 30 September 2013, available at Dışişleri Bakanı Davutoğlu "BM Güvenlik Konseyi'ni daha fazla geç kalmadan insani duruma çözüm bulacak güçlü bir karar almaya çağırıyorum" / T.C. Dışişleri Bakanlığı (mfa.gov.tr), accessed on 11 February 2024.

[244]"Dünyaya Örnek Bir Barınma Merkezi, Altınözü Boynuyoğun Geçici Barınma Merkezi," Türkiye Cumhuriyeti Altınözü Kaymakamlığı, 17 September 2018, available at Dünyaya Örnek Bir Barınma Merkezi, Altınözü Boynuyoğun Geçici Barınma Merkezi (altinozu.gov.tr), accessed on 28 November 2022.

[245]Yabancılar ve Uluslararası Koruma Kanunu, Law No: 6458, Resmi Gazete Date: 11 April 2013, No: 28615, Article 89-a, available at 1.5.6458.pdf (mevzuat.gov.tr), accessed on 26 November 2022.

[246]Türkiye Cumhuriyeti Başbakanlık, Afet ve Acil Durum Yönetimi Başkanlığı, Suriyeli Misafirlerin Sağlık ve Diğer Hizmetleri Hakkında Genelge, Circular No: 2013/8, Date: 8 September 2013, available at Suriyeli_Misafirlerin_Saglik_ve_Diger_Hizmetleri_Hakkinda_Genelge_20138.pdf (afad.gov.tr), accessed on 30 October 2023.

[247]Agreement between the European Union and the Republic of Turkey on the Readmission of Persons Residing without Authorization, Official Journal of the European Union Date: 7 May 2014, Number: L134/3, available at https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A22014A0507%2801%29&qid=1693815199982, accessed on 4 September 2023.

[248] "Başkanlık," Türkiye Cumhuriyeti İçişleri Bakanlığı Göç İdaresi Başkanlığı available at https://www.goc.gov.tr/baskanligin-gorevleri, accessed on 11 December 2022.

[249]Geçici Koruma Yönetmeliği, Law No: 6203, Resmi Gazete Date: 22 October 2014, No: 29153, available at 21.5.20146883.pdf (mevzuat.gov.tr), accessed on 18 March 2023.

Table 4.1. (continued)

Implementation Phase (2016- 2021)	Opening of the Refugee Health Training Centers, Opening of the Migrant Health Centers, Opening of Women and Girls Safe Spaces (starting from 2016)
	Turkish Ministry of Health- UNICEF and WHO Expanding Immunization Campaign (2017)

Within this context, Turkey's policy transfer in health service provision involved either the introduction of new institutions and policy arrangements, that was not available in Turkish healthcare system prior to the Syrian refugee crisis; or supporting existing mechanisms through different initiatives. All these initiatives led to different impacts in the Turkish healthcare system. Within this framework, all the three UN agencies (WHO, UNFPA and UNICEF) provided different outputs to the refugee health programs in Turkey and their program actions will be the focus of the next chapters of this thesis. These outputs resulted in different degrees of policy change in the Turkish healthcare system which was affected by the already existing grand Turkish politics on the policy areas that these agencies acted in. The foundation of Migrant Health Centers and Refugee Health Training Centers in the highly refugee populated cities of Turkey are a sort of paradigm change in the Turkish healthcare system which required an extensive legal and institutional amendment, and this process refers to what Hall names a third -order change.

Third order changes are defined as radical policy changes in policy making. [250] The employment of the Syrian health professionals and health mediators within the designed and implemented policy model is an important part of this third order change, as it is an integral part of the radical paradigm change in service provision. The foundation of the Women, Girls and Safe Spaces is a policy initiative introduced by the technical support of UNFPA, and it has led a second- order policy change in the Turkish healthcare without significantly changing the mode of service provision to women and girls. The awareness raising campaigns of UNICEF are only a sort of first order change in which the technical expertise of UNICEF provided enhancement

[250]Peter A. Hall, "Policy Paradigms, Social Learning, and the State: The Case of Economic Policy-making in Britain," *Comparative Politics*, Vol: 25, No: 3 (1993): 279.

in the existing available structures in the Turkish healthcare system. Although Hall's conceptualization of policy change is useful in understanding the nature of the policy change in analysis, it is worth to note here that this is still early to say that it is a complete paradigm change since "temporariness" is prevalent and uncertainty remains valid in the health domain of migration governance.

Next chapters are the case studies of the thesis. The same structure will be used for analysis within these chapters. Firstly, the policy sectors and then problem pressures brought by the migration crisis to the policy sectors will be analyzed and each chapter will continue with the analysis the policy capacities of the subject UN technical agency and conclude with investigating the role of the technical agency on the policy learning process.

CHAPTER 5

WHO AND PRIMARY LEVEL HEALTHCARE PROVISION FOR SYRIAN REFUGEES

This chapter is a case study to analyze the policy learning process led by the foundation of Refugee Health Training Centres within the high refugee-populated cities of Turkey and the training of Syrian health professionals in the Refugee Health Centers for providing healthcare to Syrian refugees and their employment in the Migrant Health Centers with a focus on what is learned and to what extent it is learned. In a recent article published in 2019, it is argued that the foundation of the Migrant Health Centers and employment of the Syrian health professionals within the centers is a policy learning process where “a modification in the actors' values and preferences” happened.[251] The focus of this chapter will be on the WHO inputs and to what extent and how these inputs led a policy learning process. WHO acted in analytical, operational, and political capacities here due to its technical role in organizing the adaptation training of the Syrian health professionals and the operationalization of the Refugee Health Training Centers.

Moreover, the Turkish government, in cooperation with WHO, added another model of healthcare service provision to elderly and disabled Syrian refugees, which extended the scope of Migrant Health Centres in Turkey. This model is the homecare service provision project for the refugee population and employment of the community healthcare staff within this project. The model of Migrant Health Centers and the employment of Syrian health professionals within these centers is not an adaptation of the before-implemented model to the Turkish context; instead, it is a new policy implementation instrument realized collaboratively with the Turkish government and WHO. This project also marks a different service provision method

[251] Yıldırım, Komsuoğlu, and Özekmekçi, "The Transformation of the Primary Health Care System, " *Asian and Pacific Migration Journal*, Vol: 28, No: 1 (2019):77.

for Syrian refugees within this framework. Moreover, the homecare project is also significant due to the extensive coordination expertise performed by WHO. Among all policy initiatives, the employment of foreign health professionals in a new healthcare model is the most radical change, and the role of WHO in this change requires special attention. This case study first makes a policy sector analysis to understand the nature of the policy learning process. Then, it discusses the pressures on this policy sector brought by migration. This process of policy learning is a voluntary policy change process in which the recipient country willingly accepted to cooperate with UN technical agencies to change its healthcare system to better respond to the emerging needs of the refugees and the pressures created on its healthcare system. Some specific challenges in the Turkish healthcare system make strengthening primary-level healthcare services instrumental. Moreover, the specific features of the policy sector were supported by the problem pressures brought by migration which will be discussed here. Another aim of this case study is to understand in which capacities WHO supported the policy learning process in which a third-order policy change (paradigmatic shift in healthcare provision) occurred. The following section moves to analyze the policy sector.

5.1. Strengthening Primary-Level Healthcare Services as a Policy Issue

Orientation of the Syrian health professionals in the Refugee Health Training Centers and their employment in the Migrant Health Centers through the orientation training are the fundamental output of WHO to refugee health governance in Turkey. Employment of foreign health professionals is rare among the refugee-hosting countries and the popular destination countries for the economic migration of health professionals. The model created in collaboration with the Turkish government and the WHO is a very new model which has fundamental differences from foreign healthcare professional procedures in other country contexts. The OECD data on the workforce policies in OECD countries shows that the health workforce migration from low-income to developed countries is a trend, and the USA and Great Britain are the most preferred destinations for health workforce migration.[252] Although there

[252]Organization for Economic Co-operation and Development, *OECD Health Policy Studies: Health Workforce Policies in OECD Countries: Right Jobs, Right Skills, Right Place* (Paris: OECD Publishing, 2016): 15.

are good practices of migrant health professional recruitment worldwide such as Norway, Sweden, United Kingdom, US[253], recruitment cases of refugee healthcare professionals are rare due to the unexpected nature of migration and the shocks it brings to the hosting societies and the lives of refugees. Countries allowing the recruitment of refugee healthcare professionals legally follow stages of proving diploma equivalency (through document submissions, examinations, or board decisions) and implementation of the orientation training programs. [254] These procedures are followed by a licensing procedure which takes up to two years. The education of healthcare staff is a lengthy and costly process, and healthcare professionals are essential parts of the skilled workforce of their countries. Integration of foreign healthcare professional into the host state's healthcare system requires additional resources due to the possible extra expenses on language training allowances during the orientation. Only some states are willing to finance and organize such processes in this framework. Different countries follow different procedures when recruiting foreign healthcare professionals; for example, Sweden devotes significant resources to adaptation processes, whereas the USA only spends a little on adaptation mechanisms and focuses more on recruitment and integration processes.[255] Within this context, the future of Syrian health professionals who fled Syria has been one of the questions left by the war. According to a report released by Physicians for Human Rights in 2015, 95 percent of the doctors in Eastern Aleppo were detained, killed, or fled. The war left little choices for the health professionals, but the status of the Syrian health professionals in the hosting countries varied significantly. [256]

A literature review regarding the health workforce of Syrians shows that in Lebanon and Jordan, there is no system for continuing professional development for Syrian

[253] Mehmet İnanç Özekmekçi, Ceren Ark Yıldırım, and Aysegul Komşuoğlu, "The Integration of Syrian Refugee Doctors into Turkish Health System: A Case of Good Practice in the Field of Refugee Employment," *Archives of Health Science and Research*, Vol: 7, No: 1 (2020): 88-90.

[254] Özekmekçi, Yıldırım, and Komşuoğlu, "The Integration of Syrian Refugee Doctors," 88-90.

[255] Vural Özdemir, Ilona Kickbusch, and Yavuz Coşkun, "Rethinking the Right to Work for Refugee Syrian Healthcare Professionals: A Call for Innovation in Global Governance," *British Medical Journal,* Vol: 357 (2017): 2.

[256] Physicians for Human Rights, "Physicians for Human Rights 2015 Annual Report," (2015):20, available at annual-report-2015.pdf (phr.org), accessed on 4 November 2023.

health professionals.[257] In these two countries, Syrians must follow the required procedures for any foreign nationality to practice their profession. However, refugee health professionals do not always leave their origin countries with full documentation, including diploma and certificates, which is an important impediment for licensing process. Research on the health professional employment in countries within the EU hosting and allowing the employment of Syrian refugee doctors, such as Germany[258] and Norway[259] shows that they follow lengthy procedures for licensing and integrating Syrian refugee health professionals, which is almost two years.

In Germany, there is the practice of performing as assisting doctor for two years with the temporary license gained after completing the equivalency process.[260] Some studies argue that the difficulties in collecting and submitting the whole documentation make the process very arduous for Syrian foreign health workers, as most of the documents are lost due to war conditions.[261] In Norway, the official integration phase starts after a positive decision on the claim is taken, and the process is followed by a two-year introductory program. Participants gain a monthly allowance while continuing Norwegian language training, schooling, and practical work training.[262] Prolonged orientation processes ensure full integration; however, these procedures may pressure the refugee health professional's financial situation and mental health.

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[257]Sharif A Ismail, Adam P. Coutts, Diana Rayes, Sophie Roborgh, Aula Abbara, Miriam Orcutt, Fouad M Fouad, Gladys Honein, Nour El Arnaout, Aya Noubani, Hana Nimer, and Spencer Rutherford, “Refugees, Healthcare and Crises: Informal Syrian Health Workers in Lebanon", *International Institute for Environment and Development*, Working Paper (2018): 17.

[258]Julika Loss, Yamen Aldoughle, Alexandra Sauter, and Julia von Sommoggy, "'Wait and Wait, That is the Only Thing They Can Say': A Qualitative Study Exploring Experiences of Immigrated Syrian Doctors Applying for Medical License in Germany," *BMC Health Services Research*, Vol: 20, No: 1 (2020): 10.

[259]Susanne Bygnes, "Not All Syrian Doctors Become Taxi Drivers: Stagnation and Continuity Among Highly Educated Syrians in Norway," *Journal of International Migration and Integration*, Vol: 22, No:1 (2021): 35.

[260]Loss, Aldoughle, Sauter, and von Sommoggy, ‘“Wait and Wait, That Is the Only Thing They Can Say,” 2.

[261]Loss, Aldoughle, Sauter, and von Sommoggy, ‘“Wait and Wait, That Is the Only Thing They Can Say,”7.

[262]Bygnes, “Not All Syrian Doctors Become Taxi Drivers,” 35.

In this framework, even highly- skilled refugee health professionals face social and economic difficulties in the process of full accreditation and earning a satisfactory income. These conditions affect their social and psychological well-being negatively.[263] The situation of refugee health professionals becomes even more challenging due to sudden fundamental changes in their lives. Moreover, this literature review on refugee health professional recruitments also shows that states directly run equivalency and orientation procedures, and non-governmental actors support the refugees individually, especially in stages of career development in some cases like the UK (the case of British Medical Association[264]).

Turkey followed a different model in recruiting Syrian refugee health professionals through collaborating with international actors and the EU funds given to orientation programme applied for Syrian refugee health professionals. The Directorate General for European Civil Protection and Humanitarian Aid Operations and the EU Trust funds funded the orientation programme organized and implemented by WHO. The Syrian refugee health professionals got employment in the Migrant Health Centres (187 Centres in 30 cities of Turkey founded within the scope of the Improving the Health Status of the Syrian Population under Temporary Protection and Related Services provided by Turkish authorities (SIHHAT Project). Turkey and WHO organized training of Syrian health professionals collaboratively. The Syrian health professionals who received training in the Refugee Health Training Centers are employed to provide healthcare to Syrians in the Migrant Health Centers of Turkey. Within this international cooperation model, approximately 2000 Syrian healthcare professionals, including 787 physicians, 34 dentists, and 1149 nurses who had to migrate to Turkey, have been employed in the Migrant Health Centers after completing the necessary adaptation training.[265] By 2023, with the support staff, the employed personnel numbers are approximately 4000 health professionals.[266]

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[263]Bygnes, "Not All Syrian Doctors Become Taxi Drivers," 1.

[264]"Help for Refugee Doctors", British Medical Association, available at Help for refugee doctors (bma.org.uk), accessed on 21 February 2024.

[265] "High-Level Meeting on Health and Migration in the WHO European Region was Held in Istanbul", *Republic of Türkiye, Ministry of Health*, 21 March 2022, available at https://www.saglik.gov.tr/EN,87716/high-level-meeting-on-health-and-migration-in-the-who-european-region-was-held-in-istanbul.html , accessed on 20 April 2022.

[266]European Commission, "Seven Annual Report of the Facility for Refugees in Turkey, 10.

WHO supported this network emerged as an alternative healthcare service provision to Syrian refugees in three main aspects. First and foremost, WHO supported the foundation of seven Refugee Health Training Centers (Photograph 4.1) across Turkey and provided medical supplies and equipment to these centers, as well as covering operating costs.[267] WHO organization also supported the Turkish Ministry of Health in organizing the training programs and providing refugees with allowance during the orientation process. The Refugee Health Training Centers inaugurated by WHO support later became model for the Migrant Health Centers of Turkey. WHO's support to state capacity in developing and applying such model and providing refugee health professionals with allowance during the orientation programme is a significant contribution to addressing the above difficulties discussed the refugees faced and strengthening to deal with an international crisis and it is in line with the global goals of the organization set in the Global Action Plan discussed earlier.

The impact of this model developed through the Turkish Ministry of Health and WHO is significant. There is a small body of literature that is concerned with the Syrian health professionals recruitment within Migrant Health Centers of Turkey.[268] This literature evaluates the employment of the Syrian health professionals positively, as their employment in the centers through the orientation training gave them their professional dignity back, with remaining concerns on some future problems that may emerge in the coming years due to the fast orientation of the refugee health professionals.[269] This cooperation between the Turkish government and WHO, indeed constitutes a significant change in the way of service provision as this model entailing employment of the Syrian health professionals and their employment in the Migrant Health Centers of Turkey provides an alternative method

[267] "Inauguration of Refugee Health Training Centre in Turkey," *Relief Web*, 16 May 2017, available at Inauguration of Refugee Health Training Centre in Turkey - Türkiye | ReliefWeb, accessed on 5 January 2024.

[268] Özdemir, Kickbusch, and Coşkun, "Rethinking the Right to Work for Refugee Syrian Healthcare Professionals," 1-4.; Basri Furkan Dağcıoğlu, Aylin Baydar Artantaş, Ahmet Keskin, İrep Karataş Eray, Yusuf Üstü, and Mehmet Uğurlu, "Social Adaptation Status of Syrian Refugee Physicians Living in Turkey," *Central European Journal of Public Health,* Vol: 28, No: 2 (2020), 149–154. ; Özekmekçi, Yıldırım and Komşuoğlu, "The Integration of Syrian Refugee Doctors," 87-94.; Yıldırım, Komsuoğlu, and Özekmekçi, "The Transformation of the Primary Health Care System,"75-96.

[269] Özekmekçi, Yıldırım and Komşuoğlu, "The Integration of Syrian Refugee Doctors," 92.

to the traditional was of healthcare provision in Turkey, although there are similarities between the Migrant Health Centers and Family Health Centers of Turkey. The government receptivity towards the employment of Syrian health professionals was high in Turkey compared to other hosting countries (Jordan and Lebanon) and for popular destination countries for the emigration of highly skilled health professionals (the US and the UK). Firstly, the political implications of foreign health professional employment must be understood to understand why the government receptivity was so high, as this led an extensive policy learning in providing primary level healthcare to refugees. There is also another integral part of the policy change in analysis, which is also an output of WHO to the refugee health programs in Turkey. The following section will analyze this integral part of service provision: homecare service provision to refugees.

5.2. Homecare Service Provision to Elderly Refugees and Refugees with Disabilities

Another important policy instrument developed through cooperation between the Turkish Ministry of Health and WHO is providing homecare services to Syrian refugees and employing Syrian women as healthcare staff within the scope of this project. Homecare is not directly related to healthcare provision as this service is more about supporting refugees in their needs for their personal care, but it is an instrument specifically designed for special needs of refugees responding to a need and impacting health status of refugees. Moreover, this method of service provision is not available in the Turkish healthcare system, but some municipalities in Turkey provide similar services to Turkish citizens such as the Istanbul Metropolitan Municipality.[270] It is a significant case in showing the policy capacities of WHO. It should be noted here that this project is not an EU-funded project. As discussed earlier, the EU was one of many significant donors of refugee health programs in Turkey. Other foreign donors provided grants to UN agencies as well. This specific project implemented in cooperation with WHO and Turkish Ministry of Health and its implementing partners is the Community Health Support Staff Project with

[270]"Evde Sağlık Hizmetleri", İstanbul Büyükşehir Belediyesi, available at EVDE SAĞLIK HİZMETİ | Sağlık Hizmetleri (ibb.istanbul), accessed on 21 February 2024.

German KfW Development Bank (Kreditanstalt Fur Wiederaufbau-KFW) funds. This project is an integral part of the subject policy transfer as it developed a service provision instrument for refugees and this model was not available in Turkish healthcare system. This intervention became a supportive mechanism for the SIHHAT Project and was designed for the emerging needs of the refugees.

As several studies show, disabilities among Syrian refugees are high due to conflict and war conditions, and due to some cultural values on marriage practices are among the reasons for the disabilities. Loss of limbs is prevalent among the refugee population due to the conflict and war conditions. Kinship marriage, also called consanguineous marriage, is common among Syrian refugees. According to the 2018 Turkey Demographic and Health Survey Syrian Migrant Sample, 46 percent of ever-married women aged 15-49 were related to their current husbands or last husbands (in case of divorces).[271] Moreover, some other studies also show that consanguineous marriage was traditionally high among Syrians before the war. The rates for consanguineous marriage were 39 percent of all marriages in Syria in 2009 (48 percent in rural areas and 32 percent in urban areas according to the 2011 data of the League of Arab States and the Syrian Arab Republic[272] Consanguineous marriage has negative health impacts on neonatal and infant health especially on disabilities. Moreover, conflicts and wars have interconnections with disabilities among conflict-affected populations.

The prevalent problems among Syrian refugee population were also realized by policy makers and project specialists. A project coordinator of one of the Migrant Health Centers from a non-governmental organization gave the below statements regarding observations on some problems regarding disabilities and anomalies among refugees at the beginning of the operation of the Migrant Health Centers. The project coordinator gave the below statement regarding how the model of homecare service model was designed:

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[271]Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey Syrian Migrant Sample* (Ankara: Elma Teknik Basım Matbaacılık, 2019), 34.

[272] "The Family Health Survey in the Syrian Arab Republic - 2009 (Arabic)" Cairo, Egypt , in Maia Sieverding, Caroline Krafft, Nasma Berri, and Caitlyn Keo, "Persistence and Change in Marriage Practices among Syrian Refugees in Jordan,"*Studies in Family Planning*, Vol: 51 No: 3 (2020), 228.

> There were already problems among Syrian refugees regarding healthcare services due to language barriers, health illiteracy regarding the Turkish healthcare system, as well as the rights under the temporary protection regime. However, refugees with disabilities face even more entrenched challenges, and we observed that these people were even more hesitant to visit the hospitals. Therefore, we planned a component under the ongoing WHO project on Refugee Health Training Centers.[273]

WHO designed and implemented the Community Health Support Staff (CHSS) project, funded by the German Government through KfW Development Bank, in cooperation with the Turkish Ministry of Health. WHO worked very closely with its implementing partners (Yeryüzü Doktorları, The Association for Solidarity with Asylum Seekers and Migrants, and The Association for Homecare and Social Health Services) and implemented the program in seven Refugee Health Training Centers. As of January 2020, 279 Community Health Support Staff were hired, and 815 refugees received homecare services within the scope of the project.[274]

One of the outstanding impacts of this project is the employment of Syrian women in the health sector. The research conducted in 2018 shows that female employment among Syrians was relatively low, at around nine percent.[275] The low employment among refugee women is due to cultural reasons and difficulties accessing the formal Turkish labor market. Research done with the health mediator staff, most of whom are refugee women, shows that the interviewees indicated their traditional societal/ cultural roles based on gender create an impediment to their employment. [276] This model created an opportunity for the involvement of refugee women in labor force, and accordingly the project created a life-changing opportunity for refugee women.[277] Within this framework employment of refugee women is an essential component of this project.

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[273]Interview 9, Association for Solidarity with Asylum Seekers and Migrants, İzmir, 16 August 2021.

[274]“The Story of Bashar: Helping Syrians under All Conditions,” World Health Organization Europe, 18 June 2018, available at The story of Bashar: helping Syrians under all conditions (who.int), accessed on 21 December 2023.

[275]Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey Syrian Migrant Sample*, 34.

[276]Kürşat Tutar, "Evde Bakım Hizmetinde Çalışan Kadın Göçmen İşgücünün İstihdam Deneyimleri: Ankara İli Örneği," *Bilge Uluslararası Sosyal Araştırmalar Dergisi*, Vol: 5, No:1 (2021): 5.

[277]Kürşat Tutar, "Evde Bakım Hizmetinde Çalışan Kadın Göçmen,” 8.

Another essential objective of this project was to increase the access of Syrian refugees with special needs (elderly and/ or people with disabilities) to healthcare services. The project staff, mainly composed of women refugees, received trainings on different subjects such as basic anatomy, patient caring and carrying techniques, as well as some administrative matters such patient confidentiality. Following these trainings, community health support staff found employment opportunities within the Refugee Health Training Centers. These staff basically supported elderly refugees and refugees with disabilities with their personal care, however, they did not provide directly healthcare services. Within this framework, this project is not a method for healthcare provision, but it is a "supportive mechanism to refugees with special needs on personal care".[278] In some cities, such as İzmir, the coverage of the project was extended to cover the physiotherapy and active life centers explicitly designed for the physiotherapy needs of the patients. The Project's WHO representative indicated in 2021 that "this WHO project in Turkey is important as this was a new model introduction to the Turkish healthcare system and its consequences in terms of the partnership coordination role of WHO is significant".[279] Therefore, this model needs to be considered as a support mechanism to WHO's technical role in primary level healthcare provision.

As discussed, this homecare model was not available in the Turkish healthcare system, and the national healthcare system involves home health services[280], which focuses on medical interventions, but not homecare services provided to elderly and disabled Syrian refugees, including personal care and home support. With this project designed and implemented for groups of refugees in the seven cities of Turkey, the collaboration between WHO and Turkey introduced a care model unavailable in the Turkish healthcare system. As one of WHO project coordinators indicated below, this project has introduced a new model to the Turkish healthcare system (at the time of the interview taken):

> This project has always been in the inventory of the Ministry of Health as a future projection. However, we understand that the conditions were not ready for the

[278] Interview 9, Association for Solidarity with Asylum Seekers and Migrants, İzmir, 16 August 2021.

[279] Interview 4, World Health Organization, Ankara, 12 February 2021.

[280] "Home Health Services," Republic of Türkiye Ministry of Health, available at Home Health Services (saglik.gov.tr), accessed on 21 December 2023.

> design of the home care model. Our project has been a pilot project for the Turkish healthcare system.[281]

As the homecare service model were only available to Syrian refugees within this project's scope, this project can be taken as only the introduction of a new policy instrument that was not available in the Turkish healthcare system before. However, as homecare services depended very much on fund availability and they are less likely to integrate into the Turkish healthcare system, WHO's cooperation with the Ministry of Health should not be considered a paradigm change in service provision toward disabled and elderly refugees with special needs. Still, this service provision model was very much supportive WHO's support in healthcare provision. To this aim, it can be considered part of the second-order change in which a new policy instrument is initiated to enable Syrian's efficient access to the available healthcare system.

Moreover, homecare service provision was less instrumental than the employment of foreign health professionals, and its durability does not signal a full integration into the Turkish healthcare system. Within this framework, fund availability and WHO's technical expertise led to the introduction of such policy instruments. The provision of homecare services also provides significant insight into the technical knowledge of WHO, especially in terms of its impact on extending the policy-making sphere to non-state implementing partners of WHO. WHO undertook a significant coordination role in implementing this project and integrating a new model into the Turkish healthcare system. The technical outputs of WHO have broader implications in terms of its agency in the refugee health governance structures in Turkey. The following section will analyze the problem pressure on primary-level healthcare services before moving to discuss the policy capacity of WHO in light of the role taken by WHO both within this project discussed, and WHO's support in foreign refugee health professional employment.

5.3. Strenghtening Primary-Level Healthcare Services for Syrian Refugees

Unexpected mass influx of Syrians into Turkey with approximate numbers of 3,274,059 registered Syrian refugees[282] over the last 12 years caught country's health

[281]Interview 4, World Health Organization, Ankara, 12 February 2021.

sector unprepared. Turkish healthcare system shows a high percentage of healthcare coverage of the population, which is 99.2 percent, and a considerable improvement in life expectancy compared to previous years and the OECD average rates for life expectancy age which is 78. [283] The reforms taken since 2013 aimed to cover most of the population and to improve health coverage and the share of the private sector. Every individual residing in Turkey including Syrian refugees require to be registered with the General Health Insurance Scheme.[284]

However, the country does not rank among the best regarding health spending and the quantity of healthcare professionals, including doctors and nurses. According to the World Bank data, Turkey ranks among the least devoting health spendings as of GDP (4.34 percent) (Table 5.1.). Moreover, the number of doctors and nurses per 1.000 patients ranks low, almost two doctors/ nurses per 1.000 patients (Table 5.2.).

In that sense, the Turkish healthcare system is characterized by low health expenditures (%GDP), low numbers of healthcare professionals (per 1000 patients), and an increasing share of the private sector in service provision through the Health Transformation Program started in 2013[285].

However, it is note to worth here that figures like, number of health professionals per a sample of patient is not always the best to reflect on the quality of healthcare provision in the countries. However, considering this with other indicator such as the health expenditures may provide better insights. Table 5.1. and 5.2. provides some insight to the situation of healthcare services in Turkey.

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[282] "Data Registered Syrian Refugees by Date" UNHCR, available at https://data2.unhcr.org/en/situations/syria/location/113, accessed on 23 November 2023.

[283] "Data- Life Expectancy at Birth total (years), Türkiye," the World Bank, available at https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=TR, accessed on 29 April 2022.

[284] Yabancılar ve Uluslararası Koruma Kanunu, Law No: 6458, Resmi Gazete Date: 11 April 2013, No: 28615, Section 4, Article 91-1, available at 1.5.6458.pdf (mevzuat.gov.tr), accessed on 26 November 2022.

[285] Mehtap Tatar, Salih Mollahalılıoğlu, Bayram Şahin, Sabahattin Aydın, Anna Maresso, and Cristina Hernández-Quevedo, "Turkey. Health System Review", *Health Systems in Transition*, Vol 13, No: 6 (2011), xiii.

Table 5. 1. Health Expenditure (%GDP). [286]

Country - Year	**2017**	**2018**	**2019**
Austria	10.38	10.32	10.43
China	5.07	5.17	5.35
European Union	9.88	9.87	9.92
Germany	11.33	11.45	11.7
India	2.94	2.95	3.01
Norway	10.32	10.02	10.52
OECD members	12.37	12.34	12.53
Turkey	**4.18**	**4.12**	**4.34**
United Kingdom	9.81	9.9	10.15
United States	16.81	16.69	16.77

Table 5. 2. Number of Health Professionals (doctors and nurses) per 1000 patients (for 2019). [287]

Country	**Number of health professionals per 1000 patients**
Austria	5.32
China	2.24
Germany	4.39
Great Britain	2.95
India	0.93
Norway	4.97
Turkey	**1.95**
United States of America	2.64

In addition to the above challenges, societal and cultural barriers (such as language barriers) faced by the refugees paved the way for seeking new ways of service provision for Turkey. Most of the interviewees interviewed for this study stated that

[286] "Current Health Expenditure (%of GDP)- Türkiye," The World Bank available at https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=TR, accessed on 25 April 2022.

[287] "Data- Physicians (per 1000 Patients)," The World Bank, available at https://data.worldbank.org/indicator/SH.MED.PHYS.ZS , accessed on 25 April 2022.

there was a need for new solutions.[288] Before the Migrant Health Centers, the refugees faced several problems and challenges, and the most important ones were language barriers, health illiteracy, and insufficient knowledge of the Turkish healthcare system.[289] Since the family practicians model introduced in 2005 was not familiar to Syrians as it was not available in the Syrian healthcare system before the war, Syrians were not well-informed on how to utilize the protective and primary level healthcare facilities in Turkey. Moreover, some studies and primary data of this thesis show that refugees may have had the fear of deportation in case of using health facilities and applying to the public authorities.[290] The same anxieties and health problems among UN refugees under UNHCR protection before the mass influx of Syrians into Turkey were prevalent in Turkey, as a study done with UN refugees benefiting from healthcare services from the primary healthcare facilities in Turkey shows.[291] Therefore, the problems faced by the Syrian refugees show similarities with the ones all around the world, and the difficulties are the continuation of the immigration history of Turkey. However, the increasing number of refugees coming to Turkey, which made the country hosting the largest refugee population in the world, deepened and worsened the situation in various aspects.

Another less-mentioned factor in the literature, but not a less important one, is the emotional stress imposed on Turkish healthcare staff due to their lack of knowledge on treating the refugees, who were going through trauma, cultural shocks, and orientation problems. Some of the literature analyzing the emotional stress of treating refugee patients in different refugee-hosting countries refers to this as a significant problem that emerged with mass migrations imposing a burden on the hosting healthcare systems.[292] For example, the doctors interviewed for this research gave

[288] Interview 1, the Turkish Ministry of Health, Ankara, 15 February 2021; Interview 2, the Turkish Ministry of Health, Ankara, 8 February 2021; Interview 3, World Health Organization, Ankara, 10 February 2021; Interview 4, World Health Organization, Ankara, 12 February 2021.

[289] Türk Tabipleri Birliği, *Savaş Göç ve Sağlık* (Ankara, Türk Tabipleri Birliği Yayınları, 2016), 96.

[290] Nurtaç Kavukçu, and Kerim Hakan Altıntaş, "The Challenges of the Health Care Providers in Refugee Settings: A Systematic Review", *Prehospital and Disaster Medicine*, Vol: 34, No: 2 (2019), 194.

[291] Hakan Yaman, Altuğ Kut, Aylin Yaman, and Mehmet Ungan, "Health Problems among UN Refugees at a Family Medical Centre in Ankara, Turkey", *Scandinavian Journal of Primary Health Care*, Vol: 20, No: 2 (2002), 85.

[292] Kavukçu and Altıntaş, “The Challenges of the Health Care Providers,” 194.

similar statements that it was emotionally tiring to try to understand and treat someone who does not understand Turkish and carries distinct cultural behaviors in utilizing the healthcare services. Additionally, language barriers and the already excessive workload imposed, which increased incrementally over the years since the inception of the health reform program in Turkey, overall put a heavy burden on the healthcare system and healthcare workers.

Moreover, Turkish public sentiments towards Syrians were not extensively positive with the accumulation of Syrians at the secondary level healthcare entities due to their inadequate knowledge of the healthcare services and low utilization of the primary level healthcare facilities. The public arguments evolved around the discourse of the Syrians benefiting from the health services free of charge without waiting in long queues. [293]Another important but more covert impediment against Syrian's utilization of primary-level healthcare services was the criteria of performance available in the model of family practitioners in Turkey. According to this criterion, showing high performance through intense follow-up on their patients leads to an increase in the salary of the family practitioners. This criterion created a source of anxiety on the side of the Turkish family practitioners, and it led to an unwillingness to treat refugee patients, which has shown high mobility within Turkey due to the prominent level of refugee poverty and concerns over earning livelihood through changing cities. The difficulty of following up on children's vaccinations created a concern among Turkish family practitioners that it may have reduced their earnings and overall performance score. [294]

In this framework, the societal effects of deepening health access problems of refugees, increasing financial difficulties, healthcare attrition among Turkish healthcare professionals, and increasing public reactions were very likely to cause either an increase in societal tensions between the Turkish public and refugees, worse, to lead refugees preferring not to visit curative healthcare services before

[293] "Yanlış Bilgiler Krizi Büyütüyor," *Birgün*, 22 April 2022, available at https://www.birgun.net/amp/haber/yanlis-bilgiler-krizi-buyutuyor-385192, available at https://www.birgun.net/amp/haber/yanlis-bilgiler-krizi-buyutuyor-385192 , accessed on 25 April 2022.

[294]Interview 7, UNICEF, Ankara, 15 January 2021.

having had serious emergencies which could have irreparable effects on maternal/newborn health and also could end up with increasing refugee patients in secondary level healthcare facilities. The challenges created significant impediments for refugees to enjoy fully the right to health. As a response to the challenges mentioned above and increasing tensions, Turkey change the mode of healthcare provision from the paradigm of expecting migrants to adapt to the traditional primary healthcare system designed for the native population (Family Health Centers Model) to a refuge friendly system staffed with Syrian healthcare workers in cooperation with the international actors.[295] Turkey released several circulars to regulate the health services provided to Syrians under temporary protection and made several institutional changes to change the mode of healthcare service provision as discussed earlier. The employment of Syrian healthcare professionals was the most critical component of this paradigm shift.

FRIT, as mentioned, provided the impetus for the institutional and legal changes for the foundation of the Migrant Health Centers. However, this was not the legal instrument for employment of Syrian healthcare staff. It is worth noting here that the legislative changes happened before the Facility Tranche funding began. An amendment was issued to International Workforce Law numbered 6735 on 1 April 2017, abolishing the requirement of providing equivalency of diploma/ certificate in case of loss for Syrian health professionals to provide health care for refugees.[296] This was provided as a solution to the difficulties of providing required documents due to the conditions of escape from war. Foreign healthcare professional employment was allowed by Turkish law before the arrivals of Syrians to Turkey. Foreign health professional recruitment became possible with the change brought as per the Decree Law numbered 663 published in November 2011.[297] This Decree Law

[295]Yıldırım, Komşuoğlu, and Özekmekçi, "The Transformation of the Primary Health Care System," 79.

[296]Yabancı Sağlık Meslek Mensuplarının Türkiye'de Özel Sağlık Kuruluşlarında Çalışma Usul ve Esaslarına Dair Yönetmelikte Değişiklik Yapılmasına Dair Yönetmelik, Directive No: 30025, Resmi Gazete Date: 22 February 2012, No: 28212, available at Başbakanlık Mevzuatı Geliştirme ve Yayın Genel Müdürlüğü (resmigazete.gov.tr), accessed on 23 November 2023., in European Commission, "Strategic Mid- Term Evaluation of the Facility," 28.

[297]Sağlık Alanında Bazı Düzenlemeler Hakkında Kanun Hükmünde Kararname, Decree Law No: 663, Resmi Gazete Date: 2 November 2011, No: 28193, available at 4.5.663.pdf (mevzuat.gov.tr), accessed on 20 February 2023.

changed the expression of Turkish physicians in the article 4 of the Law dated 11 April 1928 and numbered 1219 on the Execution of the Methods of Medical and Medical Profession to physicians. This change legalized foreign health professional employment in Turkey. [298] The legal amendment provided in 2017 only eased the process of foreign healthcare professional employment extensively without any similar model in other refugee hosting countries.

As a result of Turkey's concerns over the pressures on its healthcare system and the availability of EU funds, a certification earned through a specially designed orientation training with theory and practice courses would suffice for the employment of the Syrian health care staff to work under contracts provided by SIHHAT Project.[299] This legal amendment to International Workforce Law ensured the employment of Syrian healthcare professionals within the Migrant Health Centers without seeking the obligation of proving their diplomas in cases of loss, instead they were examined on their professional competencies by the Turkish Ministry of Health. Migrant Health Centers and the employment of Syrian health professionals shifted the mode of healthcare service provision in Turkey, and WHO played key roles in this process. The following section aims to focus on the agency of WHO by analyzing its technical expertise and policy capacities in all these interventions, leading to a change in the mode of health service provision towards Syrian refugees.

5.4. Understanding the Technical Expertise of WHO

As discussed, mitigating the financial and social tensions caused by the mass arrivals has been a concern for Turkey. The total EU funds dispersed for the health sector is 300 million Euros. [300] The donor contribution spent for the actual cost of the operationalization of the Migrant Health Centers and all the total health expenditures

[298] İpek Özkal Sayan, and Aziz Küçük, "Türkiye'de Kamu Personeli İstihdamında Dönüşüm: Sağlık Bakanlığı Örneği," *Ankara Üniversitesi SBF Dergisi*, Vol: 67, No:1 (2012), 194.

[299] European Commission," Strategic Mid-Term Evaluation of the Facility," 28.

[300] For details, "SIHHAT Project,"*SIHHAT*, available at http://www.sihhatproject.org/ , accessed on 20 April 2022.

for refugee health is far below the actual spending made by the host country. However, its impact in changing the course of primary-level healthcare service provision with specific consideration on responding to the health needs of the refugees is significant. Although the Turkish government did not announce the data publicly, the Turkish President, Recep Tayyip Erdoğan, mentioned the total spending in one of his speeches in the health sector as 40 billion dollars as of 2019.[301] However, a calculation methodology developed based on the data provided by the data regarding the services offered by the Directorate General of Public Health (*Halk Sağlığı Genel Müdürlüğü*) has found that Turkey was likely to spend 70 billion dollars already in 2018 on refugee health.[302] Amidst all these ambiguities in numbers, the donor contribution of 300 million Euros remains significantly less proportional than those spent by the host country. However, its impact on implementing the model addressing the health needs of the refugees is significant. The interview data of this research shows that the state authorities appreciate its effects on reducing the pressure on the healthcare system, and its impact on reducing inequalities is significant. As remarked by a Ministry of Health staff interviewed:

> Although total foreign funds are much less than the actual budget the Turkish state devoted, it is an invaluable foreign contribution, and it created a solution to the policy problems that this migration crisis led to in domestic politics. Without the donor contributions, the Turkish state may not have designed and implemented such a model addressing the health needs of the refugees. [303]

As underlined in the Global Action Plan of WHO, WHO claims to have a constitutional function as a coordinating authority with a leadership role in international health work and ensuring the health of all.[304] In its Global Action Plan for 2019 and 2023, WHO emphasizes its commitment to provide the right to health

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[301] "Cumhurbaşkanı Erdoğan: Mültecilere 40 milyar Dolar Destek Verdik", *Sözcü*, 18 November 2019, available at Cumhurbaşkanı Erdoğan: Mültecilere 40 milyar dolar destek verdik (sozcu.com.tr), accessed on 9 December 2023.

[302] İbrahim Mazman, and Lale İzci, "Ulusal ve Uluslararası Örgütler Tarafından Desteklenen Suriyeli Göçmenler", *Journal of Institute of Economic Development and Social Researches*, Vol:4 ,No:9 (2018): 283.

[303] Interview 1, the Turkish Ministry of Health, Ankara, 15 February 2021.

[304] World Health Organization, "Seventy-Second World Health Assembly, Promoting the Health of Refugees and Migrants, Draft Global Action Plan, 2019- 2023," A72/25 Rev.1. 23 May 2019, available at A72_25Rev1-en.pdf (who.int), accessed on 21 November 2023.

for all in migration situations. As argued earlier, migrant/ refugee health is not directly within the mandate of WHO. However, through this report, WHO shows commitment to program its operations in line with health for all paradigms, including the refugees. In this framework, becoming an authority and increasing international health coverage is a core aim of WHO. However, this model created through the cooperation of the WHO is much more of a technical assistance.

As discussed in the previous parts, the discussed projects implemented by the cooperation of the Turkish Ministry of Health and WHO led a paradigmatic change in the Turkish healthcare system. The below table (Table 5.3.) summarizes on what policy capacities WHO contributed to this policy learning process (described as third order policy change). The policy change in the below text box also shows the fundamental differences emerged in operational, analytical, and political policy capacities of the host country by showing the period before and after development of policy instruments developed through orientation trainings given to Syrian health professionals and start of healthcare provision to Syrian refugees by Syrian health professionals in the Migrant Health Centers (EU funded and Turkish government and WHO implemented healthcare provision model).

Table 5. 3. Provision of Primary Level Healthcare to Syrian Refugees.

	WHO	**T_0[305]**	**T_1[306]**
Analytical Policy Capacity	*Research, surveys, and reports on focusing on primary level healthcare access of Syrian refugees and employment of Syrian health professionals.	* Preliminary field surveys and research conducted by Turkish Ministry of Interior Disaster and Emergency Management Presidency, and the Turkish Medical Association. *Preliminary knowledge on the health status of Syrians.	*Advancing knowledge on the health status of Syrian refugee health professionals and Syrian health professional employment.

[305] T_0: Before orientation trainings given to Syrian health professionals and start of healthcare provision to Syrian refugees by Syrian health professionals in the Migrant Health Centers (EU funded and Turkish government and WHO implemented healthcare provision model).

[306] T_1: After orientation trainings given to Syrian health professionals and start of healthcare provision to Syrian refugees by Syrian health professionals in the Migrant Health Centers (EU funded and Turkish government and WHO implemented healthcare provision model).

Table 5.3. (continued)

Operational Policy Capacity	*Direct organization of the one- week practical and six-week theoretical orientation trainings given to Syrian health professional by the University of Health Sciences academics. * Operationalization of the Refugee Health Training Centres (venue of the trainings and primary level healthcare provision).	*Foreign health professional employment through licencing and equivalency procedures, after 2 November 2011 with the Decree Law numbered 663 and date 2 November 2011.	*Special regulation in easing employment for Syrian health professionals in the Migrant Health Centres after relatively short orientation period. *An alternative refugee- friendly healthcare provision to Syrian refugees.
Political Policy Capacity	*Strong donor contribution and collaboration with host state. *Strong coordination expertise between state and non- state actors.	*Refugees, migrants, and all foreigners are involved in the transition from state financed healthcare provision to individually contributed and privatized healthcare provision.	*EU, BPRM and foreign government funds given to financing of Migrant Health Centers, Refugee Health Training Centers and employment of Syrian health professionals in these facilities. *Civil society involvement in the operationalization of the new methods in providing healthcare services to Syrian refugees.
	Technical Role of the WHO	Paradigmatic Shift between T_0 and T_1 (Third Order Policy Change)	

As might be seen from this table, WHO's analytical, operational and political policy capacities provided resources for the paradigm shift in the primary level healthcare

provision at several aspects. The interview data of this thesis regarding the migration crisis in Turkey shows that WHO indeed applied an extensive coordination expertise between the host state, donor organizations, and civil society partners, which marks its political capacity as defined in the analytical framework of this research. Most of the interviewees of this thesis gave very affirmative statements that WHO played such an influential role in this structure, and some of the Turkish Ministry of Health representatives mentioned WHO as the primary stakeholder of the Turkish Ministry of Health.[307] In addition to the Ministry of Health representatives, the WHO's NGO partners gave similar statements regarding the role WHO played in this overall framework and its position on supporting their institutional capacities. WHO's expanding the sphere of health governance to the involvement of non-governmental actors is another critical function it undertook.

WHO collaborated with three prominent NGOs (*Yeryüzü Doktorları*, The Association for Solidarity with Asylum Seekers and Migrants, and The Association for Homecare and Social Health Services) in the refugee-populated seven cities. Some of these cities are Istanbul, Gaziantep, Şanlıurfa and Hatay, which are the most refugee-populated cities of Turkey, hosting 542,045, 462,697, 430,124, 433,875, respectively for 2023. [308] These NGOs and WHO collaborated on the operationalization of the Refugee Health Training Centres and the recruitment of Syrian refugees in the framework of the project on homecare service provision to refugees.[309]Although some studies argue that the operationalization of the Migrant Health Centers dramatically decreased the role of the NGOs, which undertook essential functions in the phases of the reception of the Syrian refugees, [310] however the interview data of this research shows the NGOs started to take a role in a more

[307]Interview 1, the Turkish Ministry of Health, Ankara,15 February 2021; Interview 2, the Turkish Ministry of Health, Ankara, 8 February 2021.

[308]Türkiye Cumhuriyeti İç İşleri Bakanlığı Göç İdaresi Başkanlığı, "Geçici Koruma, Yıllara Göre Geçici Koruma Kapsamındaki Suriyeliler,"available at https://www.goc.gov.tr/gecici-koruma5638, accessed on 28 April 2022.

[309] "Syrian Healthcare Workers Respond to the Health Needs of Refugees in Turkey," World Health Organization, 11 March 2021, available at Syrian health-care workers respond to the health needs of refugees in Turkey (who.int), accessed on 20 April 2022.

[310] Özekemkçi, Yıldırım and Komşuoğlu," The Integration of Syrian Refugee Doctors," 91.

standardized way after the inception of the SIHHAT Project with the capacity-building support of WHO and other UN agencies such as UNFPA.

The interviews taken by the NGO representatives working in the operationalization of the Migrant Health Centers show that WHO played a crucial role in bridging their relations with the public bodies, and WHO also supported their institutional capacity in adapting their internal working mechanisms with the UN and Turkish state bureaucracy. These functions refer to the coordination expertise of WHO, which contributed to the expansion of the governance area to its implementing partners. In this framework, WHO acted as an essential agent of policy learning on the matters bringing the state apparatuses and civil society actors together. In addition to broadening the governance schemes, the perceptions of different agents for WHO's coordinating role show that this coordinating role reinforces WHO's authority based on its technical expertise. Therefore, Turkey's collaboration with civil society is part of the policy change that occurred in the healthcare system. Within this framework, WHO also supported NGOs to be compelling actors. Moreover, most of the interlocutors from different NGO partners of WHO gave affirmative remarks in capacity building training provided by WHO to their organization, which affected their organizational culture positively. One of the interviewees gave the following statement:

> WHO played a significant role in the emerging organizational culture of our association. Thanks to the working guidelines and formats of WHO, we have learned how to work with donor organizations and state institutions. Before the migration cooperation operations, our monetary management needed to be institutionalized. Now we have developed an organizational capacity in financial management. [311]

State institutions has been the most influential actor in the administrative structure in Turkey, in which non-governmental actors had little role to play in. [312] Likewise, Turkey's traditional health administration does not show a civil society engagement in decision-making and operation phases. Therefore, collaborating and effectively communicating with civil society in sensitive sectors concerning public good, such as health, has been a rare situation in Turkey. Only medical associations like the

[311]Interview 11, Yeryüzü Doktorları, Istanbul, 28 October 2021.

[312] Yunus Turhan, and Şerif Onur Bahçecik, "The Agency of Faith-Based NGOs In Turkish Humanitarian Aid Policy and Practice,"*Turkish Studies*, Vol: 22, No:1 (2021): 144.

Turkish Medical Association (Türk Tabipler Birliği) providing technical information in matters concerning public health have traditionally been involved in public health matters. Most of the Turkish Medical Association members are already or former Ministry of Health staff. Although recent health sector reform in Turkey opened the health sector to the participation of different actors, such as the Association of Private Hospitals (Özel Hastaneler Birliği), this sector was still conservative regarding the involvement of various actors before the migration crisis. In this framework, WHO played an essential role in including non-traditional non-state actors in the health governance by bringing non-traditional partners together and, therefore, pooling different expertise for managing its refugee health programs.

In this matter, WHO organized regular meetings with the participation of civil society and NGO partners and ensured the active involvement of various civil society organizations in WHO-implemented interventions. Participation of civil society organizations in this process is significant in terms of opening the area of health to the participation of actors other than state and market actors. In the framework of refugee health governance in Turkey, some NGOs with specific political approach differentiations from government policy orientation gained the opportunity to be active in the significant projects/ programs and their voices to be heard. One of the project coordinators gave the below statement, which may explain how these meetings can allow civil society agents to make their voices heard:

> WHO became a bridge between civil society actors and public institutions with limited co-working experience. Moreover, WHO undertook a mediator role between civil society and state institutions in differentiating approaches.[313]

As discussed earlier, pooling large amount of EU and foreign government funds to its refugee health programs provides not only financial resources for WHO activities but also a strong political policy capacity for the organization. The EU funds pooled here transforms the mode of healthcare provision towards Syrian refugees, as such the World Bank credits transformed the primary level healthcare provision in Turkey through Health Transition Program started in 2003. The coordination expertise applied by WHO leads more active civil society engagement in primary level healthcare provision.

[313]Interview 9, Association for Solidarity with Asylum Seekers and Migrants, İzmir, 16 August 2021.

As discussed, political policy capacity is an important part of the overall policy capacity of the organization. However, operational policy capacities of the organization lie at the very core of the technical role the organization undertook which led the paradigmatic shift in the methods of healthcare provision. Within this framework, WHO applied an extensive outsourcing expertise to organize the trainings given to Syrian health professionals. WHO outsourced several aspects of the employment process in this model. Firstly, WHO designed and implemented the adaptation trainings for Syrian doctors, nurses, mental health, and psychosocial workers in cooperation with the University of Health Sciences in Ankara (Sağlık Bilimleri Üniversitesi). The content of this training was related to the general provisions and rules available in the Turkish healthcare system. The university members of the University of Health Sciences in Ankara gave the practical parts of the trainings and designed the curriculum.

WHO implemented the organization, financial management, and delivery of the trainings in collaboration with the Turkish Ministry of Health. Syrian refugee health professionals (doctors and nurses) who passed the exams conducted by the Turkish authorities received a one-week theoretical course and a six-week on-the-job follow-up training course. During the practical stage, the Turkish health professionals with supervisory functions worked with their Syrian peers, and later, the Syrian refugee health professionals started to provide healthcare services for refugees in seven WHO-supported Refugee Health Training Centres in the seven refugee-populated cities of Turkey. After the candidate Syrian health professionals completed the trainings, these professionals received their certificates, and later, they got employed by the Turkish Ministry of Health in the Migrant Health Centers across Turkey.[314] Moreover, WHO supported the training of homecare staff for a model designed for homecare service provision to Syrian refugees. [315]

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[314] Pavel Ursu, Dorit Nitzan, Serap Şener, Bahadır Sucaklı, Murat Şimşek, Mërkur Beqiri, Matteo Dembech, Akfer Karaoğlan Kahiloğulları, and Altin Malaj, "Protracted Emergency in Turkey-Supporting Provision of Essential Health Services to Syrians under Temporary Protection", *Public Health Panorama*, Vol:4, No: 1 (2018), 121–22.

[315] "Syrian Healthcare Workers Respond to the Health Needs of Refugees in Turkey," World Health Organization, available at https://www.euro.who.int/en/countries/turkey/news/news/2021/3/syrian-health-care-workers-respond-to-the-health-needs-of-refugees-in-turkey, accessed on 6 April 2022.

As argued before, the orientation process in other national contexts is run and managed by public and non-governmental bodies, and non-governmental organizations provide some support to public institutions. For example, the British Medical Association provides career consultancy to candidates selected by the authorities in the UK.[316] Compared to other examples, WHO conducted an extremely critical function in the case of the recruitment of Syrian professionals in Turkey. Moreover, the Ministry of Health used the service provision model of Refugee Health Training Centres, founded in the seven centers, to design and establish the Migrant Health Centers, founded in 30 cities later.[317] In this framework, WHO played a crucial role in the model's overall design and the refugee professionals' adaptation. As stated by the Ministry of Health staff in the below statement and similar statements from other stakeholders of WHO, it played a crucial role in the employment of Syrian health professionals in Migrant Health Centers:

> The most essential health intervention is the employment of Syrian health professionals in the Turkish healthcare system. Their employment gave them the right to practice their professions, gain their societal reputation, and support their people while taking the burden put on the Turkish healthcare system. With this project, Syrians' visits to primary-level healthcare facilities have increased, which reduced the pressures on secondary-level healthcare systems.[318]

As might be seen from these statements, the partners, and stakeholders of WHO regarded the outputs. However, these trainings also raised concerns about whether such an expedited orientation would be sufficient for integrating the Syrian health professionals. [319] Still, it was a very influential model in addressing the abovementioned problems. In this framework, the interview data of the research shows that WHO has been an influential actor. WHO's work on organizing the orientation process is also significant in addressing the challenges the refugee health professional might have faced during the orientation phase. Considering that only 4.34 percent of the national GDP of Turkey is devoted to healthcare services, which

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[316]Özekmekçi, Yıldırım and Komşuoğlu,"The Integration of Syrian Refugee Doctors," 90.

[317] Ursu, Nitzan, Şener, Sucaklı, Şimşek, Beqiri, Dembech, Kahiloğulları, and Malaj, "Protracted Emergency in Turkey-Supporting," 121-122.

[318] Interview 1, the Turkish Ministry of Health, Ankara, 15 February 2021.

[319] Özekmekçi, Yıldırım, and Komşuoğlu, "The Integration of Syrian Refugee Doctors," 92.

ranks the country low among OECD countries, the Turkish state may not be willing to increase public spending on recruiting Syrian refugee doctors and nurses. Therefore, WHO's work on this supported the host country in financing the orientation processes. Although these functions of WHO did not directly address the uncertainty dominating the future integration of health professionals, WHO still took some actions to address the problem of the future integration of refugee health professionals directly. Within this framework, the model developed through the collaboration between WHO and the Turkish Ministry of Health led a very fundamental shift in the methods of primary level healthcare provision.

The analytical policy capacities of WHO was also quite significant in rationalizing refugee health professional employment. To address the future integration problems, WHO acted as a constant knowledge provider through quantitative and qualitative reports, surveys, and interviews it conducted concerning "the status of the Refugee Health Trainings"[320], satisfaction of the Syrian health professionals with trainings received, factors affecting the employability of refugee Syrian healthcare professionals in Turkey etc. These research and evidence-based knowledge provision capacities and capabilities of the organization refer to analytical capacities, which are essential in policy learning. For example, its well-known "report on the health status of Syrians"[321] was very influential in guiding the health policies in Turkey and used by the Turkish Ministry of Health to design public health interventions in support of vaccination campaigns for Syrian refugee children as stated in an article written by WHO representatives.[322] All these are essential initiatives in response to the issues of the future integration of the Migrant Health Centers and the recruitment of Syrian health professionals.

All these should be considered steps forward for the future integration of Syrian healthcare professionals. Therefore, WHO is also in communication with Turkey's

[320] Ursu, Nitzan, Şener, Sucaklı, Şimşek, Beqiri, Dembech, Kahiloğulları, and Malaj, "Protracted Emergency in Turkey-Supporting.".

[321] Mipatrani, Balcılar, Dembech, Ergüder, and Uslu, *Survey on the Health Status, Services Utilization and Determinants of Health of the Syrian Refugee Population in Turkey* (Ankara: World Health Organization, 2019).

[322] Ursu, Nitzan, Şener, Sucaklı, Şimşek, Beqiri, Dembech, Kahiloğulları, and Malaj, "Protracted Emergency in Turkey-Supporting,"120.

core policy on migration governance, which is based on the Temporary Protection regime. In this framework, WHO continued to provide outputs for future and further integration, which the temporary protection regime does not guarantee. Moreover, through its partnership with civil society organization and their organization of the employment of health mediators, it created an outreach capacity for the work of WHO. Through creating platforms reaching out to those in need, such as elderly refugees or refugees with disabilities, the homecare services project also created a trustable connection between the beneficiaries and the service providers. The Migrant Health Centers also created a trustable environment for the refugees by eliminating most of the cultural and language-related difficulties surrounding refugees' access to healthcare services. However, the issues surrounding the future integration of health professionals still need to be solved. Within this context, the partnership of WHO with the civil society actors created outreach for service provision. All these show that WHO applied outsourcing, coordination, empirical, and outreach expertise, which refers to the organization's analytical, operational, and political capacities as discussed.

5.5. Policy Outcomes and Degree of Policy Learning

This chapter analyzed WHO's technical expertise and its role in policy change through the design and implementation of the Migrant Health Centres (MHCs) and the employment of Syrian refugee health professionals within these centers. The recent literature shows that long orientation processes may result in different challenges and inequalities for refugee health professionals. It may have an additional negative impact on their mental health and financial situation.[323] Through the orientation program for the refugee health professionals, WHO outsourced an important activity through this model in Turkey and eased the process for both the host country and refugee health professionals. Moreover, the Refugee Training Centres that the refugees received the trainings have been used as a model for the design of 187 Migrant Health Centers founded in 30 cities of Turkey in collaboration with WHO.

[323] Bygnes, “Not All Syrian Doctors Become Taxi Drivers,” 33-46.; Loss, Aldoughle, Sauter, and von Sommoggy,‘“Wait and Wait, That Is the Only Thing They Can Say,”1-12.

The employment of refugee health professionals in centers also applied an outreach function through increasing the visits to centers by Syrians. Moreover, WHO research and knowledge provision activities through its analytical capacities created an impactful resource on the benefits of future integration of the health professionals to Turkish healthcare system which is an important part of the paradigmatic shift in primary level healthcare system to Syrian refugees in Turkey. So therefore, the analytical and operational capacities and the mechanism used to operationalize is quite influential in the paradigmatic change. Moreover, the political policy capacities focusing on the relationships with other actors (host state, donor and civil society) is also significant resource for the respective paradigm shift.

Within this context, policy capacities of the organization were an important part of the policy change. These functions increased the role of WHO as an influential actor in refugee health governance in Turkey. Therefore, it can be argued that the EU funds provided an important political policy capacity in realizing such a fundamental change and the discussed policy capacities of WHO became important resource for this extensive policy change.

More importantly, the cooperation between the Turkish government and WHO resulted in a paradigm change in healthcare service provision in Turkey through the introduction of new models such as Migrant Health Centers and homecare services provided only to Syrian refugees. Within this framework, this is a third–order change in which government receptivity is high, as this policy issue could be regarded to be instrumental by the host state. Although this model is a good practice, Turkey's decision to implement the model is instrumental, and it is a policy change in which the hosting country aims to mitigate the pressures on its healthcare system by changing the mode of health service provision without taking further integration decisions in line with Temporary Protection regime applied to Syrian refugees.

Within this context, for the case of strengthening primary level healthcare services, the political context in Turkey is also a significant factor leading paradigm shift due to factors creating instrumentality. As discussed, the problem pressures are an essential factor behind this policy learning process, as arrivals significantly pressured

Turkey's healthcare system, which already showed low numbers of health professionals and low health expenditures before the war. Moreover, refugees faced several difficulties in accessing healthcare services due to language barriers and health illiteracy, as discussed. Turkish healthcare staff also experienced emotional stress due to treating patients with cultural needs. The Migrant Health Centers and the employment of Syrian health professionals to treat their fellow nationals addressed some of these challenges and inequalities to a considerable extent.

Although foreign health professional employment is a paradigmatic shift for the Turkish healthcare system, the research evidence shows that the future integration of the Migrant Health Centers and the employment of refugee health professionals remains uncertain in line with the Temporary Protection Regime, which constitutes Turkey's deep core migration policy orientation. As the evidence shows, the centers can either be transformed into Family Health Centres of Turkey, or future integration steps can be taken to integrate Syrian health professionals into the Turkish healthcare system. Although Hall's conceptualization of policy change helps understand the nature of the policy change in analysis, it is worth noting here that it is still early to say it is a complete paradigm change since "temporariness" is prevalent. Uncertainty remains valid in the health domain of migration governance. Several interlocutors of this research gave similar statements to the below statements of WHO representative which shows that the centers can easily be adaptable to the Turkish healthcare system whereas the employment part requires additional regulations.

> The transfer of the Migrant Health Centers to Community Health Centers of Turkey (Toplum Sağlığı Merkezleri) will not make too much effort, as the MHCs have been designed similarly to Family Health Centers (Aile Sağlığı Merkezleri) and Migrant Health Training Centers to the Community Health Centers of Turkey and if the state authority take the consent to make legal amendment, the centers and the Syrian health professionals could easily be integrated to the Turkish healthcare system. The difficult part is full integration of Syrian health professionals into the primary and secondary healthcare systems, which may pose different problems and challenges. [324]

However, WHO's analytical capacities also addressed the political challenges. Within this framework, this chapter also argued that WHO took critical roles in

[324]Interview 3, World Health Organization, Ankara, 10 February 2021.

addressing the issues of future integration and applied strategies to ensure future integration, such as constant evidence-based data provision and Turkish language training to refugee health professionals to provide refugees with the opportunity for citizenship. Moreover, WHO's coordinating role between the non-governmental organizations and the Turkish state and its capacity-building support to non-governmental partners to work with the UN and Turkish bureaucracy is a step towards broadening Turkish refugee health governance to incorporate non-traditional actors. This cooperation led to an important change in the Turkish healthcare administration structure, which is known to be traditionally state-dominant. Within this context, WHO supported the agency of non-governmental actors who have yet to gain prior experience collaborating with the Turkish bureaucracy. WHO used analytical, operational, and political capacities in this framework. Within this framework, this case study shows that both the instrumental nature of the policy sector, problem pressures, and the policy capacity of WHO were influential in the policy learning process concerning strengthening primary-level healthcare. In additional to all these, EU funds provided important political policy capacities in realizing this fundamental policy change.

CHAPTER 6

UNFPA AND SEXUAL AND REPRODUCTIVE HEALTHCARE PROVISION TO SYRIAN REFUGEE WOMEN

This chapter will analyze the role of UNFPA in health service provision to Syrian refugee women with a focus on two health issues posing possible health risks for Syrian refugee women. The first issue is sexual and reproductive health services provision, and family planning as an integral part of it. The second issue is the response to gender-based violence.[325] These two issues are related on two reasons. Firstly, current conservative gender policies in Turkey prioritizing family protection highlight and support a traditional role for women in the family. Secondly, Turkey's current policy follows a pro-natal approach to reproductive health provision with a rationale to fight against the threat of aging in society and these policies approach domestic gender-based violence as a private, not a political, matter, with a rationale to decrease divorces to protect the family. These two policies frame gender politics in Turkey and the provision of sexual and reproductive health.

The Syrian society is a patriarchal society which has implications for Syrian refugee women for being exposed to various health risks due to cultural and societal reasons.[326] The patriarchal characteristics of Syrian society reveal themselves in many demographic data related to Syrian refugee women, and this case study will examine these data. UNFPA, as the UN technical agency on population politics, has a mandate on both sexual and reproductive health and gender-based violence that reveals globally drop backs against international norms on gender equality during the

[325]According to UNHCR, "gender-based violence is violence committed against a person because of his or her sex or gender and can take different forms such as sexual violence, emotional or psychological violence, socio-economic violence, domestic violence, harmful practices such as polygamous marriage or child marriage", in "What is Gender- Based Violence", UNHCR, available at WHAT IS GENDER-BASED VIOLENCE - UNHCR Türkiye, accessed on 28 August 2023.

[326]Lorraine Charles, Kate Denman, "Syrian and Palestinian Syrian refugees in Lebanon: The Plight of Women and Children," *Journal of International Women's Studies*, Vol: 14, No:5 (2013), 96.

last decade. Reproductive and sexual health provision to Syrian refugee women within the framework of cultural reasons poses several difficulties, as is with the services aiming to reduce gender-based violence. Despite these difficulties in providing sexual and reproductive health services provision and gender-based violence-related services to Syrian refugee women, UNFPA, in collaboration with the Ministry of Family and Social Services, implemented a project on the foundation and operationalization of the Women and Girls Safe Spaces through the EU funds. These centers provided services related to sexual and reproductive health, as well as women empowerment activities aiming to combat different forms of gender-based violence.

The introduction of the Women and Girls Safe Space is a policy instrument providing a method for eliminating difficulties and challenges in sexual and reproductive health provision to Syrian refugee women. However, the Women and Girls Safe Spaces did not become an extensive network of service provision integral to the Turkish healthcare system, and the centers transformed into Women Advisory Units within the Migrant Health Centers of Turkey. Due to its nature of providing an alternative policy instrument without causing a paradigm change in health service provision, this is a second-order policy change. The following section will first analyze the policy sector framing the issues of sexual and reproductive health and gender-based violence. The following section will examine the health status of refugee women on these policy issues and the problem pressures brought by the health indicators here. The last section will analyze UNFPA's role in this policy change and the nature of this policy change.

6.1. Sexual and Reproductive Healthcare Provision and Gender-Based Violence as a Policy Issue

Turkey's gender politics have changed significantly over the years, and changing politics had significant implications on women's rights, especially rights regarding sexual and reproductive health and issues regarding the general well-being of women. The changing policies on gender issues defined and changed the nature of the technical collaboration between the Turkish government and UNFPA, as the

policy environment defines the working environment of the UN technical agencies. The modern Turkish republic was founded upon the idea of gender equality politics to provide the same rights to women with men. [327] The reforms of the early republic brought many changes to the lives of women, such as the modernization of family law, the abolition of polygamy and religious marriage, the introduction of monogamy and official marriage, the introduction of equal opportunities for women and men in education, the professionalization of women in fields such as medicine and law.[328] Although the foundation of the republic was based on the equal enjoyment of the rights idea, we cannot say that the policies followed after the reforms brought equal participation in politics and employment for women and the traditional role seen to fit for women in society did not change significantly. However, there was significant progress in women's political participation and education level.

The traditional approach to gender roles underlines the role of women as caretakers and birth givers within the family. This idea firstly informs the pro-birth approaches to population politics. Secondly, it avoids politicization of issues within the family, such as domestic violence, as the domestic is not approached as political within this approach. Korkut and Eslen- Ziya call these types of ideas as conservative ideas as “the traditional understanding of gender relations in caregiving, undermine women's role in the labor market, and apportion blame to women who decide to enter the labor market for decreasing population".[329] This understanding of conservative policies helps to explain the current gender policies in Turkey. Several studies on Turkish gender politics, relying on this conceptualization, argue that the current conservative gender policies in Turkey value birth increases and prioritize family unity over preventing gender-based violence due to the conservative political orientation.[330]

[327] Marella Bodur Ün, "Contestation of the Global Norm against Violence against Women in Turkey," *Turkish Studies*, Vol:1, No:22 (2023): 7.

[328] A. Aslı Şimşek, “Türkiye’de Modernleşme, Toplumsal Cinsiyet Ve Kadın Hakları,” in *Toplumsal Cinsiyet Ve Yansımaları*, ed. Lerzan Gültekin, Gül Güneş, Ceylan Ertung and Aslı Şimşek (Ankara, Atılım Üniversitesi Yayınları, 2013), 58.

[329] Umut Korkut, and Hande Eslen-Ziya, "The Impact of Conservative Discourses in Family Policies, Population Politics, and Gender Rights in Poland and Turkey,"*Social Politics*, Vol: 18, No: 3 (2011): 395.

[330] Feride Acar, and Gülbanu Altunok, "The Politics of Intimate"at the Intersection of Neo-Liberalism and Neo-Conservatism in Contemporary Turkey," *Women’s Studies International Forum*, Vol: 41,

Turkish society is indeed a patriarchal society which has a traditional understanding of the sanctity of family and the superior role of men as breadwinners within the family. Throughout the history of the republic and the late Ottoman reform times, individual/ civil society women's movements confronted this traditional approach to emancipate women from this traditional role.[331] Within this context, tension between civil society actors and state institutions on gender and women's rights always existed, and this civil society movement changed its route during the first decade of Turkey's candidacy to the EU. During these years, civil society and state institutions found ways to consolidate gender politics due to Turkey's alignment policies with the EU's gender policies aiming to promote gender equality in employment and political participation.[332] With the energizing impact of the EU accession process on gender politics in Turkey and support of civil society, "a new civil code (2002)- proposing equality between spouses-, a criminal code (2004) criminalizing marital rape and honor killings were introduced. Moreover, The Labor Law of 2003 ensured job security in the case of pregnancy and childbirth.[333] These all were significant steps in the gender politics of Turkey.

The technical cooperation between the Turkish government and UNFPA[334], as the United Nations sexual and reproductive health agency, intensified during these years of Turkey's candidacy to the EU as well. The issues within the mandate of UNFPA, such as gender equality, family planning, preventable maternal death, gender-based violence, and abolition of harmful practices were on the agenda of policy making in

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No: 11 (2013), 14–23.; A. Argun Akdoğan, Mete Yıldız, and Can Umut Çiner,"An Analysis of Policy Transfer the Policy on Protecting Women against Domestic Violence in Turkey,"*in Public Policy Making In A Globalized World,* ed. Göymen Korel and Robin Lewis (London: Routledge, 2018).; Bodur Ün, Contesting Global Gender Equality Norms,"828-847.; Coşar, and Yeğenoğlu. "New grounds for patriarchy in Turkey?," 555-573. ; Bodur Ün, "Contestation of the Global Norm against Violence against Women in Turkey," 1-22.

[331]Şimşek, "Türkiye'de Modernleşme, Toplumsal Cinsiyet ve Kadın Hakları," 53.

[332]Pınar Yıldırım, "AB İlerleme Sürecinin Türkiye'de Kadın Sorununa Etkisi: Akp İktidarı Üzerine Bir İnceleme (2002-2011)" *Toplumsal Cinsiyet ve Yansımaları*, ed. by Lerzan Gültekin, Gül Güneş, Ceylan Ertung and Aslı Şimşek, (Ankara, Atılım Üniversitesi Yayınları, 2013), 71; Korkut and Eslen-Ziya, "The Impact of Conservative Discourses in Family Policies," 391.

[333] Bodur Ün, "Contestation of The Global Norm Against Violence against Women in Turkey," 8.

[334] UNFPA defines its mission as "delivering a world every pregnancy is wanted, every childbirth is safe, and every young person's potential is fulfilled", in "About Us," *UNFPA*, available at https://www.unfpa.org/about-us , accessed on 27 August 2023.

Turkey due to the accession process, and they became a priority in the policy-making agenda to succeed in alignment. [335] The technical collaboration between UNFPA and the Turkish government primarily focused on awareness-raising campaigns on family planning, breastfeeding, gender-based violence.[336]

The positive development in the legal sphere continued until 2007 in Turkey, when the government changed its narrative towards a conservative orientation. Prime Minister Erdoğan's speech of 2007 recommended young couples at least to have "three children before it is too late" [337], marked the return to conservative orientation and initiated a political discourse on pro-natalist policies for Turkey. According to some scholars, the discourse of the politicians in this period became increasingly "unfolding as a discourse that undermines gender equality by emphasizing the centrality of the family institution by glorifying traditional gender roles".[338]

Therefore, Turkey's reproductive health and population policies can be grouped into three major phases. From the foundation of the republic till the 1960s, Turkey followed a pro-natalist population policy[339] , where the state glorified the role of women in the public sphere without sacrificing its role within the traditional family. Turkey started an anti-natalist policy after the 1960s [340] Moreover, the state collaborated with UN technical agencies and especially civil society actors during the EU accession process, and this continued up to 2007 Prime Minister Erdoğan's call for at least three children. And this conservative and pro-natalist approach was repeated either by himself or different high-level cabinet members various times on different occasions. [341] The discourse even went further in 2022 to turn into a grant

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[335] "About Us," *UNFPA*, available at https://www.unfpa.org/about-us , accessed on 27 August 2023.

[336] "UNFPA Türkiye | Hakkımızda," *UNFPA in Türkiye*, accessed on 26 August 2023.

[337] "İş İşten Geçmeden En Az Üç Çocuk," *NTV*, 10 October 2009, available at https://www.ntv.com.tr/turkiye/erdogan-is-isten-gecmeden-en-az-3-cocuk,ZEQhCeWHVkS06lEDhd72Ng, accessed on 24 August 2023.

[338] Acar, and Altunok, "The Politics of Intimate at the Intersection," 16.

[339]Belin Benezra, "The Institutional History of Family Planning in Turkey," in *Contemporary Turkey at a Glance: Interdisciplinary Perspectives on Local and Translocal Dynamics*, ed. by Kristina Kamp, Ayhan Kaya, E. Fuat Keyman, and Özge Onursal Beşgül (New York; Springer, 2014), 43.

[340]Benezra, "The Institutional History of Family Planning in Turkey," 46.

[341]"Erdoğan Yine 3-4 Çoçuk Tavsiyesinde Bulundu," *Sözcü,* 24 October 2021, available at Erdoğan yine 3-4 çocuk tavsiyesinde bulundu - Son dakika haberleri – Sözcü (sozcu.com.tr), accessed on 24 August 2023.

of an apartment to widow women with three children at a minimum within the scope of the Social Assistance and Solidarity Promotion Law numbered 3294.[342] Family planning was deprioritized in Turkey's population politics during this period after 2007.

This change in the gender policies towards a conservatist orientation had some implications for domestic violence as well, as the conservatist approach to gender reinforces the idea that domestic is not political. The latest comprehensive state report in 2014 on gender-based violence stated that approximately 36 percent of married women in Turkey experienced physical violence from their husbands, and eight percent of married/ unmarried women experienced physical violence from their partners, with a note that these were only reported cases.[343] There was no another official report issued after 2014 on gender-based violence due to the depoliticization efforts of gender-based violence and approaching it as a family issue during these years. Similarly, according to the National Research on Domestic Violence against Women in Turkey done in 2009, 39 percent of women surveyed (a sample survey of 12,795 women from 51 provinces of Turkey) stated that they experienced physical partner violence during their lifetime.[344] This data reveals that four out of ten women were exposed to physical violence by their husbands or intimate partner(s). The survey also revealed that the majority of the women were aware that cultural or religious reasons cannot justify violence. However, most of them tended to keep the violence private rather than reporting it to authorities.[345]

Indeed, cultural or societal codes prevent women from reporting violence and claiming their rights in law. Police and health authorities are important authorities for

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[342]"Erdoğan'ın En Az Üç Çocuk Şartı, Konut Destek Paketinde de Şart Oldu," *Evrensel*, 24 Ekim 2022, available at Erdoğan'ın 'en az üç çoçuk' şartı, konut destek paketinde de şart oldu - Evrensel, accessed on 24 August 2023.

[343]Aile ve Sosyal Politikalar Bakanlığı, Hacettepe Üniversitesi, "Türkiye'de Kadına Yönelik Aile İçi Şiddet Araştırması," (2014), available at 1428409374.pdf (aihmiz.org.tr), accessed on 27 August 2023

[344]Şevket Ökten, "Domestic Violence and Patriarchy in Turkey", *European Journal of Social Science Education and Research*, Vol: 11, No: 2 (2017): 368.

[345]Jennifer McCleary-Sills, Sophie Namy, Joyce Nyoni, Datius Rweyemamu,Adrophina Salvatory and Ester Steven, "Stigma, Shame, And Women's Limited Agency In Help-Seeking For Intimate Partner Violence", *Global Public Health*, Vol:11, No: 1-2 (2016), 229.

reporting the violence. According to the results of 2015 Hacettepe University Population Research (Türkiye'de Kadına Yönelik Aile İçi Şiddet Araştırması), only the 11 percent of the women subject to gender-based violence reported the violence to the authorities and the four percent of those who reported applied to the health authorities for reporting.[346] This data shows that health professionals are crucial key contact people for the victims of violence. However, lack of awareness and knowledge regarding gender-based violence among health professionals and health staff and their behavior of ignoring the violence or undermining it contributes to the perception of violence as an everyday practice.[347] The collaboration between the key institutions and health authorities is also essential.

There is an increase in femicides in Turkey as well. As the We Will Stop Femicides Platform reported, in 2022, gender-based violence led to the death of 334 women, and 245 suspicious women death cases were reported.[348] Increasing domestic violence cases and femicides in Turkey require appropriate measures to criminalize violence against women, and the current Law on Protection of Family and Prevention of Violence against Women provides the necessary legal framework for these measures.[349] However, studies show that there needs to be stricter implementation of the law instead of policy keeping shelters at a minimum level to avoid providing alternatives to male domination[350] and also to stand against the current discourse relating report of domestic violences cases to increase in divorces[351]. Finally,

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[346]Ayşe Alican Şen, "Türkiye'de Kadına Yönelik Şiddetle Mücadelede Kurumlar Arası İşbirliği Süreci ve 6284 Sayılı Yasanın Uygulanabilirliği,", *Motif Akademi Halkbilimi Dergisi*, Vol: 11, No:22 (2018): 148.

[347]Leyla Gülseren, and Ayşe Devrim Başterzi, "Kadına Yönelik Aile İçi Şiddet: Klinik Uygulamada Yaklaşım ve Sorumluluklar," *Psikiyatride Güncel Gündelik Yaşamda Şiddet ve Psikiyatri*, Vol: 2, No:3 (2012): 201.

[348] Kadın Cinayetlerini Durduracağız Platformu, "Kadın Cinayetlerini Durduracağız Platformu 2022 Yıllık Veri Raporu," 2 January 2023, available at Kadın Cinayetlerini Durduracağız Platformu 2022 Yıllık Veri Raporu (kadincinayetlerinidurduracagiz.net), accessed on 5 September 2023.

[349] Ailenin Korunması ve Kadına Karşı Şiddetin Önlenmesine Dair Kanun, Law No: 6284, Resmi Gazete Date: 20 March 2012, No :28239, available at 1.5.6284.pdf (mevzuat.gov.tr), accessed on 26 August 2023.

[350] Ece Kocabıçak, "The Causes and The Consequences of The Patriarchal State: Evidence from Turkey," *Women's Studies International Forum,* Vol. 98 (2023): 5.

[351] Kocabıçak, "The Causes and The Consequences of The Patriarchal State," 5.

Turkey's withdrawal from the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (The Istanbul Convention)[352] with a Presidential Decree[353] marked another turning point in Turkish politics with its impact on women's rights.

The Convention became a debate between progressive and conservative ideas throughout Europe and Turkey.[354] Furthermore, Turkey concluded the debate with a Presidential Decree, and the withdrawal also led to a debate on the Law on Protection of Family and Prevention of Violence against Women, numbered 6284, which identifies the forms of violence against women and the punishments for perpetrators of the crime. The law is based on the İstanbul Convention, and within this context, the withdrawal questions the future of Law numbered 6284. Therefore, the policy sector on gender-based violence and sexual and reproductive health service provision poses several challenges to the implementation of these policies. In addition to these difficulties, health service provision on gender-based violence and sexual and reproductive health provision specifically to refugee women entail further challenges on cultural and societal grounds. Before discussing the role of UNFPA, the following section investigates the health status of refugee women in Turkey concerning reproductive health and gender-based violence and the subject of cultural and societal challenges for adequate service provision on these matters.

6.2. Sexual and Reproductive Health Status of Syrian Refugee Women in Turkey

The discussed conservative and pro-natalist gender discourses and political orientation on prioritizing family and family roles do not directly target Syrian

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[352] Council of Europe, Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, 11 May 2011, https://www.refworld.org/legal/agreements/coe/2011/en/79074, accessed 22 January 2024.

[353] Cumhurbaşkanı Kararı, Decision No: 3718, Resmi Gazete Date : 20 Mart 2021, No: 31429, available at Layout 1 (resmigazete.gov.tr), accessed on 26 August 2023 .

[354] Maïa De La Baume, "How the Istanbul Convention Became a Symbol of Europe's Cultural Wars," *Politico,* 12 April 2021, available at How the Istanbul Convention became a symbol of Europe's cultural wars – POLITICO, accessed on 22 February 2024.

families and Syrian refugee women. However, the host country's policies directly affect health service provision for refugees, as reproductive health services are designed and delivered by the host country. Besides, international collaboration on gender aspects of the health service provision is directly defined by the political context. Available data on Total Fertility Rate [355] and gender-based violence regarding Syrian refugee women reveals high rates and signals a need for taking the necessary precautions for the well-being of Syrian refugee women.

According to the 2022 end-year Presidency of Migration Management data (Table 6.1), 1,655.111 of 3,561.883 of the total Syrians under temporary protection are female, which makes up 46 percent of all registered Syrians under temporary protection. 838.765 of 1,655.111 Syrian refugees are refugee girls aged between 0 and 18, which makes up 49 percent of all female Syrians under temporary protection. [356] Syrian women at reproductive age[357] are 796,429 in total, making up 48 percent of the total female Syrians under temporary protection.

According to the 2018 Turkey Demographic and Health Survey Syrian Migrant Sample, the proportion of women of reproductive age (aged 15-49 years) who had their need for family planning satisfied with modern methods was 37.8 percent. [358] These data show that both the rates of women at reproductive age with specific needs and family planning needs are high for Syrian refugee women.

[355]Total Fertility Rate refers to “the average number of children born per woman of childbearing age (15-44 years)”, in World Health Organization “World Health Organization Global Health Observatory Data- Total Fertility Rate (per woman),” available at Total fertility rate (per woman) (who.int), accessed on 27 August 2023.

[356] “Geçici Koruma- Yıllara Göre Geçici Koruma Altında bulunan Suriyelilerin Yaş ve Cinsiyete Göre Dağılımı,”, Türkiye Cumhuriyeti İç İşleri Bakanlığı Göç İdaresi Başkanlığı, data updated on 08 December 2022, available at https://www.goc.gov.tr/gecici-koruma5638, accessed on 22 December 2022.

[357] According to Sustainable Development Goal Indicators,” the reproductive age for women is between 15- 49 who can make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care”, in United Nations, “The Sustainable Development Goals Report,” (2022), available at https://unstats.un.org/sdgs/report/2022/The-Sustainable-Development-Goals-Report-2022.pdf, 37, accessed on 22 December 2022.

[358] Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey Syrian Migrant Sample* (Ankara: Elma Teknik Basım Matbaacılık, 2019), xv.

Table 6. 1. Distribution of Syrians Under Temporary Protection by Age and Gender.[359]

Age	**Men**	**Women**	**Total**
Total	1906772	1655111	3561883
Age 0-4	284587	265966	550553
Age 5- 9	270608	255443	526051
Age 10- 14	213305	200468	413773
Age 15- 18	135667	116888	252555
Age 19- 24	246448	190360	436808
Age 25- 29	207665	152150	359815
Age 30- 34	153480	114874	268354
Age 35- 39	122248	94632	216880
Age 40- 44	83524	71039	154563
Age 45- 49	57837	56486	114323
Age 50- over 90	131403	136805	268208

Moreover, there are high fertility rates for Syrian refugee women compared to the fertility rate of Turkish women. The current fertility rate of Syrian women is also higher compared to the fertility rates in the pre-war Syrian national population statistics. The total fertility rate of Syrian women in Turkey, according to the latest Turkey Demographic and Health Survey Syrian Migrant Sample conducted in 2018, was 5.8 per woman.[360] In the light of this data, we can see that migration led to an increase in the total fertility rate of Syrian refugee women, as the prior fertility rate in Syria was 3.7 in the period covering the years 2000-2010. [361] Akyon, Yılmaz, Şahin and Özkara argue that this high total fertility rate among refugees points out a phenomenon called the "baby boom" seen in the aftermath of the Second World War

[359] Türkiye Cumhuriyeti İç İşleri Bakanlığı Göç İdaresi Başkanlığı, "Geçici Koruma- Yıllara Göre Geçici Koruma Altında bulunan Suriyelilerin Yaş ve Cinsiyete Göre Dağılımı."

[360] Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey Syrian Migrant Sample*, 39.

[361] United Nations, "Syrian Arab Republic- General Information- Social Indicators- Fertility Rate, UN Data,"; available at http://data.un.org/Data.aspx?d=PopDiv&f=variableID%3A54#PopDiv., accessed on 25 November 2023.

in Europe with the recovering economic conditions.[362] They argue several possible reasons that could increase the fertility rate among Syrian refugees in Turkey, such as women's education level, age of first marriage, easy and free access to maternal and child health services, family planning, contraception knowledge and use, religious beliefs, customs and traditions, society and women's perspective on fertility, and women's low participation in the workforce.[363]

The total fertility rate can be related to any of these factors. For example, some scholars argue that there was a correlation between the educational level of Syrian refugee women and the number of births given (Figure 6.1.).[364] The current fertility rate for Syrian women with no education is 5.8, and 4.1 for refugee women with a high school education or higher level.[365] The Government of Syria, Principal Report: Syria Family Health Survey data dated 2011 also shows that the fertility rate decreases by the education level among Syrian women (Figure 6.1).[366]

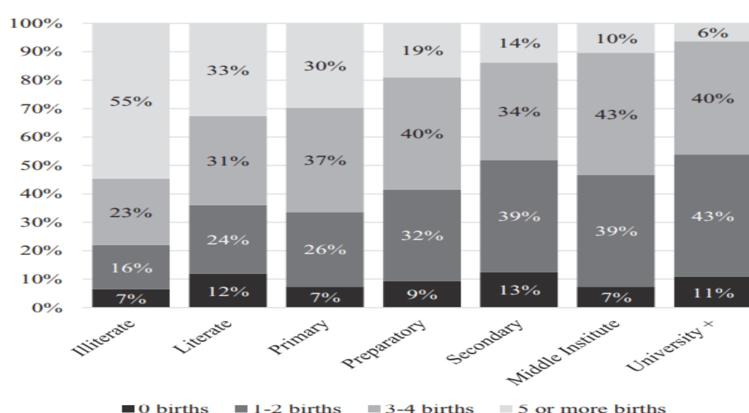

Figure 6. 1. Percent distribution of number of live births by educational status.[367]

[362]Şeyma Handan Akyon, Tarık Eren Yılmaz, Büşra Şahin, and Adem Özkara. "Fertility Rates of Syrian Migrants in Turkey, Baby Boom, And Possible Factors Related to Them." *Ankara Medical Journal*, Vol:23, No:1 (2023): 66.

[363]Akyon, Yılmaz, Şahin, and Özkara, "Fertility Rates of Syrian Migrants in Turkey," 66-69.

[364]Marty Masek, "Baseline Demographic Profile of Syria,"in 2009," in *Comparative Demography of the Syrian Diaspora: European and Middle Eastern Destinations*, ed. Carlson Elwood, and Nathalie Williams (New York, Springer, 2020), 23.

[365] Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey Syrian Migrant Sample*, 40.

[366] "Government of Syria, Principal Report: Syria Family Health Survey", (2011), in Masek, "Baseline Demographic Profile of Syria in 2009", 23.

[367]"Government of Syria, Principle Report: Syria Family Health Survey", (2011), in Masek, "Baseline Demographic Profile of Syria in 2009", 23.

In addition to education level as a possible factor increasing the fertility rate, the low employment level of Syrian refugee women may be another reason for high fertility rates. The 82 percent of Syrian refugee women in Turkey have not had in the last 12 months, according to the 2018 survey data, and the 9 percent of refugee women were never employed in their lifetime. [368] This low employment rate among refugee women can also be a possible reason for high fertility rates, according to the mentioned study, as they argue that women with high education levels tend to keep a low fertility rate worldwide. [369]

The demand for family planning among married Syrian women aged 15-49 is 62 percent. [370] The undesired fertility rate was 1.1 among Syrian refugee women, according to a calculation made through the comparison of the Total Wanted Fertility Rate and the Total Fertility Rates. [371] This data shows that if a health service provision prioritizing family planning for refugees was provided, the problem of a "baby boom", with possible negative socio-economic impacts, could be prevented, and refugee women who had undesired pregnancies could be supported to have pregnancy when desired. This discussion highlights the need to consider the gender-aspect of health service provision towards refugee women.

There are several other possible reasons for high fertility rates among Syrian refugees, such as a lack of information regarding sexual and reproductive health services. Lack of information on reproductive health increases the risk of giving birth to unwanted children, which creates another source of physical and psychological issues for refugee women[372] Effective reproductive health policies, and especially the

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[368] Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey Syrian Migrant Sample*, 23.

[369] Akyon, Yılmaz, Şahin, and Özkara, "Fertility Rates of Syrian Migrants in Turkey," 69.

[370] Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey Syrian Migrant Sample,* xv.

[371] Akyon, Yılmaz, Şahin, and Özkara, "Fertility Rates of Syrian Migrants in Turkey,", 65.

[372] Hande Albayrak, Özlem Cankurtaran, Şevkat Bahar Özvarış and Türküler Erdost, "They Taught Us not only Our Rights as Women but also How to Live, Gender-Based Violence and Empowerment Experiences of Syrian Women in Turkey and the Role of the Women and Girls Safe Spaces: A Qualitative Study," *Health Care for Women International*, Vol: 43, No: 7-8 (2021): 951.

provision of adequate family planning services, can have positive impacts on the physical and mental health of Syrian refugee women by preventing undesired births. As argued, the current pro-natal policies in Turkey do not directly target the Syrian audience. Still, gender politics in Turkey affect Syrian refugee women as well, and within the framework of the current policies, family planning is not among the prior concerns in providing sexual and reproductive healthcare. However, data shows that Syrian refugee women have family planning demands, and some of the births are unwanted. The high fertility rates and unmet family planning needs pose a problem pressure brought by migration and the peculiar conditions of the refugee women. The same concerns can be found in the data related to gender-based violence rates for Syrian refugee women.

Explaining the total fertility rate in numbers, defining that there is a need to meet family planning, and analyzing policy implication data reveals is not so complicated due to the availability of data and the understanding of policy implications the data reveal. However, when it comes to explaining other aspects of the gendered difficulties of being a refugee woman, such as gender-based violence, it becomes much more complicated since violence takes different forms, and the data on gender-based violence is quite limited. Several studies show that other gender-related threats to the health and well-being of Syrian refugee women are "forced marriage; forced prostitution; harassment, rape, gender-based violence, harmful practice such as early marriages, reproductive health problems such as lack of sufficient care during pregnancy and delivery, or having no access to family planning, discrimination based on sex, age, race, color, sexual orientation, national or social origins". [373] A comprehensive study regarding the health conditions of Syrian refugee women in the top three receiving countries, Turkey, Lebanon, and Jordan, shows that refugee women's reproductive health suffers from structural inequalities, including lack of services, gender dynamics, and fear of seeking service. Among all these, gender-based violence is one of the most significant struggles of Syrian refugee women. [374]

[373] Özlem Cankurtaran, and Hande Albayrak, *From Syria to Turkey: Being a Woman*, ed. Şevkat Bahar Özvarış and Türküler Erdost, (Ankara, Elma Teknik Basım Matbaacılık, 2019): 17.

[374] Goleen Samari, "Syrian Refugee Women's Health in Lebanon, Turkey, and Jordan and Recommendations for Improved Practice," *World Medical & Health Policy*, Vol: 9, No: 2 (2017): 266.

The risks start at the very moment refugee women leave their home country and continue through their journey towards transit/ destination countries. It does not stop at the arrival point and may even pose more significant risks to the health and well-being of refugee women. Syrian refugee women face the threat of being exposed to each type of gender-based violence during and after migration. “They first interact with several individual actors till/ at the border gates, such as police, military, other migrants, and smugglers, and there are several reported cases of abuses during their transition from home countries to transition/ destination countries, as well as there are cases of solidarity”.[375] Then, the struggle continues in the host countries as the women have additional difficulties with safe accommodation and, more importantly, a safe source of income.

Gender dynamics play an essential role for the Syrian refugee women in Turkey. Through collecting data from major newspapers in the Turkish media between 2015 and 2019, Doğutas found that violence (torture, seizure, murder, and suicide), sexual assault (rape, prostitution), and marriage (co-wife and early marriage) were the main themes of the news regarding Syrian refugee women. [376] All the themes found in the newspapers regarding refugee women refer to a form of gender- based violence. Murder[377], rape[378], prostitution[379], torture[380], co- wife[381]

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[375]Glenda Santana de Andrade, "At the Borderscape: Experiences of Syrian Women Fleeing into Turkey and Jordan" in *The Gender of Borders: Embodied Narratives of Migration, Violence and Agency*, ed. Jane Freedman, Alice Latouche, Miranda Adelina, and Nina Sahraoui (New York: Taylor and Francis, 2023): 75.

[376]Aysun Doğutaş, “Gender-Based Violence Against Syrian Refugee Women in Turkey” *Border Crossing*, Vol: 9, No: 2 (2019): 119-120.

[377]For example, “Ankara'da 4 çocuk annesi Suriyeli kadın kocası tarafından öldürüldü”, Hürriyet, 22 June 2016, available at Ankara Haberleri - Ankara'da 4 çocuk annesi Suriyeli kadın kocası tarafından öldürüldü - Son Dakika Yerel Haberler (hurriyet.com.tr), accessed on 28 August 2023.

[378]For example, “Tecavüze uğradı, ölümle tehdit edince ailesi düşük yaptırdığı bebeği gömdü”, Hürriyet, 3 March 2015, available at https://www.hurriyet.com.tr/gundem/tecavuze-ugradi-olumle-tehdit-edince-ailesi-dusuk-yaptirdigi-bebegi-gomdu-28351688, accessed on 28 August 2023.

[379] For example, “İstanbul'da yakılmış olarak bulunan cesedin sırrı... Suriyeli kadınlarla buluşturuyordu!”, *Hürriyet,* 22 April 2018, available at İstanbul'da yakılmış olarak bulunan cesedin sırrı... Suriyeli kadınlarla buluşturuyordu! - Son Dakika Haber (hurriyet.com.tr), accessed on 28 August 2023.

[380] For example, “Kilis'te Suriyeli kadına eşinden işkence”, *Habertürk*, 31 May 2017, available at Kilis'te Suriyeli kadına eşinden işkence (haberturk.com), accessed on 28 August2023.

[381] For example, “Suriyeli kuma' ticareti: Kira veremiyorsan kızını ver!”, *Sol*, 27 January 2014, available at Kira veremiyorsan kızını ver! (sol.org.tr), accessed on 28 August 2023.

Moreover, Early marriages are part of Syrian refugee women and girls living in Turkey, as is the case with the other migration settings. Moreover, the perpetrator of the violence is not always the husband or the partner. Refugee women are exposed to physical, psychological, and economic violence from their mother-in-law, father-in-law, and male children in the absence of a senior male member in the family.[382] Patriarchy is the defining mode of relations within traditional Syrian families. Early and forced marriages are also quite a common risk for Syrian refugee girls. According to Turkish Law, the legal minimum age for marriage is 18. According to the 2018 Turkey Demographic and Health Survey, the percentage of early marriages aged before 15 is 4 percent and aged before 18 is 21 percent for Turkish girls[383]; whereas the percentage of early marriages aged before 15 is 12 percent and aged before 18 is 38 percent for Syrian girls[384]. This demographic shows that early marriages are even a more significant threat for Syrian girls than for Turkish girls. It is difficult to reach out to the numbers of domestic violence cases, primarily due to the lack of reporting violence due to fear of stigma and shame[385], and also due to regional and cultural codes which also become a coping mechanism against violence and normalizing violence[386]. In 2019, a report found that "9 out of 10 refugee women experienced physical violence while exposure to emotional and sexual violence was 8 out of 10 women".[387] Therefore, a review of various studies done concerning gender-based violence and a review of the press show that domestic violence is quite common among refugee women.

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[382] Albayrak, Cankurtaran, Özvarış, and Erdost, "They Taught Us not only Our Rights as Women," 951.

[383] Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey* (Ankara: Elma Teknik Basım Matbaacılık, 2019), 46.

[384] Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey Syrian Migrant Sample,* 34.

[385] UN Women, "Gender-based Violence and Child Protection among Syrian Refugees in Jordan, With a Focus on Early Marriage," 2013, 66.

[386] Sandra Pertek, Karen Block, Lisa Goodson, Pakinam Hassan, Jeanine Hourani, and Jenny Phillimore, "Gender-Based Violence, Religion, and Forced Displacement: Protective and Risk Factors," *Frontiers in Human Dynamics*, Vol: 5, No: 11 (2023): 6.

[387] Şevkat Bahar-Özvarış İlknur Yüksel-Kaptanoğlu, Hande Konşuk-Ünlü, and Türküler Erdost, *Determining the Needs of Syrian Women Applying to Women's Health Counselling Centres Related to Services in Reproductive Health and Gender-Based Violence Survey Report* (Ankara, Merdiven Publishing, 2019), 53.

These patriarchal codes were also apparent in Syrian law in pre-war Syria. Polygamy was common, and co-wives were not illegal in Syria as per the law, and co-wives were seen as a source of safety and security due to the lack of access of Syrian women to the labor market. Moreover, a woman could not work outside without her husband's permission, and if she refused to obey, she could lose her husband's financial maintenance.[388] Moreover, although Syria signed the CEDAW in 2003, it introduced reservations to specific key provisions of the Convention. Due to the law and lack of mechanisms brought by the CEDAW, we can say that Syrian women did not know how to use these mechanisms in case of violence.

Additional cultural and structural barriers to accessing health services were discussed in the previous parts, all representing a problem of pressure. Women and Girls Safe Spaces or Women Health Consultancy Centers, initiated through collaboration between the Turkish Ministry of Health and UNFPA in cooperation with civil society partners, became an important policy instrument in addressing various issues regarding the health of Syrian refugee women and the problem pressures brought by them. UNFPA acted as a critical actor in the policy-making process of empowering women to access reproductive health services and legal mechanisms in preventing gender-based violence. The following section aims to analyze the policy change that occurred through the Women and Girls Safe Spaces and the role of UNFPA in this.

6.3. Understanding the Technical Expertise of UNFPA

The presence of UNFPA in Turkey and its collaboration with the Turkish state dates back to 1971, two years after its foundation as the United Nations technical agency in 1969. UNFPA's work for women is guided by the International Conference on Population and Development (ICPD) of 1994, emphasizing population planning through reaching demographic targets and promoting human rights and sustainable development.[389] The Convention on the Elimination of All Forms of Discrimination

[388] Cankurtaran, and Albayrak, *From Syria to Turkey: Being a Woman*, 11.

[389] "International Conference on Population and Development 5-13 September 1994, Cairo, Egypt, Background- A Focus on Individuals," United Nations, available at International Conference on Population and Development | United Nations, accessed on 29 August 2023.

against Women (CEDAW)[390], and The Beijing Declaration and Platform for Action[391] are the two primary guiding documents of UNFPA.[392] UNFPA's work worldwide focuses on three results, "ending unmet need for family planning, ending preventable maternal death, ending gender-based violence and harmful practices".[393] UNFPA's cooperation with the Turkish state focuses on the issues of "promoting mother and child health, improving reproductive health and rights, empowering young people to fulfill their potential, promoting gender equality, combatting violence against women in collaboration with state institutions, non-governmental organizations, private sector, and universities."[394] During the migration crisis, the main intervention areas of UNFPA became capacity building and service delivery, specifically on the issues of sexual and reproductive health and gender-based violence and the provision of equipment and supplies in response to the arrival of over 3 million refugees over the years.[395]

The Minimum Initial Service Package (MISP) framework is an important guideline for UNFPA's work on providing reproductive health services to refugee women.[396] The Minimum Initial Service Package, initiated by the Inter-Agency Working Group on Reproductive Health in 1996, refers to minimum sexual and reproductive health

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[390] UN General Assembly, Convention on the Elimination of All Forms of Discrimination against Women (1979).

[391] United Nations, Fourth World Conference on Women Beijing Declaration, September 1995, available at Beijing Declaration (un.org), accessed on 29 August 2023.

[392] "Background on Key International Agreements and Declarations," UNFPA, available at Background on Key International Agreements and Declarations | United Nations Population Fund (unfpa.org), accessed on 29 August 2023.

[393] "About Us- Our Three Transformative Results," UNFPA, available at About us (unfpa.org), accessed on 26 November 2023.

[394] "About Us," UNFPA Türkiye, available at https://turkiye.unfpa.org/en/about-us-, accessed on 16 January 2023.

[395] "The Women and Girls Safe Spaces Opening Ceremony," UNFPA Türkiye, available at UNFPA Türkiye | Women and Girls Safe Spaces Opening Ceremony, accessed on 30 August 2023.

[396] "The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in crises is a series of crucial, lifesaving activities required to respond to the SRH needs of affected populations at the onset of a humanitarian crisis", in "UNFPA, "Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crisis Situations- Interagency Field Manual on Reproductive Health in Humanitarian Settings,"1, available at MISP-Reference-English.pdf (unfpa.org)accessed on 15 January 2023.

services to be provided to affected populations and provision of basic package of supplies such as reproductive health kits.[397] It is an important tool aiming to prevent morbidity and mortality in emergencies.[398] Moreover, it has been the guideline of UNFPA's work on the health of Syrian refugee women, and it has also been an important strategy and technical resource of UNFPA in the subject policy change that will be discussed in this section.

As discussed, the implications of UNFPA's work on sexual and reproductive health services provision changed as Turkey's policies changed significantly in the last decade. However, as discussed earlier, the health indicators of the Syrian refugee women, especially the ones regarding the high fertility rates, created a problem of pressure here. Moreover, the EU, as the leading financial donor of UNFPA's projects on sexual and reproductive health service provision to Syrian refugees, has a particular agenda on women's empowerment. Gendered aspect of health, including sexual and reproductive health, is among the priorities of the European Union Gender Equality Strategy 2020-2025.[399] Within this framework, the problem pressures and the policy capacity provided by the EU funding on women empowerment activities were important incentive for effective implementation of the Minimum Initial Service Package guidelines for health provision to Syrian refugee women and opening the Women and Girls Safe Space. UNFPA's technical expertise based on the Minimum Initial Service Package provided important analytical and operational capacities of both the organization and the host state. Moreover, likewise WHO, UNFPA also acquired political policy capacity as an outcome of its engagement with civil society and EU funds. The below table (Table 6.2.) provides a summary of the policy capacity of the organization and how these capacities led a policy learning in the reproductive healthcare provision (by comparing T_3 and T_4,

[397]"UNFPA, "Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crisis Situations- Interagency Field Manual on Reproductive Health in Humanitarian Settings,"1-2, available at MISP-Reference-English.pdf (unfpa.org)accessed on 6 September 2023.

[398]UNFPA Inter-agency Working Group on Reproductive Health in Crises, "Inter-agency Field Manual on Reproductive Health in humanitarian Settings: 2010 revision for Field Review" (2010): 21- 23, available at IAFM 2010_English version.pdf (unfpa.org), accessed 26 November 2023.

[399] European Commission, "A Union of Equality: Gender Equality Strategy 2020-2025," COM(2020), 152 final, Brussels (2020): 16, available at https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52020DC0152 , accessed on 4 December 2023.

time periods representing before and after the foundation of Women and Girls Safe Spaces).

Table 6. 2. Provision of Reproductive Healthcare to Syrian Refugees

	UNFPA	**T_2[400]**	**T_3[401]**
Analytical Policy Capacity	*Disseminating knowledge on minimum requirements on reproductive and sexual healthcare provision (MISP).	* Limited data regarding status gender- based violence among refugee women. * Data on reproductive health status of Syrian refugee women through Hacettepe 2018 Turkey Demographic and Health Survey Syrian Migrant Sample.	* Knowledge raising on family planning and gender-based violence both for refugee women, decision makers and service providers. *Advancing knowledge on the reproductive health status of Syrian refugee women.
Operational Policy Capacity	*Outreach activities undertaken by Syrian refugee women health mediators. * Capacity building trainings.	*Reproductive healthcare provision shaped by conservatist policies.	*Trainings for refugee women for their employment in the Women and Girls Safe Spaces, women empowerment through employment. * Capacity building for decision makers and service providers. *A gender sensitive healthcare provision to Syrian refugee women.
Political Policy Capacity	*Strong donor contribution (EU funding), and collaboration with host state. *Strong coordination expertise between state and non- state actors.	*Prior EU funds given to Turkey on matters related to women empowerment, and gender equality during Turkey's alignment with EU Acquis.	*EU funds given to financing of Women and Girls Safe Spaces and employment of Syrian refugee women as health mediators in these facilities. *Civil society involvement in the operationalization of the new methods in integrating gendered aspects of healthcare-to-healthcare provision.
	Advocacy and Technical Role of UNFPA	Development of a New Policy Instrument (Second- Order Policy Change)	

Here it can be argued that development of Women and Girls Safe Spaces led a second order change in healthcare provision through strengthening the gender sensitive approach to healthcare provision. An important part of UNFPA refugee health programming was trainings to state officials (state institutions), civil society representatives (implementing partners), and service providers (health professionals)

[400] T_2: Before opening of the Women and Girls Safe Spaces (Policy Instrument 2)

[401] T_3: After opening of the Women and Girls Safe Spaces (Policy Instrument 2)

as well as to its staff as in-service trainings (to UNFPA staff) on the Minimum Initial Service Package.[402] The interview data of this research shows that these trainings were beneficial for explaining the general framework on sexual and reproductive health service provision in emergencies and the necessary notion on implementing the framework on service provision. The interviewees gave statements acknowledging UNFPA's technical expertise in providing the necessary information to the participants.[403] UNFPA used the Minimum Initial Service Package as the technical framework to provide minimum requirements for refugee women in Turkey. UNFPA representative explained how the Minimum Initial Service Package framework enabled UNFPA to create this policy instrument and integrate it into healthcare service provision to refugees as follows:

> The Minimum Initial Service Package trainings given to officials and service providers were important. Thanks to these guidelines, we were able to talk about services and but also policy decisions. We explained well why considering reproductive health is essential and what will be the possible outcomes in years if reproductive health issues are not taken seriously. Thanks to the framework established by the Minimum Initial Service Packages, we had the chance to integrate Women and Girls Safe Spaces into Migrant Health Centers when the Project was over, so the impact is still ongoing.[404]

Within this framework, the Minimum Initial Service Package trainings functioned as an essential analytical capacity for UNFPA, as the trainings provided a platform to explain the benefits of providing reproductive health to refugee women, which refers to a highly technical expertise. The statements of UNFPA representative below show how this institutional guideline and technical knowledge triggered the development of a policy instrument.

> The main content of these trainings given to local authorities, municipalities, and various service providers was to explain that reproductive health was not a luxury in

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[402] "Training On The Minimum Initial Service Package (MISP) For Sexual And Reproductive Health In Crises", UNFPA Türkiye, 19 September 2017, available at [training on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crises (unfpahumtr.org)](), accessed on 26 November 2023.

[403] Interview 13, Hacettepe University Research and Implementation Centre on Women's Issues, Ankara, 21 January 2021; Interview 12, Association for Youth Approaches to Health, Ankara, 10 August 2021.

[404] Interview 5, UNFPA, Ankara, 5 August 2021.

> times of war and conflict but a lifesaver. We also explained the middle- and long-term effects of the adequate provision of reproductive health on health spending, national health indicators, and sustainable development goal indicators.[405]

The Minimum Initial Service Package, through providing UNFPA's technical expertise on the issues related to sexual and reproductive, UNFPA succeeded to develop Women and Girl Safe Spaces in collaboration with the Ministry of Family and Social Services. Women and Girl Safe Spaces (*Kadın ve Kız Çocukları için Güvenli Alanlar*) or Women Health Counseling Centers (*Kadın Sağlığı Danışma Merkezleri*), founded through the technical cooperation between UNFPA Turkey Country Office and the Turkish Republic Ministry of Family and Social Policies with the grants of the European Union Civil Protection and Humanitarian Aid Operations (ECHO) was an important policy initiative. [406]

The Turkish government collaborated with UNFPA in developing a new policy instrument addressing the sexual and reproductive health needs of Syrian refugee women and combatting different kinds of gender-based violence (domestic violence, early and forced marriages, etc.). These centers were opened originally to provide clinical and psycho-social services on sexual and reproductive health and gender-based violence for refugees in İzmir (3), Bursa (1), İstanbul (5), Eskişehir (1), Ankara (3), Konya (1), Mersin (1), Adana (1), Hatay (2), Kahramanmaraş (1), Gaziantep (1), Adıyaman (1), Şanlıurfa (5), Diyarbakır (1), Mardin (2) and Batman (1).[407] The location of the UNFPA Centers including theWomen and Girls Safe Spaces can be seen in Figure 6.2. These centers are integrated into Migrant Health Centers under the name of Women Health Consultation Centers after the ending of the project implemented by UNFPA and its implementing partners. The Ministry of Health Provincial Health Directorates were responsible for executing the centers at the provincial level.

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[405]Interview 5, UNFPA, Ankara, 5 August 2021.

[406]"UNFPA's Women and Girls Safe Spaces," UNFPA Türkiye, available at UNFPA Türkiye | UNFPA's Women and Girls Safe Spaces, accessed on 29 August 2023.

[407] "UNFPA Centers," UNFPA Türkiye, available at Humanitarian Programme | UNFPA (unfpahumtr.org), accessed on 15 January 2023.; "UNFPA's Women and Girls Safe Spaces," UNFPA Türkiye, available at UNFPA Türkiye | Women and Girls Safe Spaces Opening Ceremony, accessed on 30 August 2023.

Figure 6. 2. UNFPA Centres (including the Women and Girls Safe Spaces).[408]

Women and Girls Safe Spaces were the ultimate result of the operational capacities provided by UNFA and its implementing partners. Turkey's collaboration with UNFPA in refugee health governance in Turkey involves not only the foundation of the Women and Girls Safe Spaces but also the employment of Syrian refugee women as health mediators in the centers, as well as training and awareness raising campaigns aiming knowledge provision for refugee women on the issues of reproductive health and gender-based violence. The centers were run by different implementing partners in different cities, by Hacettepe University Research and Implementation Centre on Women's Issues in Ankara, Harran University in Şanlıurfa, Osmangazi University in Eskişehir and KAMER Foundation in Adıyaman. The service provision within the centers aimed at women's empowerment through training and employment.[409]

The centers were located within the Migrant Health Centers. As stated by one of the interviewees, who was a project coordinator in one of the implementing partners of UNFPA, the Women and Girls Safe Spaces' location within the Migrant Health Centers in a public institution created trust for women and their husbands as well in visiting the centers with trust built. The trust created through integrating the Women and Girls Safe Spaces to the Migrant Health Centers within this framework created

[408] "UNFPA Centers," UNFPA Türkiye, available at Humanitarian Programme | UNFPA (unfpahumtr.org), accessed on 26 November 2023.

[409] Interview 13, Hacettepe University Research and Implementation Centre on Women's Issues, Ankara, 21 January 2021.

outreach.[410] Each center employed a female social worker, a psychologist, an assistant doctor, and a nurse—all fluent in Arabic, and psycho-social support was provided for women. As psycho-social support was being provided through individual or group sessions, these centers were acting as platforms where the women could share their common experiences regarding different forms of gender-based violence (Figure 6.3.). The psycho-social support experts were Turkish citizens who could also speak Arabic natively.[411]

Figure 6. 3. A Psycho- Social Support Room in the Women and Girls Safe Spaces.[412]

The Women and Girls Safe Spaces project within this framework had two components. The first one was providing outreach activities such as regular trainings on gender-based violence, early and forced marriages, and reproductive health to refugee women. Through these trainings and awareness-raising sessions, Syrian refugee women had the opportunity to receive the required information on sexual and reproductive health rights and services available. Figure 6.4. shows a training session on family planning organized by the Hacettepe University Research and Implementation Centre on Women's Issues.

[410] Interview 13, Hacettepe University Research and Implementation Centre on Women's Issues, Ankara, 21 January 2021.

[411] Interview 13, Hacettepe University Research and Implementation Centre on Women's Issues, Ankara, 21 January 2021.

[412] Hacettepe University Women's Research and Implementation Center (HUWRIC), "Women Empowering Together,"(2019): 18, available at Hacettepe Üniversitesi Kadın Sorunları Uygulama ve Araştırma Merkezi (HUKSAM), accessed on 15 January 2023.

Figure 6. 4. The Women and Girls Safe Spaces- Training on Family Planning.[413]

The second component was trainings given to health mediators to be employed in the centres by UNFPA technical experts and the employment of the health mediators in the centers. The health mediators employed within the scope of the project were Syrian refugee women who received trainings on providing rights-based and gender-sensitive services to their communities, including sexual and reproductive health and women's rights on gender-based violence; laws and services regarding violence against women, the civil rights of women, asylum seekers' rights, and everyday life in the respective cities (transportation and the locations of hospitals and important institutions).[414] The centers also had support personnel such as a translator, cleaning personnel, and security staff who were Turkish speakers. Syrian refugee women's health mediators were among the most critical part of this project as the centers also employed Syrian refugee women. Syrian female health mediators were trained and employed for the centers, which was an essential component of the project as this gave some Syrian refugee women employment opportunities. The Hacettepe University Women's Research and Implementation Center representative explained the work done by the Syrian refugee women's health mediators as follows:

[413] Hacettepe University Women's Research and Implementation Center (HUWRIC), "Women Empowering Together," 17.

[414] Albayrak, Cankurtaran, Özvarış, and Erdost, "They Taught Us not Only our Rights As Women," 947.

> We selected Syrian women who could take the functions of health mediators with the necessary leadership skills. They worked very actively in the field for our centers' outreach activities. They knocked on the doors and talked with women individually to inform them of the trainings. They also conveyed the problems of Syrian refugee women to us. More importantly, the centers empowered these women by giving them employment opportunities. [415]

As might be seen from this statement, the employment of Syrian refugee women firstly empowered by giving them the opportunity to work and earn and moreover, they created an extensive for the centers and their functions were quite like the midwives employed in the Health Centers (*Sağlık Ocakları*) of Turkey before the 2003 Health Transition Program which will be discussed in detail in the next chapter. UNFPA, within this overall framework, provided extensive outsourcing, outreach expertise, as well as empirical and coordination expertise to attain the policy goal of sexual and reproductive healthcare provision to Syrian refugee women. UNFPA acted in analytical, operational, and political capacities and played a policy-changing role through advocacy activities in the issues discussed above.

As discussed before, WHO's role was much more on outsourcing some state functions as it coordinated the trainings directly to service providers, which were Syrian health professionals employed in the migrant health centers. WHO was discussed not to undertake an advocacy role but to be engaged with future integration issues. UNFPA's target group is Syrian refugee females directly and some public officials through the trainings given on Minimum Initial Service Package. Moreover, the overall content of the trainings was, to a certain extent, a policy issue that the host country needs to prioritize further in overall health policy. Therefore, UNFPA applied an advocacy role in this project for refugee women's rights.

The below statement of UNFPA representative summarizes the policy-changing role and advocacy role UNFPA played through introducing policy instruments to change the overall dominant policy:

> While the Ministry of Health was opening the Migrant Health Centres, reproductive health issues were not on the agenda specifically. The priority was the provision of

[415] Interview 13, Hacettepe University Research and Implementation Centre on Women's Issues, Ankara, 21 January 2021.

> sufficient health facilities and basic health needs such as vaccination and medical treatment. We provided here the technical support to integrate issues of reproductive health, family planning, gender-based violence, and mental health support. Our technical trainings on the Minimum Initial Service Package ensured a gender-sensitive approach to healthcare provision.[416]

This statement of the UNFPA representative shows here through capacity development, referring to outsourcing expertise with a target group of public officials and service providers, and more importantly, through the trainings targeting Syrian refugee women within the Women and Girl Safe Spaces, UNFPA created policy learning in considering gender aspects of health. UNFPA's work on giving trainings on the Minimum Initial Service Package refers to an analytical capacity as the organization relied on organizational knowledge. Consequently, UNFPA integrated the issues of family planning and gender-based violence into the Migrant Health Centers. This work is quite important and refers to an advocacy role played by the technical agency. Most of the interviewees of the research gave similar statements indicating that the Migrant Health Centres were not established to provide services for gender-based violence and specifically advisory services on reproductive health.[417] The respondents gave affirmative statements regarding the role of the Women and Girls Safe Spaces in responding to that specific need. Later, the Women and Girls Safe Spaces were transited to Migrant Health Centers as Women Health Advisory Units. Within this framework, UNFPA's expertise was much more on changing some aspects of healthcare provision toward refugee women.

UNFPA also undertook coordination roles, and in that sense, it applied coordination expertise, which refers to its political capacity as part of its stakeholder management resources. Just like WHO, UNFPA also used coordination expertise to broaden the scope of the health governance of refugee health governance to include various non-state actors. The below statement of a representative from one of the implementing partners of UNFPA confirms the policy capacity of UNFPA:

> We had coordination meetings with the participation of all the relevant parties once every three months. We discussed our problems in those meetings and found

[416] Interviewee 5, UNFPA, Ankara, 5 August 2021.

[417] Interview 5, UNFPA, Ankara, 5 August 2021.

> solutions to those problems. For instance, the authorized people from the Turkish Ministry of Health revealed their requests, provided feedback, and tried to find alternative solutions to the problems. This communication was critical. [418]

This expertise led to the communication between state and civil society actors and coordinated the project by integrating the expertise of different experts. While undertaking all this outsourcing and coordination expertise, UNFPA also applied extensive outreach expertise, which refers to its operational capacities. Within this framework, the trainings of the health mediators and the function they undertook became significant for the overall aims of the Women and Girls Safe Spaces Project. Data from this research shows that its outreach expertise was one of the most substantial assets of UNFPA, specifically in the health governance of Syrian refugee women in Turkey. The health mediators trained to be employed in the Women and Girls Safe Spaces were at the heart of the organization's outreach activities. The Syrian refugee women acted as health mediators between their communities, and the Women and Girls Safe Spaces became very efficient in integrating gender aspects of health. As indicated by one of the interviewees, "the Syrian refugee women health mediators first created trust in centers, which enabled Syrian refugee women to be part of the trainings. Moreover, the centers provided opportunities for Syrian women, empowering them." [419]

Within this framework, the outreach expertise of UNFPA was influential in integrating the gender aspects as a policy initiative. One of the research interviewees stated that the "centers always remained full, due to the work of health mediators". [420] The statement also shows the need for the service being provided. The employment of health mediators as an outreach activity is familiar to UNFPA's interventions in Turkey. This model of health mediators was designed for the Seasonal Agricultural Workers Project aiming to enhance the access of seasonal agriculture workers to protective healthcare services and the model was

[418] Interview 13, Hacettepe University Research and Implementation Centre on Women's Issues, Ankara, 21 January 2021.

[419] Interview 13, Hacettepe University Research and Implementation Centre on Women's Issues, Ankara, 21 January 2021.

[420] Interview 6, UNFPA, Şanlıurfa, 16 August 2021.

implemented by UNFPA between 2006 and 2011.[421] The same model of health mediators was used for the Women and Girls Safe Spaces and the model was also used by the WHO within the scope of the Community Health Support Staff Project as discussed earlier. The following section will discuss the policy outcomes led by this initiative.

6.4. Policy Outcomes and Degree of Policy Learning

UNFPA calls the centers a key strategy[422], however, the centers are a new policy instrument with its specific aims to deliver gender-sensitive sexual and reproductive service healthcare for refugee women. Since this is a policy instrument integrating gendered aspects of health, which is not available in standard healthcare provision at this level in Turkey, we can argue that the centers led to a policy change in health service provision towards a more gender- and culturally sensitive mode. Within this framework, the discussed policy capacities of UNFPA provided resources for the policy change in reproductive healthcare provision. Within this context, the implementation of such a policy instrument was not prioritized in line with the current gender politics. However, the Minimum Initial Service Package framework and the impetus of the problem pressures caused by the demographic statistics discussed earlier made the implementation easier. Within this context, UNFPA's technical expertise in operationalizing the centers and supporting state capacity had significant implications for the overall policy change on reproductive health service provision.

Moreover, the Women and Girls Safe Spaces project created employment for refugee women and resulted in outreach through the activities of the refugee women health mediators communicating the project to the refugee population. However, the extent of the Women and Girls Safe Spaces was not extended to all 30 Syrian-populated cities of Turkey as was with the Migrant Health Centers. Only some of the outputs of the projects was integrated to Migrant Health Centers as of the end of of DG ECHO

[421]"Proje Hakkında- Proje Öyküsü," *Mevsimlik Tarım İşçileri*, available at Mevsimlik Tarım İşçileri (mevsimliktarimiscileri.org), accessed on 17 February 2024.

[422] " The Women and Girls Safe Spaces Opening Ceremony", UNFPA Türkiye available at UNFPA Türkiye | Women and Girls Safe Spaces Opening Ceremony, accessed on 30 August 2023.

financing in 2019. The Women and Girls Safe Spaces remained part of the Migrant Health Centers as an advisory unit for women health. A Ministry of Health Official gave the following statement regarding this situation. “Both UNFPA and WHO gave solid and strong outputs to migration management in Turkey. We recruited health mediators as possible we could for the SIHHAT project after UNFPA project ended.”[423] This statement shows that the outputs of the project were transferred in line with the needs foreseen and remained limited due to constraints. Therefore, this does not address a third- order change referring to a paradigm change to Turkey's healthcare system as was in the case of the extended Migrant Health Centres. However, this policy initiative became a vital policy instrument that led to a significant change in the lives of refugee women who received trainings on gender-based violence and reproductive and sexual health services. Moreover, refugee women found employment opportunities as health mediators in the centers as discussed.

The centers led to a second-order policy change in a policy issue which does not fully go in parallel with grand politics. The analytical, operational, and political policy capacities of UNFPA undertook an advocacy function here in integration gendered aspects to healthcare provision.

[423] Interview 1, The Turkish Ministry of Health, Ankara, 15 February 2021.

CHAPTER 7

UNICEF AND IMMUNIZATION HEALTHCARE PROVISION TO SYRIAN REFUGEE CHILDREN

The collapse of the healthcare system in Syria prior to the mass migration of Syrians became a cutback in the access of the refugee population to vaccines, which is a prerequisite for the fulfillment of the right to health.[424] The challenges mentioned above of the Syrian refugees in accessing healthcare services, as well as their unsatisfying life conditions in Turkey, created additional barriers for Syrian refugees to be protected from infectious diseases.[425]

The available data prove that refugees are not a source of infectious diseases as put forward as a social stigma. However, the conditions of the migration make them vulnerable to be exposed to infectious diseases.[426] Therefore, available, and accessible immunization services are challenging but vital for refugee populations.

Turkey did not launch a separate expansive campaign designed for the specific needs of Syrian refugees. Instead, Turkey developed a policy to integrate the Syrians under temporary protection to the Expanded Campaign on Immunization applied in Turkey

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[424]Please see the Relief Web article for the impact of the collapsed healthcare system and medical supply change in Syria on human lives, in "Syria: Healthcare System Crumbling," 11 December 2012, Relief Web, available at Syria: Healthcare system crumbling - Syrian Arab Republic | ReliefWeb, accessed on 27 November 2023.

[425]Türk Tabipleri Birliği, , *Suriyeli Sığınmacılar ve Sağlık Hizmetleri Raporu* (Ankara: Türk Tabipleri Birliği Yayınları, 2014), 42, available at https://ttb.org.tr/kutuphane/siginmacirpr.pdf?ysclid=lfpfpbidc2314012336, accessed on 26 March 2023.

[426] "Migrants And Refugees at Higher Risk Of Developing Ill Health Than Host Populations, Reveals First-Ever WHO Report on the Health of Displaced People in Europe," World Health Organization Europe, 21 January 2019, available at Migrants and refugees at higher risk of developing ill health than host populations, reveals first-ever WHO report on the health of displaced people in Europe, accessed on 27 November 2023.

since 1981.[427] This national immunization campaign started as a response to WHO Global Expanded Program on Immunization in 1974 to ensure that all children benefit from vaccines and are protected from preventable infectious diseases.[428] In 2017, UNICEF and the Turkish Ministry of Health collaborated on a campaign integrating Syrian children into the Expanded Campaign on Immunization through funding from Kuwait.[429] WHO was also one of the partners of this initiative. However, this chapter aims to analyze this initiative concerning the policy capacity of UNICEF in this collaboration on integrating Syrian refugees into the Expanded Campaign on Immunization in Turkey.

This collaboration supported the already available policy instrument to integrate refugees. Within this framework, the collaboration on the campaign on integrating the refugees aimed to support the existing mechanisms through different collaborative interventions, which can group as first-order change in Hall's conceptual framework. "A first-order change in policy is the process where instrument settings are changed in the light of experience and new knowledge, while the overall goals and instruments of policy remain the same."[430] The campaign aimed to integrate the Syrian refugee population into an already existing policy tool, and only some changes were included for integration purposes. Therefore, this was only a change in the settings of an existing policy instrument, and UNICEF supported these changes for integration.

Within this framework, the level of policy change was significantly less intensified compared to the introduction of other new policy instruments created for healthcare

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[427] "The vaccines in the national immunization program aim to provide immunization for the following infectious diseases: pertussis, diphtheria, tetanus, measles, rubella, mumps, tuberculosis, polio, chickenpox, hepatitis A, hepatitis B, invasive Streptococcus pneumoniae and invasive Haemophilus influenzae type b, in "The Expanded Programme on Immunization (EPI)", in "The Expanded Programme on Immunization," the Turkish Ministry of Health, available at The Expanded Programme on Immunization (EPI) (saglik.gov.tr), accessed on 24 August 2023.

[428] "Essential Programme on Immunization," World Health Organization, available at Essential Programme on Immunization (who.int), accessed on 28 November 2023.

[429] Donatella Lorch, "In Turkey, Two Rounds of Country-Wide Vaccinations Target Children under Age Five," UNICEF Türkiye, 15 June 2017, available at In Turkey two rounds of country-wide vaccinations | UNICEF, accessed on 27 November 2023.

[430]Hall," Policy Paradigms, Social Learning, and the State," 278.

provision (Refugee Health Training Centers and employment of the refugee health professionals within the centers through the collaboration between WHO and the Turkish government; and the Women and Girls Safe Spaces created through the collaboration between UNFPA and the Turkish government). The collaboration between UNICEF and the Turkish government on immunization service provision was ad-hoc, with specific targets unlikely to other policy instruments developed by WHO and UNFPA. The following section will analyze the policy sector of immunization in Turkey. Then, the second section will examine the problem pressures brought by migration to the policy sector of immunization. The last section will examine the role of UNICEF in this policy change through the analytical framework established earlier.

7.1. Immunization Policies in Turkey

Immunization of infants (adults also in case of outbreaks) and women as part of pre/ post-natal care protects infants and mothers from vaccine-preventable diseases, and their benefits have been proven through ongoing studies for decades.[431] Within this framework, immunization has significant proven impacts on reducing infant mortality and morbidity.[432] However, applying an effective nationwide immunization program is costly and requires solid national health infrastructure and trained health staff on immunization services. Countries planning to undertake an extensive immunization program aiming for high vaccine coverage must devote considerable resources to applying the required strategies to make early childhood vaccines accessible to every child. In this framework, it is unsurprising that there is a relation between the income level of countries/ regions and the vaccination coverage rates of the required vaccines for specific ages. For example, most of WHO African region countries remain below global levels and targeted vaccination rates aimed by WHO's Global Vaccine Action Plan.[433] National income is an essential determinant of the

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[431]K Khaled Maman, York Zöllner, Donato Greco, Gerard Duru, Semukaya Sendyona, and Vanessa Remy , "The Value of Childhood Combination Vaccines: From Beliefs to Evidence," *Human Vaccines and Immunotherapeutics*, Vol: 11, No: 9 (2015).

[432] “Vaccines and Immunization,” World Health Organization Europe, available at Vaccines and immunization EURO (who.int), accessed on 30 July 2023.

[433]Rebecca Mary Casey, Lee McCalla Hampton, Blanche-philomene Melanga Anya, Marta Gacic-Dobo, Mamadou Saliou Diallo, and Aaron Stuart Wallace , "State of Equity: Childhood

effective nationwide immunization program. However, financial resources, sufficient healthcare infrastructure (cold supply chains), and trained healthcare staff are some determinants of vaccination coverage. Policymaking and political determination to apply an extensive immunization campaign are essential components of an effective immunization campaign. Considering that financial resources and political determination are significant determinants of an effective immunization program, it is unsurprising to see some exceptional country cases with low Gross National Income levels but high vaccination coverages. For example, Rwanda achieved more than 80 percent of vaccination coverage in DTP3 (diphtheria, pertussis (whooping cough), tetanus) and above 90 percent in all required vaccinations despite its low ranking in the Gross National Income level at the global scale. [434] The example of Rwanda shows how political will is a significant determinant of an effective immunization campaign. Rwanda is an exceptional case, as the data from around the world reveals many examples of state policies feeding vaccine rejection due to increasing anti-vaccine discourses among populist political parties. Studies show that populist political parties use vaccines to decrease trust in institutions.[435]

Turkey achieved a high coverage rate (over 90 percent) in some of the vaccines in its national immunization program, such as the coverage of DTP3 (UNICEF data in Figure 7.1.). Turkey is also among the countries with well-trained staff on immunization services and possesses the necessary infrastructure to implement the national immunization program as it did for more than four decades. Turkey also performs relatively high rates of immunization in pre-natal care. In the 2018 Turkey Demographic and Health Survey, 81 percent of the women in Turkey are reportedly vaccinated against tetanus as part of pre-natal care. [436]

Immunization in the World Health Organization African Region," *The Pan African Medical Journal*, Vol: 27, No: 3 (2017):5-6.

[434] Casey, Hampton, Anya, Gacic Dobo, Diallo, and Wallace, "State of Equity- Childhood Immunization," 5.

[435] Almudena Recio-Román, Manuel Recio-Menéndez and María Victoria Román-González, "Political Populism, Institutional Distrust and Vaccination Uptake: a Mediation Analysis", *International Journal of Environmental Research and Public Health*, Vol: 19, No:6 (2022), 1. ; Olga Khazan, "What is Really Behind Global Vaccine Hesitancy," *The Atlantic*, 06 December 2021, available at What is Really Behind Global Vaccine Hesitancy - The Atlantic, accessed on 19 August 2023.

[436] Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey* (Ankara: Elma Teknik Basım Matbaacılık, 2019), 105.

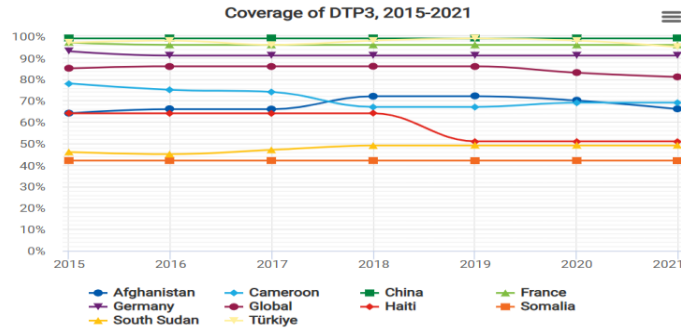

Figure 7. 1. UNICEF- Immunization Coverage Estimates Dashboard.[437]

Turkey's vaccination rate on some vaccines, such as DTP3, remains among the best rates in the country rankings, as can also be seen in the WHO data set.[438] However, according to the data of the latest 2018 Turkey Demographic and Health Survey, there is a decreasing trend in the overall vaccination coverage rate (all vaccines required to be applied for infants between 12- 23 months as per the Turkish national immunization program) compared to the data of the previous health surveys. A comparison between the previous year's Demographic and Health Surveys shows a decrease in overall vaccination coverage. The overall vaccination coverage rate was 40.4 percent.[439] in 1998, 48 percent in 2003[440] , 74.6 percent in 2008[441], and 74,1 percent in 2013[442]. However, it should be noted here that there was a significant

[437] UNICEF, "Immunization Coverage Estimates Dashboard, WUENIC Analytics," updated on July 2022, UNICEF, available at https://unicef.shinyapps.io/wuenic-analytics-2022/, accessed on 24 May 2023.

[438] World Health Organization, "The Global Health Observatory- Diphtheria Tetanus Toxoid and Pertussis (DTP3) Immunization Coverage Among 1-Year-Olds (%)," World Health Organization, available at Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (who.int), accessed on 27 November 2023.

[439] Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü, *Türkiye Nüfus ve Sağlık Araştırması 1998*, (Ankara: Hacettepe Üniversitesi Hastaneleri Basımevi, 1999), 114, available at http://www.sck.gov.tr/wp-content/uploads/2020/02/Turkiye-Nufus-ve-Sa%C4%9Flik-Arastirmasi-1998.pdf, accessed on 17 June 2023.

[440] Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü, *Türkiye Nüfus ve Sağlık Araştırması 2003*, (Ankara: Hacettepe Üniversitesi Hastaneleri Basımevi, 2004), xviii, available at http://www.sck.gov.tr/wp-content/uploads/2020/02/Turkiye-Nufus-ve-Sa%C4%9Flik-Arastirmasi-2003.pdf, accessed on 17 June 2023.

[441] Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü, *Türkiye Nüfus ve Sağlık Araştırması 2008*, (Ankara: Hacettepe Üniversitesi Hastaneleri Basımevi, 2009), 162, available at http://www.sck.gov.tr/wp-content/uploads/2020/02/Turkiye-Nufus-ve-Sa%C4%9Flik-Arastirmasi-2008.pdf, accessed on 17 June 2023.

[442] Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü, *2013 Türkiye Nüfus ve Sağlık Araştırması*, (Ankara: Elma Teknik Basım Matbaacılık, 2014), 176, available at Turkiye-Nufus-ve-Sağlik-Arastirmasi-2013.pdf (sck.gov.tr), accessed on 17 June 2023.

change in the national immunization program with the addition of several other vaccines to the required vaccines for infants between 15-26 months in 2013. Moreover, these changes encompassed changes in the children's ages to complete all the required vaccines.[443] Within this framework, Turkey extended the obligatory vaccine package after 2013, and this more extensive package is also a possible reason behind this decrease, as in the current situation, there are more types of vaccines in the national program. Still, the comparison between 2013 and 2018 shows a decrease in the overall vaccination coverage rate, which addresses a need to consider this to prevent future decreases in fatal infectious diseases for infants.

The rates for the consecutive doses of the subject-required vaccines also decreased significantly compared to the first doses (Figure 7.2.). Within this framework, the overall coverage rate for the required vaccines for infants between 12- 23 months is 67 percent, according to the 2018 Demographic and Health Survey. The vaccination coverage rate for the third dose of the DTaP-IPV-Hib vaccine, which protects against diphtheria, pertussis (whooping cough), tetanus, polio, and Haemophilus influenzae type b vaccines, is 79 percent. The vaccination coverage rate for the third dose of pneumococcal conjugate vaccine (PCV) is 75 percent of infants between 12 and 23 months.[444] This data show that the coverage for the first doses is significantly high but decreases in the second and third doses. The follow-up vaccines are an integral and significant part of an effective immunization program.

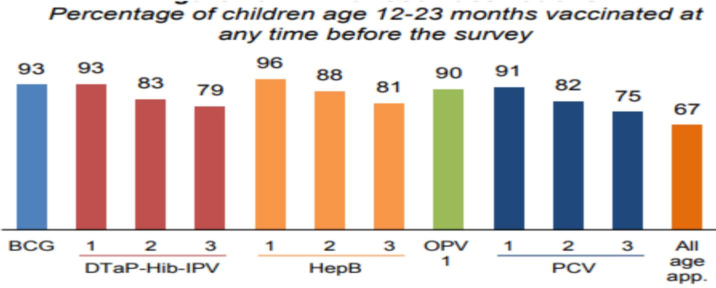

Figure 7. 2. Vaccination Coverage Rates of the Infants (12- 23 months) - 2018 Turkey Demographic and Health Survey-[445]

[443]Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey*, 126.

[444] Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey*, 126.

[445] Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey*, 126.

Close follow-up on the consecutive dose is not only related to the availability and accessibility of the healthcare system but also to the parent's consent. Parents' knowledge, beliefs, and behaviors impact vaccination coverage rates within this framework.[446] Vaccine rejection is an outstanding public health concern in Turkey and all around the world, and it has been an increasing trend in recent years. According to WHO, vaccine hesitancy was one of the ten threats to global health in 2019. [447] Vaccine rejection is also a significant public health concern in Turkey. "183 families in 2011, 980 families in 2013, 5400 families in 2015, 12,000 families in 2016, and 23,000 families in 2018 are reported to have refused to vaccinate their children".[448] A study also found that between 2014 and 2021, 628 families refused vaccination in Adıyaman, a relatively small city in the southeast of Turkey.[449] Although vaccine rejection may be related to many factors, a lack of knowledge of the benefits of vaccines is an essential cause, especially in urban settings.[450] Therefore, outreach activities aiming to create trust between parents and health professionals play an essential role. Recent studies show vaccine mistrust among family health physicians in Turkey, negatively affecting the physician's attitude toward vaccine recommendations to parents.[451] This data address a need for knowledge and awareness-raising activities on the benefits of vaccines for infant health. Other factors also affect the vaccination coverage rates and the vaccine rejection phenomenon. The changes in immunization policies and the healthcare system and their impact on immunization require a more detailed analysis to understand the policy sector on immunization.

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[446] Zuhal Emlek Sert, Sevcan Topçu, and Aysun Çelebioğlu, "Knowledge, Beliefs, and Behaviors of Turkish Parents about Childhood Vaccination," *Vaccines*, Vol:11, No: 1285 (2023): 1.

[447] "Ten Threats to Global Health in 2019," World Health Organization, available at Ten threats to global health in 2019 (who.int), accessed on 28 November 2023.

[448] Emel Gür, "Vaccine Hesitancy - Vaccine Refusal," Turkish Archives of Pediatrics, Vol:54, No:1 (2019): 2.

[449] Osman Kurt, Osman Küçükkelepçe, Erdoğan Öz, Hülya Doğan Tiryaki, and Mehmet Emin Parlak, "Childhood Vaccine Attitude and Refusal among Turkish Parents," *Vaccines*, Vol:11, No:1285 (2023): 1.

[450] Sert, Topçu, and Çelebioğlu, "Knowledge, Beliefs and Behaviours," 6.

[451] Selda Yörük, Hülya Türkmen, Aysegul Durgut and Meliz Erbek, "Vaccine Mistrust among Family Healthcare Professionals and Vaccine Hesitancy in the Communities They Serve in Turkey in 2019: A Cross-Sectional Study," *Human Vaccines and Immunotherapeutics*, Vol:16, No: 12 (2020): 3160.

Some studies argue that these factors are mostly related to the changes brought by the Health Transition Program of 2003, which significantly changed the structure of primary-level healthcare provision.[452] The Turkish healthcare system experienced a significant change in the primary-level health service provision with the change of the Primary Healthcare Centers (*sağlık ocağı*) to the Family Health Center (*Aile Sağlığı Merkezi*) and the Community Healthcare (*Toplum Sağlığı Merkezi*) System (led by the Health Transition Program) with the transition program. This change in the primary level healthcare service provision profoundly changed the nature of implementing the national immunization program in Turkey.[453] The Primary Healthcare Centers, as the central service provision units of the Turkish healthcare system prior to 2003, were significant in providing immunization services to the people. The midwives (*ebe*), who were Turkish Ministry of Health personnel, acted as focal points for providing trust between the health personnel and the families by explaining the benefits of the vaccines and possible results of the non-vaccinations for infant health.[454] Erbayraktar describes the functions of the midwives as socializing primary-level healthcare and extending the scope of service provision from Primary Level Healthcare Centers (*sağlık ocağı*) to the districts, villages, and eventually households, more importantly to have personal humane interaction with the household.[455] Therefore, the primary healthcare centers and the midwives, as the leading service providers, performed a vital outreach function before the healthcare transition.

The current Family Health Center (Aile Sağlığı Merkezi) is based on entirely different working mechanisms. First, the family physicians in these centers are the primary service providers, acting as medical doctors in the centers. The family physicians also act as business administrators of the Family Health Centers due to their responsibility to manage the centers' costs with state funds provided for the

[452] Muzaffer Eskiocak, Bahar Marangoz, *Türkiye'de Bağışıklama Hizmetlerinin Durumu* (Ankara, Türk Tabipleri Birliği Yayınları, 2021), 21, 43.

[453] Eskiocak, and Marangoz, *Türkiye'de Bağışıklama Hizmetlerinin Durumu*, 20.

[454] Eskiocak, and Marangoz, *Türkiye'de Bağışıklama Hizmetlerinin Durumu*, 20-21.

[455] Nüket Paksoy Erbaydar, "Sosyalleştirilmiş Sağlık Hizmetlerinde Ebelerin Sağlık Ocağı ile İlişkisinin Mekânsal İncelemesi," *Fe Dergi*, Vol: 10, No: 2 (2018):140, 143.

running expenditures (*cari gider ödenekleri*), defined by the number of patients treated in the centers. [456] Therefore, demand is essential for healthcare provision in the family healthcare systems. Within this framework, a family practitioner may not be assigned and willing to run the Family Health Center where demand is insufficient to receive required state allocations meeting the running expenditures.

This commercial working nature of the Family Health Centers also created difficulties for the medical staff, who had to pay bills and consider the expenditures while providing healthcare services. The statistics of the Ministry of Health dated 2018 show that there are no family practitioners in the 2250 Family Health Centers of Turkey, and the Family Health Centers where family practitioners are undertaking the duties are %91.4 complete.[457] This data show that commercial considerations hinder providing primary-level healthcare services to reach a wide range of geographical coverage. Since the Primary Healthcare Centers and Family Health Centers are essential places for providing immunization services and their follow-up later, we can argue that this change affected the national immunization program in Turkey since the outreach capacities of the Family Health Centers remained relatively limited due to financial concerns.

Contrary to the family health center system, the primary healthcare system did not seek demand for service provision and aimed at accessing every household to provide expanded health service provision. This fundamental difference between the two systems is likely to affect vaccine rejection, a factor in decreasing vaccination coverage rates. Some field studies also found a decrease in coverage rates during the first years following the launch of the Health Transition Program. For example, a study examining the vaccination coverage rate in Gaziantep during the first years of the Health Transition Program found a decrease in the overall coverage rates for consecutive doses. [458]

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[456] Ferhat Sayım, and Dilara Eyüpoğlu, "Finansal İşleyiş Açısından Aile Hekimlikleri". In 4. *Uluslararası İşletme Öğrencileri Kongresi Bildiriler Kitabı*, ed. by Selami Özcan, Şenay Yürür, Vildan Taşlı, Volkan, and Polat, (Yalova, Yalova Üniversite, 2019), 84.

[457] Eskiocak, and Marangoz, *Türkiye'de Bağışıklama Hizmetlerinin Durumu*, 24.

[458]Birgül Özçırpıcı, Neriman Aydın, Ferhat Coşkun, Hakan Tüzün, and Servet Özgür, "Vaccination Coverage of Children Aged 12-23 Months in Gaziantep, Turkey: Comparative Results of Two Studies

Although it is not easy to say that the transition program directly impacted the decrease, as there might be other factors affecting the decrease, this change impacted the immunization program. Within this framework, the overall status of the national immunization program and service provision accordingly were affected by the overall paradigmatic change in the healthcare system in Turkey, which signified a state-financed and implemented service provision towards an individual financed and requested service receipt. Some critiques of the change in the primary level healthcare service provision claimed that the Family Health Centers (*aile hekimliği*) were less inclusive compared to the old system, as the Primary Healthcare Center (*sağlık ocağı*) system was based on the idea of covering all regions, cities, and districts of Turkey and making primary level healthcare accessible for everyone independent of ethnicity or socio-economic status. [459]

Moreover, there is a policy leaving the vaccine decision to the will of individuals and demand-supply market conditions in recent years.[460] However, the overall policy of leaving the vaccination to individual preferences increases the risks of "vaccine rejection" despite its proven positive impacts on decreasing mortality and morbidity rates.[461] Therefore, political will is the primary source of increasing individual demand in a context where vaccines are not obligatory, as in the case of some countries such as France.[462] Where institutions are assigned to apply outreach activities to reinforce the implementation of the immunization program.

The years of the migration crisis and the emerging immunization needs of the Syrian refugees corresponded to the years when there were significant changes in the immunization policy of Turkey. In this context, the immunization policies to be

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Carried out by Lot Quality Technique: What Changed after Family Medicine?," *BMC Public Health*, Vol: 14, No: 1 (2014), 6.

[459] Eskiocak, and Marangoz, *Türkiye'de Bağışıklama Hizmetlerinin Durumu*, 83.

[460] Eskiocak, and Marangoz, *Türkiye'de Bağışıklama Hizmetlerinin Durumu*, 22.

[461] Eskiocak, and Marangoz, *Türkiye'de Bağışıklama Hizmetlerinin Durumu*, 22.

[462]Shazia Sheikh, Eliana Biundo, Soizic Courcier, Oliver Damm, Odile Launay, Edith Maes, Camelia Marcos, Sam Matthews, Catherina Meijer, Andrea Poscia, Maarten Postma, Omer Saka, Thomas Szucs, and Norman Begg, "A Report on The Status of Vaccination in Europe,"*Vaccine*, Vol: 36, No:33 (2018): 4982.

applied to Syrian refugees were affected by the overall change in the healthcare system of Turkey. This paradigmatic change in the Turkish healthcare system directly affected how immunization services are provided. Policymaking also determines the provision of immunization services to refugees, as policymakers determine the spending on the vaccine infrastructure and healthcare staff. Although current immunization politics in Turkey marks a service provision environment where individual decisions are prioritized, Turkey sought additional solutions for increasing immunization rates among refugees, which was mainly due to problem pressures brought by migration that will be discussed in the next section.

7.2. Immunization of Refugees as a Policy Issue

There are several studies showing that immunization of refugees became an essential topic for refugee-hosting countries, as there was evidence of cases of measles, diphtheria-associated wound infections, and other vaccine-preventable diseases in migrant settings within destination/transit countries for Syrian refugees.[463] These cases were reported both in neighboring countries of Syria, which hosted most of the refugee population, but also in the refugee-hosting countries of Europe. WHO confirmed the outbreak of polio disease in northeast Syria in 2013, which had not been seen since 1999.[464] The reported cases mainly were measles, polio, Hepatitis A and B Viruses, Tuberculosis, Human Immunodeficiency Virus, cutaneous leishmaniasis, schistosomiasis, MERS-CoV, Haemophilus influenzae type b (Hib) were reported among refugee populations in Turkey, Lebanon, Jordan, and Iraq without turning to be an outbreak.[465]

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[463] See the following studies done with regards to the cases of infectious diseases among refugees: G Jones , S Haeghebaert, B Merlin, D Antona, N Simon, M Elmouden, F Battist , M Janssens , K Wyndels and P Chaud , "Measles Outbreak in a Refugee Settlement in Calais, France: January to February 2016," *Eurosurveillance*, Vol: 21, No: 11 (2016): 1.; D. M. Meinel, et al. "Outbreak Investigation for Toxigenic Corynebacterium Diphtheriae Wound Infections in Refugees from Northeast Africa and Syria in Switzerland and Germany by Whole Genome Sequencing," *Clinical Microbiology and Infection*, Vol: 22, No: 12 (2016), 1003, e1; Ali Alawieh, Umayya Musharrafieh, Amani Jaber, Atika Berry, Nada Ghosn and Abdul Rahman Bizri, "Revisiting Leishmaniasis in the Time of War: The Syrian Conflict and the Lebanese Outbreak,",*International Journal of Infectious Diseases*, Vol: 29 (2014): 115–19.

[464] Nada Melhem, Khalil Kreidieh, and Sami Ramia, "The Syrian Refugees Crisis Brings Challenges to the Health Authorities in Europe: Hepatitis A Virus Is a Case in Point," *European Journal of Epidemiology*, Vol: 31, No: 7 (2016): 712.

[465] Melhem, Kreidieh, and Ramia, "The Syrian Refugees Crisis Brings Challenges", 711.

These reported cases do not mean that refugee populations carry diseases to the destination or transit countries. Refugees are vulnerable to getting caught with infectious diseases due to the worsening life conditions in the destination countries during migration. Within this framework, such outbreaks are associated with war and migration conditions, as the refugees leave their homes, jobs, and finances to travel to places for safety, which is mainly unsatisfying life conditions. WHO resources do not show any relation between migration and the importation of infectious diseases. However, likewise, some relevant reports emphasize that outbreaks can be seen among migrant populations due to bad living conditions of refugees, such as overcrowded accommodations, and lack of access to clean water.[466] The same conditions are valid for Syrian refugees in Turkey, and they are also vulnerable to being caught up with infectious diseases due to these conditions, as discussed earlier. There was no outbreak of infectious diseases, although some cases were seen in other contexts. Several interviewees from the Turkish Medical Association[467], WHO[468] and the Turkish Ministry of Health[469] gave similar statements to the WHO findings stating that Syrian refugees were not importers of infectious diseases from the country of origin to Turkey. However, they became more vulnerable to being exposed to infectious diseases due to migration conditions.

Several studies regarding the health risks associated with the outbreaks of conflicts and wars and studies conducted explicitly regarding the health needs of Syrian refugees show that the vaccination and immunization programs implemented efficiently reduce the health risks both for refugee populations and host populations.[470] An effective immunization program is significant for the health

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[466] "Migration and Health: Key Issues", World Health Organization Europe, available at http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/migranthealth-in-the-european-region/migration-and-health-key-issues , accessed on 17 May 2020.

[467] Interview 16, Turkish Medical Association, Ankara, 9 January 2021.

[468] Interview 3, World Health Organization, Ankara, 10 February 2021.

[469] Interview 1, The Turkish Ministry of Health, Ankara, 15 February 2021.

[470] Cristina Giambi, Martina Del Manso, Maria Grazia Dente, Christian Napoli ,Carmen Montaño-Remacha , Flavia Riccardo , Silvia Declich, Network for the Control of
cross-border health threats in the Mediterranean Basin, and the Black Sea for the ProVacMed Project, "Immunization Strategies Targeting Newly Arrived Migrants in Non-EU Countries of the

conditions of refugees due to their vulnerabilities stemming from the migration conditions. Within this context, applying the required strategies to integrate refugees into the national immunization programs or to build up new instruments for an effective immunization policy is essential in protecting public health and meeting the health needs of refugees. However, their integration into immunization programs poses several challenges, and these challenges are like the general problems they encountered when accessing the available healthcare services in Turkey, such as language barriers, cultural barriers, fear of deportation, health illiteracy, as discussed earlier. The vaccines are accessible and free for Syrian refugees in the Family Health Center and Migrant Health Centers, as this is the case with the Turkish citizens. Syrians with temporary protection cards numbered 99 have full access to the Turkish healthcare system and immunization services. For example, within these conditions discussed, the system of Family Health Centers reveals several other challenges and difficulties for temporary protection holders due to 'performance criteria' applied for Turkish family practitioners, which affect their salaries and running expenditures of the family health centers mentioned earlier. The UNICEF Representative gave the below statement on this issue:

> In the Turkish healthcare system, a performance indicator is being applied to family physicians. The state first gives the budget to Family Health Centers and family physicians and then applies a reduction on the budget based on the performance indicator. These performance indicators may cause difficulties for the groups who are difficult to be followed up such as refugees or Roman minority groups who are mobile communities. Within this system, family physicians are not obliged to apply the vaccine, but they are obliged to follow up the vaccine, and a failure in follow-up may lead to a reduction in performance indicators.[471]

For example, this criterion led to hesitation among family practitioners to have refugee patients with the fear of being cut off the budget due to the possible failures in applying consecutive doses of the vaccines of the mobile refugee population. Therefore, the problems associated with the current healthcare system, such as the performance criteria, created various non-visible impediments to refugees' access to vaccination.

Mediterranean Basin and the Black Sea," *International Journal of Environmental Research and Public Health*, Vol: 14, No: 5 (2017), 10.; R. Assi, S. Özger-İlhan, and M. N. İlhan, "Health Needs and Access to Health Care: The Case of Syrian Refugees in Turkey,", *Public Health*, Vol: 172 (2019), 150.

[471] Interview 7, UNICEF, Ankara, 15 January 2021.

The 2018 Population and Health Survey shows that the vaccination coverage rates for Syrian refugee infants are far below the national vaccination coverage rates (60 percent for Syrian refugees and 67 percent for Turkish citizens for the vaccination coverage rate of all required vaccines).[472] The immunization became a problem for the non-camp urban refugees especially, as most of the camp urban refugees were not maintaining the satisfying living condition.[473] Immunization, especially for infants, became much more important in the living conditions of the refugees.

While the problems associated with the healthcare system and refugees' living conditions constituted significant problems, the main problems in extending immunization services to refugees started at the reception phase, discussed earlier, where Turkey still needed to apply a structured and regularized registration policy. The problems regarding proper registration at the reception phase and the difficulties in following up with the refugees due to non-regularized registration and ongoing mobility created additional challenges for Syrians' integration into immunization services.

Several studies on the good practices in providing immunization services to refugees show that a well-managed registration policy is the prerequisite of an effective refugee immunization policy.[474] An effective immunization policy requires a well-managed registration and documentation of the initial vaccination doses and a close follow-up for consecutive doses. For example, by prioritizing the most vulnerable refugees, such as women at risk, and those at risk of being discriminated against, such as the LGBTQ+ community, Canada applied a strict examination process for asylum seekers in entry. This screening process conducted by certified physicians, which was not only applicable to Syrian refugees but to all immigrants, called the Immigration Medical Examination, was used as a screening tool to define the immigrants' healthcare needs and possible security threats to public health and

[472] Hacettepe University Institute of Population Studies, *2018 Turkey Demographic and Health Survey Syrian Migrant Sample* (Ankara: Elma Teknik Basım Matbaacılık, 2019), 104.

[473] Türk Tabipleri Birliği, *Suriyeli Sığınmacılar ve Sağlık Hizmetleri Raporu*, 39-43.

[474] L. Hansen, and P. Huston, "Health Considerations in the Syrian Refugee Resettlement Process in Canada," *Canada Communicable Disease Report*, Vol: 42, No: 2 (2016): 5.

safety.[475] Such procedures were also applicable in European countries such as Germany, where "the asylum law requires a screening examination for certain infectious diseases in asylum seekers upon arrival" as well.[476]

Turkey applied an open-door policy during the early phases of the arrivals and provided emergency healthcare services to the refugees upon arrival. Within this framework, the registration procedures at the reception phase were not regularized, and Canada example shows that a well-managed registration is a prerequisite for an effective immunization policy. It should be noted that Turkey did not have a severe vaccine-preventable disease outbreak after the mass influx. However, there was no initial expanded screening of infectious diseases either.

As argued earlier, Turkey did not have a proper refugee policy for Syrians until the adoption of the temporary protection status. The foundation of the Directorate General for Migration Management standardized the registration processes and the monitoring of the stays later. Turkey applied emergency treatment to those who were affected by the war in Syria through the mobile services sent to the borders by some non-governmental organizations and the Ministry of Health during this phase. Some NGOs founded healthcare facilities at the borders at the reception phases.[477] The provision of health services through mobile vehicles and temporarily assigned health staff were to treat emergent cases as loss of organs due to war was a common incident during the ongoing violence.

At this phase, as part of the non-institutionalized health policy, there was no immunization policy toward refugees. The health interventions at the borders were symptom-based, not screening processes or medical examinations (such as in the Canadian and German cases discussed) with standard protocols. The expanded national vaccination program included children at the borders, including vaccines for

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[475] Hansen, and Huston, "Health Considerations in the Syrian Refugee Resettlement," 5.

[476] A.Z. Kortas , J. Polenz, J. von Hayek, S. Rüdiger , W. Rottbauer, U. Storr , and T. Wibmer, "Screening for Infectious Diseases among Asylum Seekers Newly Arrived in Germany in 2015: A Systematic Single-Centre Analysis," *Public Health*, Vol: 153 (2017): 1.

[477] İltica ve Göç Araştırmaları Merkezi, *Sivil Toplum Örgütlerinin Türkiye'deki Suriyeli Mülteciler için Yaptıkları Çalışmalar ile İlgili Rapor* (Ankara: Anıl Matbaa, 2013), 23, available at https://igamder.org/uploads/belgeler/IGAMSuriyeSTK2013.pdf , accessed on 26 March 2023.

oral polio, measles (MMR), TdaP-HiB-IPV (quintet vaccine), and hepatitis-B conjugated pneumococcus.[478] UNICEF and WHO supported immunization services at this phase as well.[479] This may be called the first collaboration between the Turkish government and the UN agencies on the provision of immunization services to Syrian refugees.

However, as argued earlier, an efficient immunization program does not only entail only one dose implementation, but it also requires monitoring and follow-up (*izlem ve aşı takibi*) of the consecutive doses, and proper implementation of consecutive doses requires permanent settlement in a registered address. However, the mobility of Syrians in Turkey continues, which is caused by the lack of secure and legal employment for Syrian refugees, and it is still an ongoing impediment for service providers. Several resources and the interview data of this research show that the monitoring and follow-up steps were the most challenging part of implementing the national vaccination package for Syrian refugees.[480]

Moreover, the uncertainty in the resettlement processes is still ongoing with the temporary protection status granted to the Syrians in Turkey. Like Turkey, the other central transit countries of the migration where full integration is not achieved, including Lebanon and Jordan, follow-up vaccination procedures still need to be improved.[481] The vaccination coverage rate of all required vaccines in these refugees-settings remained low due to similar difficulties in following the refugee settlements. Therefore, integrating refugees into the national immunization program becomes a problem in countries where integration still needs to be fully achieved. In refugee-receiving countries such as Canada, which gave direct permanent residence after the careful screening process, the follow-up procedures of the vaccines did not become a big problem. Within this context, in Canada, the refugees were provided temporary

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[478] Hakan Leblebicioğlu, "Managing Health and Infections in Refugees: Turkey's Experience," *International Journal of Infectious Diseases*, Vol: 45 (2016): 56.

[479] Interview 7, UNICEF, Ankara, 15 January 2021.

[480]Interview 5, UNICEF, Ankara, 15 January 2021.; Interview 16, The Turkish Medical Association, Ankara, 9 January 2021.

[481]Timothy Roberton, William Weiss, The Jordan Health Access Study Team, The Lebanon Health Access Study Team, and Shannon Doocy ,"Challenges in Estimating Vaccine Coverage in Refugee and Displaced Populations: Results from Household Surveys in Jordan and Lebanon," *Vaccines*, Vol: 5.No: 3 (2017): 1.

accommodation till a permanent settlement was guaranteed, and this eased the follow-up of the catch-up vaccines, which were organized through local health authorities and the provincial healthcare systems. [482]

Despite the data showing some potential health risks, Turkey's first extensive immunization attempt for Syrian refugee children for further integration came in 2017. Turkey launched an immunization campaign in 2017 in collaboration with UNICEF six years after the beginning of the civil war in Syria. Within this context, this campaign marked the most significant policy action in integrating the Syrian refugees into the national immunization program. The main aim of this collaboration was to integrate the Syrian refugees into the existing Expanded Campaign on Immunization. The following section aims to analyze this campaign and UNICEF's technical role in providing immunization services to Syrian refugees. The immunization policies applied to Syrian refugees in Turkey, considering this introductory discussion, are affected both by the current immunization policies in Turkey and the resources available in the current Turkish healthcare system.

7.3. Understanding the Technical Expertise of UNICEF

The collaboration campaign between the Turkish Ministry of Health and UNICEF in 2017 was conducted as a supplementary vaccination campaign to integrate Syrian refugee children and children of other nationalities into the Expanded Campaign on Immunization. This immunization campaign was not a new policy initiative or instrument. Instead, it was a support and supplement to a state program. The campaign provided immunization of 376,000 refugee children under five years old. It assessed their immunization status for the penta-valent (DaPT-IPV-Hib), MMR (Measles, Mumps, Rubella), and Hepatitis B vaccines and provided them with the relevant vaccines. The campaign covered 20 refugee-populated provinces of Turkey and took place in three rounds. [483] The Figure 7.3. from the UNICEF website shows a photograph taken during the campaign.

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[482] Hansen, and Huston, "Syrian Refugees: Health Considerations in the Syrian Refugee Resettlement," 5.

[483] UNICEF Türkiye, "Turkey – UNICEF Country Programme of Cooperation 2016-2020- Annual Report 2017," (2017) available at Yıllık Rapor | UNICEF Türkiye, 29, accessed on 22 August 2023.

Figure 7. 3. UNICEF Photo from the Vaccination Campaign. [484]

Prior to the 2017 vaccination campaign, The Turkish Ministry of Health, UNICEF, and WHO carried out other smaller-scale immunization campaigns for local and refugee children. The polio mop-up vaccination campaign between 2013 and 2015 started as a response to the outbreak of 35 polio cases in Northern Syria in five refugee-populated cities of Turkey close to the Syrian border. Then the campaign was extended to Istanbul in 2014.[485] This campaign for polio mop-up vaccination was also a supplement to the ongoing national effort as a response to an outbreak due to the ongoing war in Syria. The 2017 campaign specifically targeted the immunization of refugee children. Therefore, the 2017 campaign is the first collaboration between the Turkish Ministry of Health, WHO, and UNICEF explicitly conducted for the refugee population. The campaign targeting the completion of all the required vaccines by certain ages explicitly conducted for refugee children came six years after the beginning of the crisis and the first arrivals. UNICEF used operational and empirical capacities and took some key activities here by applying outreach, outsourcing, and empirical expertise (combining the medical knowledge and technical knowledge on the vaccines).

As discussed, there were several challenges in integrating refugees into the national immunization program. Moreover, the problem of vaccine rejection increasing

[484] "Immunization," UNICEF Türkiye available at https://www.unicef.org/turkiye/en/immunization, accessed on 21 May 2023.

[485] Bilge Erten, Pınar Keskin, Miray Omurtak, and İlhan Can Özen, "Syrian Refugee Inflows, Healthcare Access, and Childhood Vaccination in Turkey," *World Bank Economic Review*, Vol: 37, No: 1 (2023): 131.

among Turkish citizens was an even bigger problem for the refugee population, as refugees were not able to speak Turkish to access related information about vaccines, and they did not have adequate information on the Turkish national immunization program. Within this framework, the refugees were not well-informed on the benefits of the vaccines. The unstructured registration policies up to the foundation of the Directorate General for Migration Management and the ongoing mobility of the refugee population across the country posed a severe challenge for the fulfillment of all required vaccines for Syrian refugee children. This issue specifically became a problem for the non-camp urban refugees.[486] It should be noted here that vaccine rejection is a conscious decision, and it is mostly sourced by inaccurate information, and it is an ongoing problem in Turkey. However, the lack of vaccines may not always be a conscious decision for refugees. Because the Syrian refugees in Turkey needed adequate information about the Turkish healthcare system, especially in the early years of their arrival, as discussed. Moreover, they even had fear of deportation in case of application to health authorities. There were also challenges related to primary-level healthcare in Turkey. Within this framework, these conditions are a more significant source of their absence in the national immunization program rather than taking a vaccine rejection decision. However, there might be cultural and religious decisions for vaccine refusal. The below table (Table 7.1.) summarizes the policy capacities of UNICEF and to what extent these capacities led a policy change in immunization healthcare provision to Syrian refugees in Turkey.

Table 7. 1. Provision of Immunization Healthcare to Refugee Children.

	UNICEF	**T_4[487]**	**T_5[488]**
Analytical Policy Capacity	* Global databases on vaccination rates and various reports on the benefits of child immunization.	* Several sources of knowledge on the immunization status of Syrian refugee children.	*Advancing knowledge on the immunization status of Syrian refugee children.

[486]Interview 3, World Health Organization, Ankara, 10 February 2021.; Interview 4, World Health Organization, Ankara, 12 February 2021.; Interview 7, UNICEF, Ankara, 15 January 2021.; Interview 16 The Turkish Medical Association, Ankara, 9 January 2021.

[487]T_4: Before Conduct of 2017 Expanded Program on Immunization (in support to the Expanded Campaign on Immunization, (Support Policy Instrument).

[488] T_5: After Conduct of 2017 Expanded Program on Immunization in support to Expanded Campaign on Immunization, (Support Policy Instrument).

Table 7.1. (continued)

Operational Policy Capacity	*Capacity building for service providers. *Outreach activities conducted within the scope of the ad- hoc immunization campaign. * Immunization of 376,000 refugee children under five years old. The campaign assessed their immunization status for the penta-valent (DaPT-IPV-Hib), MMR (Measles, Mumps, Rubella), and Hepatitis B vaccines and provided them with the relevant vaccines in cooperation with WHO and the Turkish Ministry of Health in 20 refugee-populated cities.	*Ongoing Expanded Campaign on Immunization applied in Turkey since 1981, Expanded Campaign on Immunization.	*A support initiative to the Ongoing Expanded National Immunization Programme in action.
Political Policy Capacity	* Funds from the Government of Kuwait (for a short term during the campaign), to the conduct of campaign, *Civil society cooperation for outreach activities.	* State- funded Expanded Campaign on Immunization.	*Conduct of 2017 Expanded Program on Immunization (ad- hoc time and scope limited) in support to the Expanded Campaign on Immunization. *Ad- hoc civil society support for the outreach activities of the campaign.
	Technical Role of the UNICEF	**First- order policy change with the conduct of a supportive mechanism**	

UNICEF undertook a technical role by outsourcing state activities in the immunization campaign, supporting cold supply chains in Turkey, and providing capacity development to Syrian health professionals. According to UNICEF records, UNICEF, together with the Ministry of Health, expanded the refugee health response in Turkey beyond immunization to support and build the capacity of Syrian healthcare providers.[489] These were technical outsourcing activities the organization took. Moreover, UNICEF supported Turkey's cold supply chains. [490] Turkey is a middle-income country with financial resources and capabilities to provide complete vaccination packages for Syrian refugees. The literature on the finance of

[489]"Immunization," UNICEF Türkiye, available at https://www.unicef.org/turkiye/en/immunization, accessed on 21 May 2023.

[490] UNICEF Türkiye, "Turkey – UNICEF Country Programme of Cooperation 2016-2020," 29.

immunization shows that vaccines are generally a problem for developed countries. Several interviewees of this research stated that purchasing the vaccines was not a big problem for Turkey, such as the below statement of WHO interviewee who used to be a Ministry of Health official before his role at WHO:

> Turkey is a developing country that does not require extensive support to cold supply chains and its overall immunization infrastructure. WHO could provide general vaccination guidance if needed, and UNICEF could provide provisional and logistical support. Nevertheless, our data shows that Turkey does not need such a chain and logistical support.[491]

According to several data sources, Turkey's cold supply chain for the vaccines was enough, and there was no problem in financing additional vaccines required for Syrian refugee children. There was also vaccine support for refugees under the SIHHAT Project.[492] However, studies show that providing vaccines to new populations, such as refugees, requires increasing health spending and conducting widespread information campaigns. It may become challenging to provide vaccines in emergency setting where the need increases due to increasing risks of infectious diseases.[493] Within this framework, UNICEF supported the Turkish state and provided outreach functions.

After the foundation of the Migrant Health Centers, the vaccine supplies were provided with regular sources from the Turkish state, and some vaccines were also purchased within the scope of the SIHHAT Project.[494] The Ministry of Health staff interviewed below statement regarding the content of the cold supply chain support to the SIHHAT Project:

> Within the budget of 65 million TRY, we procured everything required for cold-chain supply. We procured transfer vehicles, vaccine cabinets (*aşı dolapları*),

[491] Interview 3, World Health Organization, Ankara, 10 February 2021.

[492] "Proje Faaliyetleri," SIHHAT, available at http://www.sihhatproject.org/faaliyetler.html , accessed on 30 July 2023.

[493] Keskin, Omurtak, and Özen, "Syrian Refugee Inflows, Healthcare Access,"129.

[494] "Proje Faaliyetleri", Sıhhat Project, available at http://www.sihhatproject.org/faaliyetler.html , accessed on 30 July 2023.

> injections and anything that could be required for vaccine implementation. We also procured vaccines which were in Turkey's vaccine schedule.[495]

Therefore, UNICEF provided sources here for the increasing need for vaccination. There was a need for outreach activities in Arabic, and we can argue here that UNICEF applied outreach expertise by using the already-developed communication tools with refugees. The knowledge transfer on the benefits of vaccines was also difficult unless the document was in Arabic. UNICEF representative interviewed on 15 January 2021 explained that the agency used its usual social media channels (Instagram, Facebook, etc.) to reach out to the refugees in Arabic. [496] This interview with UNICEF representative also showed that UNICEF used specific institutional tools to reach out to the refugees to inform them of the benefits of immunizations and the vaccination schedule in Turkey. These tools were initially developed to reach out to the refugees for the Conditional Cash Transfer of Education dispersion. [497] Therefore, UNICEF used some institutional tools for its outreach activities. As part of the outreach activities UNICEF collaborated with non- governmental organizations in information dissemination. [498] The review of public and international organizations' reports shows that the vaccination services are accessible to refugees' access. However, their access to these services requires special activities based on refugees' particular needs, and knowledge provision to the refugees is needed here. The outreach activities of UNICEF were significant due to the previously argued challenges in providing immunization services for refugees due to cultural structural and other reasons discussed.

However, unlike the coordination expertise applied by WHO and UNFPA, UNICEF’s coordination expertise for civil society engagement here remains limited due to time limitation of the national immunization campaign. The data shows that UNICEF conducted ad- hoc cooperation with the NGOs to disseminate knowledge

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[495] Interview 1, the Turkish Ministry of Health, Ankara, 15 February 2021.

[496] Interview 7, UNICEF, Ankara, 15 January 2021.

[497] “The Conditional Cash Transfer for Education (CCTE) Programme,” UNICEF Türkiye, available at The Conditional Cash Transfer for Education (CCTE) Programme | UNICEF, accessed on 21 August 2023.

[498] UNICEF Türkiye, “Turkey – UNICEF Country Programme of Cooperation 2016-2020,” 29.

among refugees for outreach activities.[499] The coordination expertise provided by UNFPA and WHO was discussed as an essential part their political policy capacity and UNICEF's coordination expertise here stayed much more time and resources limited compared to the cases of UNFPA and WHO. The outreach and outsourcing expertise provided by UNICEF refers to the operational capacities of the organization. The organization also has analytical capacity as it has influential global databases on vaccination rates and various reports on the benefits of child immunization. However, the limited civil society cooperation as part of stakeholder management for this specific campaign shows that the political policy capacity of the organization could have been used to a wider extent for this specific initiative. Within this framework, UNICEF did not produce a separate policy instrument such as the Women and Girl Safe Spaces to address the discussed problems fostering vaccine rejection. It supported an ongoing state campaign by collaborating with the Turkish government on the 2017 National Campaign. The data show that UNICEF also supported the vaccine cold chain and capacity support to Syrian health professionals. This cooperation on the 2017 Expanded Program on Immunization supported the ongoing national immunization campaign with a focus on the immunization needs of Syrian refugees.

7.4. Policy Outcome and Degree of Policy Change

The 2017 campaign was a collaboration between the Turkish Ministry of Health, UNICEF, and WHO to respond to the difficulties in integrating refugees into the national immunization program. The applied migration management policy, marked with unregistered and irregular entries up to 2015, made the follow-up of vaccinations of the refugee population challenging, and the other discussed structural reasons made integrating the refugee population into the national program difficult. UNICEF took a a limited advocacy function here by providing outreach for the effective campaign. However, considering the increasing vaccine rejection and threats by migration, an advocacy role could create much more of a long-term intervention here. The organization provided technical support here, such as

[499] UNICEF Türkiye, "Turkey – UNICEF Country Programme of Cooperation 2016-2020," 29.

supporting the cold supply chain. The training of the Syrian health professional was much more outsourcing functions in support of this ad-hoc campaign.

Some studies reported a lack of coordination among public health authorities of neighboring countries and non-governmental organizations, including the UN technical agencies, which may determine either duplications or lack of vaccine administration.[500]. UNICEF's activities show little coordination activity, and due to the nature of the campaign, civil society cooperation was limited to the campaign's duration. Within this framework, we can argue that UNICEF's outreach activities did not produce a new policy instrument, such as the Women and Girls Safe Spaces, which acted as an advocacy unit. UNICEF here supported the state activities without producing a new policy initiative. Within the framework of its impact, this initiative is a first-order change referring to a change where no new instrument is developed, and only the settings and level of the previous instruments are changed, its overall role is quite technical. Complete advocacy expertise here would entail developing extensive outreach activities to provide information to parents on the benefits of vaccination. Within this framework, the outreach activities of UNICEF were quite limited. Moreover, UNICEF's coordination expertise could have been improved compared to other cases.

The main challenge in extending immunization services to refugees is the above-discussed state immunization policy based on market conditions and the general and specific challenges refugees face in accessing healthcare services. Therefore, there was a need on supporting the demand conditions rather than the supply of the vaccines for of the National Campaign on Immunization. We can argue here that UNICEF did not undertake such outreach expertise as was the case in UNFPA's outreach activities applied to fighting against gender-based violence and raising awareness in sexual and reproductive health through the Women and Girls Safe Spaces. Therefore, the technical role of UNICEF was ad-hoc but firm, and the advocacy role was also short-term but minimal. More to the point, its outreach

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[500] Ecem Şahin, Tolga Dağlı, Ceren Acartürk, and Figen Şahin Dağlı, "Vulnerabilities of Syrian Refugee Children in Turkey and Actions Taken for Prevention and Management in Terms of Health and Wellbeing", *Child Abuse and Neglect*, Vol: 119, No: 104628 (2021): 9.

activities on immunization were less potent than UNFPA's on reproductive health. The organization did not take an extensive advocacy function concerning migration governance. Within this framework, due to ad- hoc nature of the campaign, stemmed from limited and short time funding and also less intensified need towards the campaign due to strong political capacities of the state, the policy capacities of the organization were less operationalized compared to other two prior cases.

It is still note to worth here that UNICEF's technical role on migration governance in Turkey focused much more on supporting the Turkish educational system to integrate the Syrian refugee children. Moreover, the agency's outreach activities also focused on the Emergency Social Safety Net Programme in supporting refugee children's access to the education system through cash transfers. We can also explain this with the short-term funds in covering all areas required to protect the health of refugees and prioritizing some areas over others through the Refugee Resilience Programme applied.

CHAPTER 8

CONCLUSION

This thesis was an empirical examination of the role of the UN agencies in policy change that occurred in the Turkish healthcare system for healthcare provision to Syrian refugees, and it was an exploration of the capacities in which these agencies acted as the actors of policy change. This thesis examined three UN agencies (WHO, UNFPA, and UNICEF) which took key roles in healthcare provision in three policy sectors, and these policy sectors are primary-level healthcare provision, sexual and reproductive healthcare provision (family planning and fighting gender-based violence) to refugee women and immunization healthcare provision to refugee children. This thesis accordingly searched for answers to the following questions: What was the nature of the policy change in Turkey's health sector after the Syrian migration crisis? What kind of capacities and expertise did the UN agencies hold in the process of the policy change? How did these policy capacities of the UN agencies affect policy capacity of the host state in three policy sectors, and how did these policy capacities lead policy learning accordingly?

The policy capacity (analytical, operational, and political), the policy learning literatures and policy sector and technical expertise concepts (outsourcing, outreach, empirical, and coordination expertise) are used to examine the empirical findings of the research collected through in- depth semi structured interviews, an extensive review of national and international policy documents, national and international legislation as well as press in English and Turkish. Within this framework, this thesis firstly analyzed policy change as policy learning and engaged with the nature of the policy change to understand the policy learning processes. This thesis used policy learning analysis to understand how the policy change in the Turkish healthcare system occurred, whether through developing a new policy instrument or changing the settings of an existing policy instrument. Peter Hall's analytical framework on

policy learning is used here to differentiate between first, second, and third-order changes by acknowledging the timing scope of this study is so limited (ten years only between 2011 and 2021) to understand if these changes are temporary or permanent solutions, especially within the framework of the temporary protection regime defining the legal status and rights of the Syrians in Turkey. The second main aim of the research was to understand the how the policy capacities of the UN agencies are used in the development of the policy instruments in analysis. Here, the analytical framework of policy capacity developed by Wu, Ramesh and Howlett is used and adapted to understand the resources and capabilities of these three UN agencies in the policy change occurred in the three different sectors of healthcare provision. The taxonomy of the analytical, operational, and political policy capacities is used to differentiate between types of policy capacities.

Policy capacities of the UN are not the only source of the policy change. The policy sector itself is also an important factor in determining to what extent the policy capacities of the UN agencies lead a policy change in healthcare provision. Therefore, the issue of to what extent political capacities of the UN agencies led a policy change in the political capacities of the host country is related to various contexts including the political context in Turkey. The analytical framework used here is conducted to address the complexity in analyzing the subject which has connections to different units of analysis. The policy sector analysis is conducted for each case to understand the level and content of the policy learning process, along with the analysis of the problem pressures brought to each sector by the migration crisis. The technical expertise framework is established based on the thesis' empirical data. Within this framework, outsourcing and outreach expertise are related to operational policy capacities, empirical expertise is related to analytical capacities, and coordination expertise is related to political policy capacities. Within this framework, the coming parts will first present the empirical findings of the thesis, and then will discuss the theoretical findings.

8.1. Empirical Findings

The three policy sectors that the UN agencies provided inputs to policy change differs in terms of the nature of the policy sectors and degree of the problem

pressures brought by migration. As discussed in the fifth chapter of the thesis, the most significant change happened in the policy sector of primary-level healthcare provision, as there was a significant change in the policy instruments and methods used in providing primary-level healthcare to Syrian refugees. The policy instruments enabling this change are the foundation of the Refugee Health Training Centers, the Migrant Health Centers, the Extended Migrant Centers, and employment of Syrian refugee health professionals within these centers. The problem pressures here are strong and any policy change towards creating resources for healthcare provision to more than 3 million registered Syrians is needed and much acceptable by the host state. Within this context, the political context in this policy sector created receptivity towards a fundamental policy change. Moreover, this policy sector did not involve any cultural impediments towards creating a policy change, and the policy change occurred involved mechanisms to overcome the cultural challenges becoming an impediment for the access of Syrian refugees to the Turkish healthcare system.

The most significant part of this model is foreign health professional employment, as the empirical data collected through interviews show that the Migrant Health Centers can be turned into Turkey's Family Health Centers with some essential legal amendments. However, the process of foreign policy employment signifies a longer-term arrangement and a radical change with future implications. Comparison of different country cases in the fifth chapter showed that foreign health professional employment is a rare, lengthy, costly, and demanding process in the most popular destinations for healthcare workforce migration, as is the case with the other refugee health professional, welcoming countries such as Norway and Germany. The model of Refugee Health Training Centers and employment of Syrian health professionals in Migrant Health Centers is a unique case of foreign health professional employment through the fast orientation trainings given to Syrian health professionals for their adaptation to the Turkish healthcare system and their employment in Migrant Health Centers instead of long practicing periods before full-employment pursued in other countries.

WHO acted as an important influential actor in the design and delivery of the orientation trainings given to Syrian health professionals and the foundation of the

Refugee Health Training Centers in collaboration with the Turkish Ministry of Health, the University of Health Sciences, and several civil society organizations. To address the future integration problems, WHO acted as a constant knowledge and evidence provider through surveys, reports, and research concerning the status of the Migrant Health Centers, the satisfaction of the Syrian health professionals with trainings received, and factors affecting the employability of refugee Syrian healthcare professionals in Turkey. This evidence-based knowledge production capacity of WHO is part of the organization's analytical capacities The outsourcing and outreach activities of the organization for the organization of the orientation trainings of the Syrian health professionals are significant in terms of their impact on easing this demanding process of orientation and employment both for health professionals and the host country, and it is an important part of this change. The outsourcing functions and the outreach functions realized through the Migrant Health Centers and Syrian health professionals, as well as the Syrian health mediators, refer to the operational capacity of the organization. The coordination expertise of the WHO is important in terms of creating capacity building for its implementing partners and raising its agency as a technical authority. The coordination expertise and affirmative partnership with other actors are sources of its political policy capacity.

Consequently, this policy change is a paradigmatic third-order change in healthcare provision that can be further integrated into the Turkish healthcare system in the future. WHO acted as an important actor in this change by providing outsourcing, outreach, empirical, and coordination expertise. The analytical, operational, and political policy capacities of WHO resulted in advancing knowledge on the health status of Syrian refugee health professionals and Syrian health professional employment, and supported civil society involvement in the operationalization of the new methods in providing healthcare services to Syrian refugees. All these led a paradigmatic shift in primary level healthcare services. Although there is a paradigmatic shift in Turkey's healthcare system towards a more refugee friendly model realized through the foundation of the Migrant Health Centers and foreign refugee health professional employment, the temporary protection regime does not

allow a guaranteed understanding of these changes, as a backdrop or improvement in integration can be decided at any time.

The policy learning process in sexual and reproductive healthcare provision through the Women and Girls Safe Spaces marks a second-order change with the foundation of the Women and Girls Safe Spaces, as discussed in the sixth chapter of the thesis. The policy sector analysis here proves that these centers also signified a policy change in sexual and reproductive health provision, as Turkey's current conservative gender politics is based on a pro-natal population policy. The Women and Girls Safe Spaces provided services prioritizing elimination of unmet family planning needs and created awareness raising on gender-based violence to refugee women. As the discussion in the thesis showed, gender- based violence was a prevalent issue among Syrian refugee women, mostly due to cultural reasons and also to the risks increasing during the migration. Although there are compelling problem pressures in this policy sector, such as high total fertility rates among Syrian women, this policy sector is a less instrumental policy sector compared to the case of technical assistance on strengthening primary level healthcare services.

UNFPA acted as an important actor in the policy change occurred in this policy sector, which did not fully conform with the grand policies. Women and Girls Safe Spaces became very effective policy instruments in integrating gendered aspects of health to healthcare provision The data of the research shows that outreach activities performed by the refugee women health mediators trained by UNFPA experts and their recruitment as health mediators-built trust and created encouragement for other refugee women using the centers. These outreach activities increased the center visits and impacted women's lives through awareness raising on various issues. Moreover, centers created employment for women. The in-service trainings and capacity trainings on the Minimum Initial Service Package provided to various audiences and implementing partners was also a critical emprical and also outsourcing activity the organization performed. The coordination expertise of the organization held between the host state and civil society actors is an important part of the technical expertise provided by UNFPA. These political policy capacities led civil society engagement in the operationalization of the new methods in integrating gendered aspects of

healthcare provision for Syrian refugees. Moreover, the publications and research done by UNFPA and its implementing partners provided important evidence for sound policy-making and academic works. This study also benefited from the findings of these sources. Within this framework, the analytical capacities of the organization led advancing knowledge on the reproductive health status of Syrian refugee women and provided resource for analytical capacities of the host state. UNFPA's analytical, operational, and political policy capacities provided necessary impetus for policy change. In overall, a gender sensitive healthcare provision to Syrian refugees prioritizing fighting against gender-based violence and family planning is achieved through Women and Girls Safe Spaces. However, future integration of the project into regular healthcare provision seems less likely compared to the previously discussed policy instrument of Migrant Health Centers. Accordingly, this policy change is assessed as a second-order policy change.

The policy learning in providing immunization services for refugees is quite limited compared to other policy sectors. The policy change here only encompasses a conduct of a supportive campaign to the national immunization program with a collaborative vaccination campaign conducted by the Turkish Ministry of Health, UNICEF, and WHO through providing vaccines to refugee children under five. The change here is only a change in the settings of an already functioning policy initiative through provision of outreach expertise in collaboration with non- governmental organizations for information dissemination, an extent of outsourcing activities in supporting state capacities, and much limited coordination function between state institutions and civil society organizations due to the limited time scope of the immunization campaign. The change in this policy sector was not as extensively instrumental as it was with the policy sector on strengthening primary level healthcare provision. Still, a technical assistance and support to cold supply chains was more demanded compared to the policy sector of sexual and reproductive healthcare provision.

Moreover, problem pressures here were less compelling than in the other two policy sectors, as there was no severe infectious disease outbreak. As discussed, there were several risks regarding the migration and outbreak of infectious diseases. However,

in collaboration with UNICEF and WHO, Turkey had already undertaken small-scale vaccination campaigns (in five cities at the beginning and then extended to Istanbul as well) in response to the outbreak of polio cases in Northern Syria in 2013. The 2017 national immunization campaign targeted directly providing immunization services for refugees. Therefore, this policy sector encompassed several problem pressures, but the problem pressures here were less compelling than the other two sectors. As there was not a new policy instrument developed to respond to the problem pressures here, it is not surprising to see less intense policy change here realized through changes in the settings of an already ongoing policy initiative. Within this framework, this policy change was a first-order change in which only support was given to already functioning policy initiatives. Within this framework, policy change was least intensified, but still UNICEF undertook a technical role on this process.

UNICEF's global databases on vaccination rates and various reports on the benefits of child immunization and field research prior to the campaign is important inputs and provided knowledge on the immunization status of refugee children. This expertise of providing knowledge is part of the analytical capacities of the organization and supported the analytical capacity of the host state in advancing knowledge on the immunization status of Syrian refugee children. UNICEF's civil society engagement here was time limited and provided ad- hoc coordination expertise between state and non- state actors. As discussed, the organization provided outreach activities in collaboration with NGOs. Within this framework, the political policy capacities of the organization, underlined by its expertise coordinating different parties, were less used compared to other cases due to limited scope of the campaign. In overall, this UNICEF, WHO and the Turkish government collaboration on immunization resulted in a support initiative to the ongoing Expanded Campaign on Immunization in action.

Within this framework, WHO and UNICEF undertook very technical roles whereas UNFPA undertook and advocacy role in addition to its technical role through its analytical and operational capacities for providing capacity building and evidence-based knowledge in explaining the benefits of providing minimum requirements for

sexual and reproductive health in emergencies. These expertise provided by UNFPA which eventually led to the foundation of the Women and Girls Safe Spaces and ensured that awareness raising on family planning and gender-based violence is integrated to healthcare provision to refugee women. The coordination expertise of the organization providing political policy capacity enabled the development of this new policy instrument. For the policy sector of immunization, such a political capacity is used much more in other sectors ,as this policy sector of immunization did not involve a significant problem pressures such as disease outbreak. Moreover, the host state has also a strong capacity on providing immunization services for decades. Within this framework, the role of UNICEF is ad-hoc technical support. The low level of coordination activities between state and non-governmental organizations and the need for long-term donor contribution in this sector is another reason for a less intensified policy change. WHO undertook an intense technical role in the paradigmatic change in healthcare provision as this policy sector does not require an advocacy role due to the conformity of the policy change with the grand policies.

Comparative analysis of these three cases shows that political capacity, involving secure financial sources and coordination expertise, is essential for the UN agencies to act as important actors in policy change and to take an advocacy role when needed. Moreover, these empirical findings inform some theoretical conclusions and policy recommendations that will be discussed in the coming part.

8.2. Theoretical Findings

One of the theoretical challenges of this study was the fact that much of the existing scholarship dealt with policy learning and policy capacity from a state perspective and engaged with the concepts as of something belonging to the state. This thesis attempted to adapt these state- centric literatures to the study of international organizations. Within this framework, one of the theoretical contributions of this thesis is its adaptation of these mostly state- centric literatures to study the capabilities and capacities of the international organizations and to link them to policy learning studies. Moreover, this thesis also contributed to health literature of

Syrian refugees through undertaking a comparative political analysis of an extent of empirical data regarding governance of refugee health. This is another contribution of this study.

The analytical framework constructed to understand the policy capacities of actors set out by Wu, Ramesh, and Howlett was very practical to adapt to the policy capacities of the international organizations. Their analytical framework with its focus on the question of "what constitutes policy capacity" was very helpful in explaining how these capacities were developed. However this framework on its own was not sufficient to explain how these policy capacities interacted with political context in Turkey and led a policy change accordingly. The analytical framework constructed for this thesis responds to these limits of policy capacity literature in understanding the policy making processes fully, as this literature was mostly interested in describing the policy capacities of the states and organizations. Within this framework, I used the literature of policy capacities as only one side of coin and used it with the literature on policy learning. This framework used here also provided empirical insights how to operationalize the literature of policy capacity.

Like the policy capacity literature, Hall's analytical framework taking policy as social learning is originally state- centric. However, the focus of this literature on policy instruments and their outcomes helped me to analyze the policy change in three policy sectors and compare them and it was adaptable to the research aims of this study. However, this analytical approach has limits in analyzing the empirical data of this research, as the temporary protection regime creates uncertainties for the future integration of these policy instruments. Within this framework, the degrees of policy change and their nature can change in the future, as the uncertainty regarding the status of Syrians in Turkey prevails The policy sector concept was also insightful to understand the political context of the host country that the change is taking place in. The concept of technical expertise was only used for conducting a taxonomy within different policy capacities of the UN agencies. Using policy capacities literature with other literatures, as in this study, may provide insights for future studies as well.

This thesis argued policy learning is an instrumental decision in which the host state naturally seeks news ways to tackle the problem pressures brought by migration, and as argued in the thesis, policy change can be more challenging when policy sectors is related to an area shaped by cultural dimensions. The instrumentality here refers to Turkey's will to cooperate to tackle with the pressures on its healthcare system (such increasing health spendings, increasing burden and emotional stress of the healthcare professionals), to eliminate the difficulties met by refugees (such as language related or cultural barriers, lack of information regarding the Turkish healthcare system, and financial insecurities), to respond to the issues related to demographic data (high fertility rates and increasing gender- based violence among refugee women), and to eliminate or to respond to the challenging issues on full immunization of refugee children (such as the mobility of refugees impeding a full follow- up on consecutive doses). The policy sector and degree of instrumentality in that specific sector along with the problem pressures brought to the specific policy sector by migration defines the scale of policy learning. An analysis on the policy context of the host state is essential to understand the changes occurred and how these organizations engaged with these issues.

Through this empirical examination of the UN technical agencies' role, this thesis showed that the UN agencies are essential actors with significant abilities and resources in providing outreach, empirical, outsourcing, and coordination expertise, which affect the policy learning process in different ways. The comparison of these three empirical cases shows that policy learning drives an extent of policy change in the case of the health governance of Syrians in Turkey. Policy learning is only one of the factors leading to policy change in the Turkish healthcare system. Problem pressures brought by migration are also an important driving factor in the subject of policy changes in different sectors. However, policy learning can still occur even if any change in the policy sector and the problem pressures on it are not instrumental in its policy objectives. In such cases, the policy capacities, including the capabilities and resources of the UN agencies and the advocacy role they take, are influential in driving policy change and undertaking an advocacy function.

The theoretical findings of this research as follows. When the policy sector allows instrumental decisions, receptivity is likely to be higher and this may trigger policy

learning processes. This also creates more fundamental and paradigmatic changes as shown in the case of WHO and foundation of Refugee Health Training Centres and employment of Syrian refugee health professionals within the centers. When the problem polity/ mandated area of the UN agency is related to fundamental cultural values and social structures and the policy sector allows less instrumentality and policy learning can be discarded unless the policy sector is characterized by fundamental problem pressures. Moreover, policy capacities of the UN agencies can also provide grounds for policy learning as shown in the case of the development of Women and Girls Safe Space as a policy instrument by the technical expertise of UNFPA. When the problem polity area/mandate is related to an area where the state's technical capacity is strong, the policy sector again does not allow instrumentality. It is less likely to expect deep fundamental policy changes in cases of policy environments characterized by low problem pressures and less involvement of advocacy actors that can affect the policy learning process as shown in the case UNICEF and providing immunization healthcare for refugee children. These are the theoretical findings of this research, however, more understanding of this relationships are needed through studying other cases of governance.

Consequently, although there is no specific UN agency which has direct mandate in refugee health, the UN agencies that has mandate relevant to social or medical aspects of public health can affect policy changes, as they have the resources and capabilities for supporting healthcare access for refugees in overcoming different access challenges. Within this framework, the UN technical agencies, through institutional resources or strategies, can lead policy changes. Besides this, problem pressures can also lead to policy learning. Within this framework, the UN technical agency acts as an advocacy actor besides their technical agency. Moreover, they can support the national healthcare systems in dealing with the challenges and problems brought by migration. Within this framework, UN agencies are well-endowed actors with technical, empirical, outreach, and outsourcing expertise. This expertise marks their analytical and operational capacities. Syrian refugees, as discussed, faced several problems in their access to healthcare services during the reception phase of the migration crisis in Turkey The complexities in reception and registration processes during mass arrivals made healthcare provision even more challenging in

Turkey's migration management. However, as discussed throughout the thesis, Turkey in cooperation with other actors provided significant changes for enhancing refugees' access to healthcare system.

As the case of Syrian refugees in Turkey shows, the United Nations agencies can support necessary changes when required. However, they require the necessary political capacity and financial resources to operationalize their analytical and operational capacities, which is necessary for their operations. Moreover, their mandate on international protection and in overseeing settlement processes by preventing refoulement requires to be strengthened, which may prevent leaving all burden on the welfare systems of only specific countries hosting refugees, as is the case with the Syrian civil war started in 2011 and neighboring countries of Syria hosting most of the displaced Syrians. A more efficient implementation of refugee law and providing the necessary political and financial support for UN agencies can enhance their effectiveness and ensure that "no one is left behind".

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APPENDICES

APPENDIX A. APPROVAL OF THE METU HUMAN RESEARCH ETHICS COMMITTEE

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

ORTA DOĞU TEKNİK ÜNİVERSİTESİ
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02 KASIM 2020

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın *Ebru BOYAR*

Danışmanlığını yaptığınız Evrim TANDOĞAN'ın "Türkiye'deki Suriyeli Mültecilerin Sağlık Yönetişimi: Uluslararası Örgütler ve Türk Hükümeti " başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülmüş ve 289-ODTU-2020 protokol numarası ile onaylanmıştır.

Saygılarımızla bilgilerinize sunarız.

APPENDIX B. LIST OF INTERVIEWS

INTERVIEW NUMBER	INSTITUTON	DATE
1	The Turkish Ministry of Health	15 February 2021
2	The Turkish Ministry of Health	8 February 2021
3	World Health Organization- Ankara	10 February 2021
4	World Health Organization- Ankara	12 February 2021
5	UNFPA- Ankara	5 August 2021
6	UNFPA- Şanlıurfa	16 August 2021
7	UNICEF- Ankara	15 January 2021
8	Association for Solidarity with Asylum Seekers and Migrants - Ankara	17 August 2021
9	Association for Solidarity with Asylum Seekers and Migrants - Izmir	16 August 2021
10	Yeryüzü Doktorları- Istanbul	12 February 2021
11	Yeryüzü Doktorları- Istanbul	28 October 2021
12	Association for Youth Approaches to Health, Ankara	10 August 2021
13	Hacettepe Unıversity Research and Implementation Centeron Women's Issues- Ankara	21 January 2021
14	Turkish Red Crescent- Ankara	26 January 2021
15	Turkish Red Crescent- Istanbul	13 January 2021
16	The Turkish Medical Association- Ankara	9 January 2021
17	Gynecologist	4 January 2021
18	Pediatrist	12 February 2021
19	Pharmacist- Ankara	04 October 2022

APPENDIX C. VITA

Evrim Tandoğan

EDUCATION

Degree	Institution	Year of Graduation
PhD in International Relations	*Middle East Technical University,* Ankara	2024
Thesis: The Role of the United Nations Agencies in Providing Healthcare for Syrian Refugees in Turkey (2011- 2021)		
MA in International Relations	*University of Kent,* Kent	2015
	Funded by European Commission Jean Monnet Scholarship	
Thesis: A Critical Approach to the EU'S Security Policies in North Africa: The Case of Libya		
BA in International Relations	*Ege University,* Izmir	2014
	GPA: 3.80/ 4.00	
High School	*İzmir Milli Piyango Anadolu High School,* İzmir	2008

WORK EXPERIENCE

Year	Place	Enrollment
May 2023- Present	UNDP Türkiye	Administrative Associate

October 2018- May 2023	UNDP Türkiye	Administrative Assistant
September 2017- June 2018	WYG Türkiye	Business Development Analyst
July 2016- January 2017	Research Intern	The Economic Policy Research Foundation of Turkey
July 2013- October 2013	Research Intern	Ödemiş Yıldız City Archival Museum

FOREIGN LANGUAGES

Advanced English, Intermediate German, Beginner French

Awards, Grants,

July 2022 : Academic Council on the United Nations System- UCL 2022 Annual Workshop, London, Workshop and Travel Grant

2014- 2015: European Commission Jean Monnet Scholarship for Graduate Studies

2014 : First Honour Student of Ege University Faculty of Economics and Administrative Sciences (GPA: 3.80/ 4.0)

July 2012 : European Commission Erasmus Scholarship- Summer School on Good Governance in *Stainslaw Staszic College of Public Administration*, Poland.

Computer Skills and Skills:

IBM Certificate Program |September 2021, Excel Basics for Data Analysis

ODTÜ SEM Training| March 2017 MaxQDA: Software for Qualitative Data Analysis in Social Sciences

University of Kent Certificate Program| October 2014- April 2015, Global Skills Awards

Microsoft Office| MS Offices (advanced),

HOBBIES

Drama, Latin Dances, Yoga, Hiking

APPENDIX D. TURKISH SUMMARY / TÜRKÇE ÖZET

2011 yılının mart ayında Suriye hükümetine yönelik protestolarla başlayan ve kısa süre içinde bugün hala devam etmekte olan bir iç savaşa dönüşen Suriye İç Savaşı'nın yarattığı zorunlu göç, İkinci Dünya Savaşı'ndan sonra dünyanın gördüğü en büyük göç hareketidir. Bu göç hareketi, milyonlarca Suriyelinin başka ülkelere sığınmasına sebep olmuştur. Söz konusu göç hareketinden en çok etkilenen ülkeler, Suriye'nin sınır komşuları olan Türkiye, Lübnan ve Ürdün'dür. Ancak Kanada ve Almanya başta olmak üzere bazı Avrupa ve Batı ülkeleri de Suriye'nin komşu ülkeleriyle kıyaslanması zor olsa da Suriyeli mülteciler için ev sahipliği yapmaya devam etmektedir. 2023 yılı itibariyle kayıtlı 3,274,059 Suriyeli 'ye ev sahipliği yapmaya devam eden Türkiye, göçten sayı bakımından en çok etkilenen ülkedir ve bu haliyle, Suriyeli mültecilere ev sahipliği yapan ülkeler arasında ilk sırada yer almaktadır. Türkiye, son 13 yılda söz konusu göçü ve etkilerini yönetebilmek için ulusal mevzuatında düzenlemeler yapmış ve bu düzenlemeler, çeşitli politika sektörlerinde önemli değişiklikler yaratmıştır. Sağlık sektörü, tüm bu alanlar içinde en köklü politika değişikliğinin yaşandığı alan olarak ön plana çıkmaktadır.

Sağlık sektöründe yaşanan bu politika değişikliği, bu tezin odak konularından birini oluşturmaktadır. Söz konusu politika değişikliği, göçün yarattığı belirsizlikleri ve göçün etkilerini yönetmek için yapılmıştır. Bu politika değişikliğinin bir diğer önemli özelliği, ana karar vericinin ev sahibi ülke olmasına karşın, devlet dışı aktörlerin de bu süreçte önemli bir rol oynamasıdır. Bu tezin bir diğer odak noktası da bu bağlamda süreçte rol oynayan devlet dışı aktörler arasında bulunan Birleşmiş Milletler (BM) kuruluşlarıdır. Süreçte en etkin rolü oynayan üç Birleşmiş Milletler kuruluşu, Dünya Sağlık Örgütü (WHO), BM Nüfus Fonu (UNFPA) ve BM Uluslararası Çocuklara Acil Yardım Fonu (UNICEF)'dur. Bu tez temel olarak şu sorulara cevap aramaktadır. Suriye'deki iç savaş sonrasında meydana gelen göç krizinden sonra Türkiye'nin sağlık sektöründe meydana gelen politika değişikliğinin niteliği nedir? Politika değişikliği sürecinde BM kuruluşları ne tür kapasiteler ve uzmanlıklarla süreçte rol oynamışlardır? Birleşmiş Milletler kuruluşlarının, söz

konusu politika kapasiteleri, ev sahibi ülkenin, mültecilere birinci basamak sağlık hizmetlerinin sağlanması, kadın mültecilere cinsel ve üreme sağlığı hizmetlerinin sağlanması ve çocuk mültecilere bağışıklama hizmetlerinin sunulmasına ilişkin politika alanlarında politika kapasitesini nasıl etkilemiştir? Bu kuruluşların politika kapasiteleri, bu üç politika sektöründe politika öğrenimine nasıl öncülük etmiştir? Tezin verileri, yarı yapılandırılmış derinlemesine mülakatlar, ulusal ve uluslararası politika belgelerinin ve mevzuatın kapsamlı taraması ve Türkçe ve İngilizce basın kaynaklarının kapsamlı incelemesi sonucu toplanmıştır. Ayrıca yukarıda sunulan araştırma sorularına cevap verebilmek için bu tez karşılaştırmalı vaka analizi yapmaktadır. Bu vaka çalışmaları, öncelikle sağlık hizmetlerinin verilmesine ilişkin bu üç politika sektörünü geliştirilen politika araçları bakımından incelemektedir. Akabinde de Dünya Sağlık Örgütü, Birleşmiş Milletler Nüfus Fonu ve BM Uluslararası Çocuklara Acil Yardım Fonu'nu analitik, operasyonel ve siyasi olarak sınıflandırılan politika kapasitelerini ve bu kapasitelerin politika öğrenimini nasıl etkilediğini karşılaştırmaktadır. Tezin üçüncü bölümü, verilerin analizi için geliştirilen analitik çerçeveyi tartışmaktadır. Dördüncü bölümde Birleşmiş Milletler kuruluşlarının mülteci sağlığı konusundaki rolü uluslararası mevzuat bakımından incelenmekte ve Avrupa Birliği (AB) ve Türkiye ilişkilerine odaklanılarak bu kuruluşların politika kapasitelerinin gelişimi incelenmektedir. Beşinci, altıncı ve yedinci bölüm tezin vaka çalışmalarını analiz etmektedir.

Bu araştırma, yukarıdaki sorulara cevap verebilmek için bazı kavramları kullanmıştır. Tezin üçüncü bölümü kullanılan kavramları tanıtmaktadır. Bu kavramlardan ilki Peter Hall tarafından geliştirilen ve politika öğrenimini (political learning), sosyal öğrenme (social learning) olarak ele alan ve bu öğrenme sürecini birinci, ikinci ve üçüncü derece politika değişikliği (first, second and third- order policy change) olarak tanımlayan kavramsal çerçevedir. Bu noktada üçüncü derece politika değişimleri, derin ve köklü paradigmatik değişikliklere işaret ederken, ikinci derece politika değişimleri yeni politika araçlarının (policy instrument) oluşturulduğu ancak oluşturulan politika araçlarının çok köklü ve derin bir paradigmatik değişim yaratmadığı süreçleri ifade etmektedir. Birinci derece değişiklikler ise, yeni bir politika aracının oluşturulmadığı sadece var olan politika araçlarının desteklenerek politika değişikliğine katkıda bulunan süreçleri ifade etmektedir. Burada mevcut

politika araçları üzerinden politika değişikliği yaratılmaktadır. Bu kavramsal politik öğrenme çerçevesi, tezin birincil kaynak verisinin analizinde oldukça işlevseldir. Ancak bu kavramsal çerçevenin bu tez kapsamında önemli bir kısıtı da bulunmaktadır. Böyle bir derecelendirmeyi yapmak için politika araçlarının yarattığı etkilerin çok uzun dönemde incelenmesi daha derin bir analiz imkânı sunmaktadır. Ancak bu tez, 2011 ve 2021 yılları arasında sadece on yıllık bir süreye odaklanmaktadır. Bu anlamda da özellikle geçici koruma rejiminin Suriyeli mültecilerin Türkiye'deki gelecekleri konusunda yarattığı belirsizlikler sebebiyle bu derecelendirme incelenen politik sektörler açısından değişiklik gösterebilir. Ancak tezin temel bulgularına ışık tutması açısından bu derecelendirme oldukça işlevseldir.

Kullanılan ikinci önemli analitik çerçeve, Wu, Ramesh ve Howlett'in devletlerin kaynak ve kapasitelerini incelemek için oluşturdukları politika kapasitesi (policy capacity) analitik çerçevesidir. Burada operasyonel (operational), analitik (analytical) ve siyasi (political) politika kapasitelerine odaklanılırken, aktörlerin bu süreçteki kaynak ve kapasitelerine ışık tutulmaya çalışılmaktadır. Politika kapasitesini daha derin bir şekilde analiz edebilmek için teknik uzmanlık (technical expertise) kavramı, erişim (outreach), görev aktarma (outsourcing), ampirik (emprical) ve koordinasyon (coordination) uzmanlıkları olarak sınıflandırılarak bu analiz çerçevesine dahil edilmiştir. Yaşanan politika değişikliğini anlamlandırabilmek için politika sektör analizi de kavramsal çerçeve içinde yer almaktadır. Tezin üç vaka çalışması üzerinden gerçekleştirilen karşılaştırmalı analiz, ilk olarak politik sektörlerin incelenmesi ve karşılaştırılmasıyla gerçekleştirilmiştir. Daha sonra teknik uzmanlık ve politika kapasitesi kavramları ışığında vaka çalışmaları incelenmiştir.

Tezin üçüncü bölümü, göç krizinin 2011 ve 2013 yılları arasına tekabül eden ve tez içinde kabul (reception) dönemi olarak isimlendirilen dönemi ve 2013 ve 2016 yılları arasını ifade eden kurumsallaşma (institutionalization) olarak adlandırılan dönemi inceleyerek başlamıştır. Burada Suriyeli mültecilere sağlık hizmetlerinin verilişi iki dönemi ayıran temel özellikler bakımından incelemiştir. Ayrıca bu bölüm yine söz konusu dönemlerde, Suriyelilere sağlık hizmeti sunulmasının hukuki boyutlarını ulusal mevzuat bakımından araştırmıştır. 2016 ve 2021 yılları arası uygulama (implementation) dönemi olarak ele alınmış ve bu dönemin incelenmesi, tezin vaka

çalışmaları içerisinde derinleştirilmiştir. Bu bağlamda ulusal ve uluslararası mevzuat arasında, mülteci tanımlaması bakımından bulunan farklılıklar da yine bu bölümde incelenmiş ve bu farklılıkların Suriyelilerin yasal statüsünü ve sağlık hizmetlerinin sunumunu nasıl etkilediği de mevzuat bakımından analiz edilmiştir. Bu noktada birincil kaynak verileri ışığında sağlık hizmetlerine erişimde Suriyeli mültecilerin yaşadığı sorunlar irdelenmiştir.

Üçüncü bölümde tartışıldığı üzere, Türkiye Cumhuriyeti'nin 1951 tarihli Birleşmiş Milletler Mültecilerin Hukuki Statüsüne İlişkin Sözleşmeye taraf olması, ancak ilgili sözleşmenin 1966 yılında kabul edilen Ek Protokolü'ne coğrafi çekince koyması, Türkiye'de sığınma arayan Suriyeli sığınmacıların statüsü için belirsizlik yaratmıştır. Bahsi geçen çekince sebebiyle Türkiye, sadece Avrupa dışından gelen sığınmacılara mülteci statüsünün verilmesini öngörmüştür. Bu durum yıllar içinde sığınmacılar için geçiş ülkesi olmaya devam eden ve son yıllarda da yaşadığı ekonomik büyüme sebebiyle özellikle 2015'e kadar ekonomik göçmenler için de tercih edilen bir ülke olan Türkiye'de farklı sığınmacı gruplarına karşı farklı düzenlemeler uygulanmasına sebep olmuştur. Bu anlamda tez içinde tartışılan bazı çalışmalar, örneğin 1989 yılında Bulgaristan'dan gelen Türk kökenli kişilere mülteci statüsü verilirken, 1990 yılında Saddam Hüseyin rejiminden kaçarak Türkiye'ye sığınan Kürtlere mülteci statüsü verilmemesini, Türkiye'nin her sığınmacıya uygulanan tek tip bir göç politikası olmaması bakımından eleştirmiştir.

Tarihsel süreçte tek tip bir uygulama olmasına kısıt yaratan coğrafi çekince, Suriyeli mültecilerin hukuki statüsü bakımından da karışıklığa yol açmış ve bu karışıklık, 2013 yılında Yabancılar ve Uluslararası Koruma Kanunu'nun kabulüne kadar devam etmiştir. 2013 yılında bu kanunun kabul edilmesine kadar geçen bu süre tezde 'kabul dönemi' olarak ele alınmıştır. Bu dönemin en büyük özelliği Suriyelilerin hukuki statüsünde yaşanan bu belirsizliklerdir. Kanunun kabulüne kadar Türkiye'deki Suriyeliler "misafir" gibi hukuki bir arka planı olmayan tanımlamalar içinde tutulmaya çalışılmıştır. Ancak Türkiye'de sığınma arayan Suriyelilerin sayısının yıllar içinde giderek artması, artık yaşanan hukuki belirsizliğin sürdürülebilir olmadığını gün yüzüne çıkarmıştır.

2013 yılında kabul edilen Uluslararası Koruma ve Yabancılar Kanunu ile Suriyeli sığınmacılara Geçici Koruma statüsü verilmiştir. Bu Kanun'un kabulünden önce Suriyelilerin hukuksal statüsünde yaşanan belirsizlikler, mültecilerin sağlık hizmetlerine erişiminde de bazı sorunlar yaratmıştır. Sağlık hizmetlerine erişimdeki sorunlar, büyük oranda sağlık hizmetlerini kullanmada karşılaşılan dil engeli ve diğer kültürel engellerle tanımlanabileceği gibi hukuksal statüdeki belirsizliğin sebep olduğu sorunlar da mevcuttur. Afet ve Acil Durum Yönetimi Başkanlığı'nın (AFAD) 2013 ve 2015 yıllarında kabul ettiği iki önemli genelge, Suriyelilerin sağlık hizmetlerine ücretsiz erişimini öngörmüş olsa da özellikle kabul ve kayıt süreçlerinde yaşanan sorunlar, sağlık hizmetleri sunumunda bazı sorunlar yaratmıştır. Bu aksaklıklar özellikle, bağışıklama hizmetlerinin etkin ve sürekli bir biçimde uygulanabilmesine engeller oluşturmuştur. Ayrıca mülakat verilerinden de anlaşıldığı üzere hukuksal statüdeki belirsizlik, sınır dışı edilme korkusuyla sağlık hizmetlerini kullanmama yönünde de eğilimler yaratmıştır.

Bir başka önemli nokta ise, 2013 Suriyelilerin Yabancılar ve Uluslararası Kanunu'na kadar yasal çalışma hakkının olmamasıdır. Bu da özellikle sağlığın sosyo-ekonomik belirleyenleri açısından sıkıntılar yaşanmasına ve Suriyelilerin incelenen çeşitli raporlarda da görüldüğü gibi sağlıksız barınma şartlarında yaşamasına sebep olmuştur. Bu sebeple Uluslararası Koruma ve Yabancıları Kanunu, Suriyelilerin yasal statüsünü belirlemesi bakımından bir dönüm noktasını oluşturmaktadır. Kanun, Suriyelilere sağlık hizmetlerinin sağlanmaya başlanmasının başlangıcı değildir. Çünkü Türkiye, hem krizin en başından beri başlangıçta sınır kapılarında mobil sağlık araçlarıyla sağlık hizmeti sunumu yaparak ve hem de AFAD'ın 2013 ve 2015 tarihli genelgeleriyle sığınmacılara sağlık hizmetleri verilmesini sağlamıştır. Ayrıca sivil toplum örgütlerinin de bu dönemde sağlık hizmet sunumunu desteklediği bilinmektedir. Bu anlamda Türkiye'nin hem koruyucu hem tedavi edici sağlık hizmetlerinin sağlanması, hem de ilaç masraflarının karşılanabilmesi için bu alanda oldukça büyük miktarlarda önemli bir harcama yaptığını belirtmek gerekir.

Bu verilere ulaşılması bu tez kapsamında oldukça önemli olsa bu harcamaların kırılımlarıyla ilgili kamuya açık bir bilgi olmaması sebebiyle, Suriyeli mültecilerin sağlık hizmetlerine erişimi ile ilgili rakamlara ancak bazı resmî açıklamalar ve bazı

hesaplamalar dikkate alınarak tahmini ulaşılabilmektedir. Ancak mültecilere sağlık hizmeti sunumunun hem personel istihdamı hem de finansal kaynaklar bakımında gayri safi milli hasıladan önemli bir miktarın bu alana ayrılmasını gerektiren bir konu olduğu söylenebilir. Ayrıca mültecilere kesintisiz sağlık sunumu, hem mültecilerin sağlık hakkına erişimi bakımından, hem de kamu sağlığı açısından çok önemli bir konudur. Bu anlamda Uluslararası Koruma ve Yabancılar Kanunu öncesi AFAD genelgeleri ile mültecileri sağlık hizmetlerinin ücretsiz sağlanması düzenlenmiş olsa da bu konu kanunun kabulü ile daha temel bir kanunla sağlık hizmetlerinin sunumu düzenlenmiştir.

Tezin dördüncü bölümü, Birleşmiş Milletler kuruluşlarının mülteci sağlığı alanındaki rollerini hem uluslararası mevzuat bakımından incelemekte hem de Avrupa Birliği (AB)- Türkiye ilişkilerine ve dolayısıyla son otuz yıllık bir süreye odaklanarak, Birleşmiş Milletler kuruluşlarının Türkiye'deki varlıklarını tarihsel bir çerçeveye oturtmaya çalışmıştır. Bu bölümün ilk kısmında uluslararası mevzuat, mülteciler ve sağlık hakkı bakımından incelenirken önemli iki uluslararası hukuk konusuna odaklanılmıştır. Bunlar 'uluslararası koruma' ve evrensel 'sağlık hakkı' dır. 1951 Sözleşmesi, mülteci statüsünü ırk, din, ulusal kimlik, herhangi bir gruba üyelik veya siyasi görüş sebebiyle haklı nedenlere dayanan zulüm korkusu yaşayan ve başka bir ülkeye sığınma talebi bulunan kişilere verilebilir bir statü olarak tanımlamaktadır. Bu kişilerin ülkelerine geri gönderilmesinin önüne geçmek amacıyla da uluslararası korumayı temel bir prensip olarak tanımlamaktadır. Bu bağlamda Birleşmiş Milletler'in göç ve mültecilere ilişkin temel otoritesinin kaynağını uluslararası koruma prensibi oluşturmakta ve tezde tartışıldığı üzere uluslararası hukuk, tüm BM kuruluşları arasında Birleşmiş Milletler Mülteciler Yüksek Komiserliği'ne (UNHCR) uluslararası koruma prensibinin tam uygulanabilirliğini sağlaması için önemli bir yetki tanınmaktadır. Ancak tez içinde de etraflıca tartışılan AB- Türkiye İlişkileri ve özellikle Suriyeli sığınmacıların AB sınırlarına yasadışı yollarla girmesi halinde güvenli ülke olarak görülen Türkiye'ye geri gönderilmesini öngören 2014 tarihli Geri Kabul Anlaşması bu konuda, uluslararası korumanın tüm mültecilere sağlanması ve geri göndermemenin esas tutulmasını öngören mülteci hukukuna ihlal oluşturduğu gerekçesiyle bazı eleştirilere yol açmıştır.

Bu eleştiriler, Geri Kabul Anlaşması ile Birleşmiş Milletler Mülteciler Yüksek Komiserliği'nin geri göndermeme gibi prensiplerin uygulanmasını gözetleme ve bu konudaki savunuculuk rolüne ihlal oluşturduğunu tartışmaktadır. Bu da AB ve Türkiye arasındaki bu iki taraflı düzenlemenin, BM'nin mülteci hakları konusundaki gözetmenlik ve savunuculuk rolü sebebiyle sahip olduğu otoritesinin ve uluslararası koruma prensibinin ihlalinin olduğuna dair tartışmalara yol açmıştır. 2020 yılında Türkiye ve AB arasında yaşanan bir gerginlik sonrasında Türkiye'nin sınır kapılarını açacağını duyurması ve sonrasında Yunanistan'ın sınırları geçip Avrupa'ya ulaşmak isteyen sığınmacılara zor ve şiddet uygulamasıyla çok sayıda mültecinin yaralanmasına ve dört mültecinin ölmesine sebep olan olaylar, aslında geri göndermememe, uluslararası koruma gibi prensiplerin ihlal edildiğini gözler önüne sermektedir. Bu sebeple Birleşmiş Milletler 'in göç ve mültecilere ilişkin temel sorumluluk ve otoritesi zaten yıpratılmış durumdadır denilebilir.

Uluslararası hukuk bakımından sağlık hakkının kapsamı ve mültecilerin bu hakka tam erişebilmesi konusundan Birleşmiş Milletler kuruluşlarının sorumlulukları da yine dördüncü bölümde tartışılmıştır. 1951 tarihli Birleşmiş Milletler Mültecilerin Hukuki Statüsüne İlişkin Sözleşme, esasen sağlık hakkıyla ilgili madde içermemektedir. Bunun temel sebeplerinden birisi de bu sözleşmenin esasında İkinci Dünya Savaşı sonrası göç etmek zorunda kalan Avrupalı göçmenler için hazırlanmış olmasıdır. Bu sebeple, daha çok Avrupalı mültecilerin ihtiyaçlarına cevap verecek ekonomik ve sosyal haklar bu sözleşmeyle düzenlenmiştir. Sağlık hakkına erişim gibi konular Avrupalı mültecilerin temel olarak sorun yaşadığı alanları oluşturmamaktadır. Esasen mültecilerin sağlık hakkına ilişkin özel bir mevzuat ve bunun üzerine yetkilendirilmiş bir Birleşmiş Milletler kuruluşu da bulunmamaktadır. Çünkü uluslararası hukuk, mültecilerin sağlık hakkını temel insan haklarından biri olan sağlık hakkından ayırmamakta ve ancak özellikle acil durumlarda ev sahibi ülkelere ve ilgili Birleşmiş Milletler kuruluşlarına ne gibi sorumluluklar düştüğünü çeşitli hukuksal metinler aracılığıyla çizmektedir.

Bu bakımdan 1948 tarihinde kabul edillen İnsan Hakları Evrensel Beyannamesi ve 1966 tarihinde kabul edilen Ekonomik, Sosyal ve Kültürel Haklar Uluslararası Sözleşmesi, bu hakkın tanımlanmasındaki en temel dokümanlar olarak karşımıza

çıkmaktadır. Ancak 1989 tarihinde kabul edilen Birleşmiş Milletler Çoçuk Hakları Sözleşmesi, 1979 yılında kabul edilen Kadınlara Karşı Her Türlü Ayrımcılığın Önlenmesi Sözleşmesi de sağlık hakkına ilişkin dolaylı ya da dolaysız hükümler içermektedir. Yine biraz daha teknik bir tanımlama yapsa da Dünya Sağlık Örgütü Anayasası da sağlık hakkının tanımlandığı temel uluslararası belgelerden biridir. Ekonomik, Sosyal ve Kültürel Haklar Uluslararası Sözleşmesi'nin yaptığı sağlık tanımlamasında, sağlığın barınma, temiz ve güvenli su ve gıdaya erişim gibi sosyal ve ekonomik yönlerine de değinilmektedir ve devletlerin mültecilere eşit sağlık hizmetlerine erişimi tanıması talep edilmektedir. Dünya Sağlık Örgütü Anayasası ise sağlık hakkını tanımlarken sağlığın bu bileşenlerine değinmemekte ve daha teknik bir tanım yapmaktadır. Ekonomik, Sosyal ve Kültürel Haklar Birleşmiş Milletler Komitesi'nin sağlığın sosyal ve ekonomik bileşenlerine yaptığı vurgu, konuyla ilgili dolaylı da olsa uzmanlığı bulunan çeşitli kurum ve kuruluşları da devlet kapasitelerini desteklemek için iş birliğine çağırmaktadır.

Sağlık hakkının tam anlamıyla kullanılması için devletlerin iş birliği yapabileceği temel Birleşmiş Milletler kuruluşu Dünya Sağlık Örgütü'dür. Ekonomik, Sosyal ve Kültürel Haklar Birleşmiş Milletler Komitesi, devletleri ulusal sağlık stratejilerini belirlerken DSÖ'nün teknik tavsiye ve programlarını dikkate almaya çağırmaktadır. Ancak Komite, hem mülteci statüsünün içinde kadınlar, çocuklar ve engelliler gibi farklı gruplar içermesi, hem de sağlık hakkına erişimin gıdaya ve emek piyasalarına erişim gibi sosyal ve ekonomik boyutlarının olması sebebiyle farklı alanlarda sorumluluk ve yetkileri bulunan diğer Birleşmiş Milletler kuruluşlarını da iş birliğine çağrılmaktadır. Bu anlamda Dünya Sağlık Örgütü'nün yanı sıra çocuk hakları söz konusu olduğunda Birleşmiş Milletler Uluslararası Çocuklara Acil Yardım Fonu, cinsel ve üreme sağlığına ilişkin konularda Birleşmiş Milletler Nüfus Fonu gibi kuruluşlar da önemli aktörler haline gelebilmektedir. Bu teknik kuruluşların, mültecilere sağlık hizmetlerinin sunulması ve sağlık hakkına erişimlerinin sağlanması için alabilecekleri roller sağlık hakkının bu teknik ve sosyal ve ekonomik tanımlamaları içerisinde bu şekilde çizilmiş durumdadır.

Dördüncü bölümün ikinci kısmında ise Birleşmiş Milletler kuruluşlarının Türkiye'deki programları özellikle Avrupa Birliği- Türkiye ilişkileri ışığında

değerlendirilmiştir. Burada Avrupa Birliği ve Türkiye ilişkilerinin, Birleşmiş Milletler kuruluşlarının kapasitesine katkısı odak noktası olarak tutulmuştur. Avrupa Birliği, hem Türkiye'nin Avrupa Birliği'ne adaylık sürecinde Avrupa Birliği müktesebatıyla uyum sağlama sürecinde sağladığı, hem de göç krizi sonrasında oluşturduğu Türkiye'deki Mülteciler için Mali Yardım Programı (FRIT) aracılığıyla sağladığı kaynaklar sebebiyle bu kuruluşların etkin aktörler haline gelmesinde önemli kapasiteler sağlamış durumdadır. Türkiye'nin Birleşmiş Milletler kuruluşlarıyla olan iş birliği, 1999 Helsinki Avrupa Konseyi ile başlayan iş birliği ile hız kazanmaya başlamıştır. Avrupa Birliği Müktesebatıyla uyum sağlamaya çalışan Türkiye, politika yapım süreçlerinde önemli değişikliklere gitmiş ve Birleşmiş Milletler kuruluşlarıyla da bu bağlamda teknik iş birlikleri kurmuştur. Bu uyum süreci, göç yönetişiminde İç İşleri Bakanlığı altında Sınır Yönetimi, Dış İlişkiler ve Proje Daire Başkanlığı gibi birimlerin kurulması gibi kurumsal değişiklikler de getirmiştir. 2014 yılında ise Türkiye Göç İdaresi Genel Müdürlüğü'nü kurmuş ve 2021 yılında Genel Müdürlük, Göç İdaresi Başkanlığı'na dönüştürülmüştür.

Aslında hem Genel Müdürlüğün kuruluşu hem de Uluslararası Koruma ve Yabancılar Kanunu'n kabulü, 2005 yılında Ulusal Eylem Planı'nın hazırlanmasıyla başlayan ve bir göç kanunun kabulünü öngören sürecin devamı niteliğindedir. Bu anlamda göç, şüphesiz ki dönüştürücü ve hızlandırıcı bir etki yaratmış durumdadır. 2011'de başlayan ve hala devam etmekte olan göç, Türkiye'de devlet, devlet dışı kurumlar ve sivil toplum kuruluşlarıyla iş birliğini barındıran bir yönetişim politikasının oluşmasına sebep olmuştur. 2014 yılı ise bu politikanın oluşmasında oldukça önemli bir yıldır. Türkiye Avrupa Birliği Geri Kabul Anlaşması 2014 yılında yürürlüğe girmiş ve Uluslararası Koruma ve Yabancılar Kanunu da yine bu yıl kabul edilmiştir.

Avrupa Birliği'nin Türkiye dışında başka üçüncü ülkelerle imzaladığı Geri Kabul Anlaşmaları da bulunmaktadır ve bu anlaşmalar, literatürde Avrupa Birliği'nin dışsallaştırma politikaları (externalization politics) olarak sıklıkla analiz konusu olmuştur. Dışsallaştırma, Avrupa Birliği'nin kendi sınır güvenliği için diğer ülkelerle yürüttüğü politikalara denmektedir. Daha önce de tartışıldığı gibi uluslararası koruma adına sorunlar yaratan bu ikili anlaşmanın, bu tezin kapsamında çok önemli bir

özelliği bulunmaktadır. Anlaşma sonrası Türkiye'deki Mülteciler için Mali Yardım Programı (FRIT) adı altında bir yardım fonu sağlamıştır. 2025 yılının ortası itibariyle tamamlanması planlanan 6 milyarlık Avroluk bir bütçesi bulunmaktadır. Birleşmiş Milletler kuruluşları, sağlık alanında hem Avrupa Birliği hem de başka fon sağlayıcılar ile sağlık hizmetlerinin sağlanması ve sağlık hizmetlerine erişiminin kolaylaştırılması bakımından oldukça önemli çalışmalar yapmışlardır.

Türkiye'deki Mülteciler için Mali Yardım Programı (FRIT)'nın 300 milyon Avrosu 2016 yılında, 210 milyon Avrosu 2020 yılında SIHHAT Projesi olarak adlandırılan ve Türkiye'nin mültecilerin yoğun olarak yaşadığı 30 şehrinde 187 Mülteci Sağlığı Merkezi'nin açılmasını kapsayan projeye verilmiştir. Bu projenin önemli bir ayağı da Dünya Sağlık Örgütü ve Türkiye iş birliğiyle geçekleştirilen Suriyeli mülteci sağlık personelinin istihdamıdır. Suriyeli sağlık personeli, Türkiye'nin 7 şehrinde kurulan Mülteci Sağlığı Eğitim Merkezleri'nde, Sağlık Bilimleri Üniversitesi öğretim görevlileri tarafından hazırlanan ve sunulan bir haftalık teorik bir eğitim ve hemen sonrasında da Türk hekim ve hemşireleriyle merkezlerde birebir çalışarak tamamladıkları 6 haftalık pratik eğitimler almış ve Göçmen Sağlığı Merkezleri'nde istihdam edilmişlerdir. Göçmen Sağlığı Merkezleri'nde Suriyeli mültecilere sağlık hizmeti sunmak üzere istihdam edilen Suriyeli sağlık personeli ve destek personelinin sayısı 4000'ü bulmuştur. Gerek Mülteci Sağlığı Merkezleri'nin kurulması ve operasyonu, gerekse 7 haftalık teorik ve pratik eğitimin organizasyon ve finansmanı Dünya Sağlık Örgütü tarafından gerçekleştirilmiştir. Mülteci Sağlığı Eğitim Merkezleri'nin kurulmasında Avrupa Birliği'nin yanı sıra, ABD Nüfus, Mülteciler ve Göç Bürosu Norveç hükümetleri fon sağlamışlardır.

Birleşmiş Milletler Nüfus Fonu ise, Kadın ve Kız Çocukları için Güvenli Alanlar projesiyle, hem kadın mültecilerin sağlık aracısı olarak istihdamlarını sağlamış, hem de mülteci kadınlara cinsel ve üreme sağlığı sağlanmasında aile planlaması ihtiyaçlarının karşılanmasını ön planda tutan ve toplumsal cinsiyete dayalı şiddete karşı farkındalık yaratma bileşenleri de bulunan ve bu anlamda da toplumsal cinsiyet eşitliğini gözeten sağlık hizmeti sunumunu, Göçmen Sağlığı Merkezleri'ne entegre olarak verilmesini teknik olarak desteklemiştir. Birleşmiş Milletler Uluslararası Çocuklara Acil Yardım Fonu ise 2017'de Dünya Sağlık Örgütü ile mülteci

çocukların tam bağışıklamasını hedefleyen ulusal bir aşı kampanyası için Türkiye devleti ile iş birliği yapmış, öncesinde küçük çaplı salgınlar için de kısa süreli iş birlikleri sağlamıştır. Tezin beşinci, altıncı ve yedinci bölümlerinde bu üç Birleşmiş Milletler kuruluşunun mültecilere sağlık hizmetleri sağlanmasındaki rolü ve söz konusu alanlarda gerçekleşen politika değişikliği karşılaştırmalı olarak analiz edilmiştir.

Tezin bu bölümlerinde kullanılan vaka çalışmaları, söz konusu üç Birleşmiş Milletler Kuruluşu'nun sağlık hizmet sunumunu desteklediği üç politika sektörünü hem politika sektörlerinin analizini yaparak, hem de göç krizinin bu alanlara getirdiği zorluklar ve ilgili Birleşmiş Milletler kuruluşunun bu politika alanındaki değişikliğin gerçekleşmesinde kullandığı teknik deneyim ve politika kapasitesi bakımından incelemiştir. Bu politika sektörleri ve incelenen Birleşmiş Milletler kuruluşları, birinci basamak sağlık hizmetlerinin güçlendirilmesi ve Dünya Sağlık Örgütü, mülteci kadınlara cinsel ve üreme sağlığı hizmetlerinin sağlanması ve toplumsal cinsiyete dayalı şiddetle mücadele ile ilgili farkındalık ve bilgilendirme sağlanması ve Birleşmiş Milletler Nüfus Fonu, ve son olarak çocuk mültecilere bağışıklık hizmetlerinin sağlanması ve Birleşmiş Milletler Uluslararası Çocuklara Acil Yardım Fonu şeklindedir.

Bu politika sektörleri, ev sahibi ülkenin bu alanlardaki politikaları açısından farklılık göstermektedir. Araçsallık kavramıyla ele alınan bu farklılıklar, bu alandaki politika değişikliğine dair bir talebin olup olmadığıyla ilişkilendirilmiştir. Her bir vaka çalışması araçsallık ve söz konusu politika sektöründeki sorunlar bakımından analiz edilmiş ve ilgili BM kuruluşunun politika kapasitesine ve teknik uzmanlığına odaklanılmıştır.

Bu politika sektörlerinden birinci basamak sağlık hizmetlerinin güçlendirilmesi, en araçsal olan politik sektör olarak analiz edilmiştir. Çünkü Türkiye, gerek sağlık harcamalarının gayri safi milli hasılaya oranı bakımından, gerekse 1000 hastaya düşen sağlık personeli bakımından Ekonomik İşbirliği ve Kalkınma Örgütü (OECD) ülkeleri arasında gerilerde yer almaktadır. Ancak bazı çalışmalar, bu nicel verilerin sağlık hizmetlerinin verilmesinin niteliği anlamında bir veri sağlamayacağını da

tartışmaktadır. Ancak artan mülteci sayısının sağlık sistemi üzerinde bir baskı yarattığı bir gerçektir. Dünya Sağlık Örgütü ile iş birliği ile gerçekleştirilen Suriyeli sağlık personelinin yine Dünya Sağlık Örgütü ile iş birliği ile kurulan Mülteci Sağlık Eğitim Merkezleri'nde 1 hafta teorik ve 6 hafta pratik eğitimleri sonrası, SIHHAT Projesi kapsamında açılan 187 Göçmen Sağlığı Merkezleri'nde istihdam edilmesi, en geniş çaplı politik öğrenme sürecini oluşturmaktadır ve bu anlamda bir paradigma değişikliğine işaret etmesi bağlamında üçüncü derece politika değişikliği olarak değerlendirilmiştir.

Tez içinde yapılan yabancı sağlık personeli istihdamına ilişkin ülke karşılaştırması, yabancı sağlık personelini göçü için popüler ülkeler arasında yer alan ABD ve İngiltere'de ve ayrıca Suriyeli mülteci sağlık personelinin istihdam edildiği Norveç, İsveç ve Almanya gibi ülkelerde yabancı sağlık personeli istihdamının iki seneye varan uzun oryantasyon süreçleri sonunda ve gerekli tüm belgelerin sağlanması koşuluna istinaden verildiğini göstermektedir. Dolayısıyla bir hafta teorik ve altı hafta pratik eğitimden sonra Göçmen Sağlığı Merkezleri'nde gerçekleştirilen yabancı sağlık personeli istihdamı bu ülkelerle kıyaslandığında çok hızlı bir şekilde gerçekleştirilmiştir diyebiliriz. Her ne kadar bu oryantasyon sürecinin kısa tutulması akademik ve basın kaynaklarının incelemesinin gösterdiği gibi bazı kaygılara yol açmış olsa da mülteci yabancı sağlık personelinin istihdamının uzun süreler alması ve mültecilerin sığındıkları ülkelere ani gelişleri sonucu hayat şartlarının kötüleşebileceği düşünüldüğünde bu süreçlerin maddi ve psikolojik olarak yıpratıcı olduğu söylenebilir.

Ayrıca Türk sağlık sistemini bilmeyen ve Türkçe konuşamayan çok sayıda mültecinin gelişi tartışıldığı gibi, Türk sağlık sistemini de derinden etkilemiş durumdadır. Dolayısıyla tüm bunlar yabancı sağlık personelinin istihdamı kararını hızlandırmıştır diyebiliriz. Ayrıca Suriyeli mülteci sağlık personeli, tezin kapsamı içindeki 2021 yılı itibariyle hala Suriyeli Mülteci Sağlık Merkezleri'nde istihdam edilmiş durumdadır. Ancak Suriyeli doktor ve hemşirelerin Türk hastanelerinde istihdamı ve Mülteci Sağlık Merkezlerinin Türk sağlık sistemindeki Aile Sağlığı Merkezleri'ne ve Toplum Sağlığı Merkezlerine dönüştürülebilmesi mümkün ve olası gözükmektedir.

Dünya Sağlık Örgütü'nün hem yabancı sağlık personeli istihdamı için düzenlenen eğitimlerin organizasyonuna hem de merkezlerin operasyonel hale gelmesine verdiği teknik uzmanlık, gerçekleşen politik değişikliğin önemli bir etmenidir. Dünya Sağlık Örgütü, sağlık hizmeti sunumunda yalnızca mülteci personel istihdamına destek vermemiş aynı zamanda evde bakım hizmetlerinin mültecilerinin ulaştırılmasıyla sağlık hizmetlerine destekleyici bir proje de uygulamıştır. Dünya Sağlık Örgütü, hem bu proje kapsamında hem de sağlık hizmetlerinin verildiği Suriyeli sağlık personelinin eğitimlerinin verildiği Mülteci Sağlığı Merkezleri'nin operasyonel hale gelmesinde önemli derecede bir koordinasyon uzmanlığı uygulamış ve uygulama partnerleri olan bazı sivil toplum kuruluşlarıyla devlet kurumları arasında koordinasyon faaliyetleri yürütmüştür. Bu anlamda AB fonlarının büyük bir kısmının SIHHAT Projesi'ne entegre projeler yapan Dünya Sağlık Örgütü'ne aktarıldığı düşündüğünde önemli bir politika kapasitesinin olduğu söylenebilir. Sivil toplum kuruluşlarıyla olan iş birliği hem sağlık yönetişimini bu aktörlerinde katılımına açmış hem de bu aktörlerin faaliyetleri yapılan ve sağlanan sağlık hizmetleri için erişimi arttırmıştır. Dolayısıyla Dünya Sağlık Örgütü'nün erişim uzmanlığının da bulunduğu söylenebilir.

Yabancı sağlık personeli istihdamı gibi diğer ülkelerde devlet dışı aktörlerin çok dahil olmadığı bir sürece bu aktörlerin etkin bir aktör olarak katılması bir devretme uzmanlığı olduğunu da göstermektedir. Bu anlamda operasyonel kapasitesi de oldukça etkin bir şekilde kullanılmıştır. Bunun dışında Dünya Sağlık Örgütü tarafından hem Suriyeli mülteciler hem de Suriyeli sağlık personeli istihdamına dair yayınlanan araştırma, rapor ve diğer yayınlar, kuruluşun ampirik uzmanlığı ve analitik kapasitesinin de güçlü olduğunu göstermektedir. Bu anlamda DSÖ, önemli bir aktör olarak süreçte yer almış ve sağlık sisteminde köklü bir paradigmatik değişikliğe sebep olan yabancı personel istihdamında önemli bir teknik rol oynamış durumdadır.

BM Nüfus Fonu iş birliğiyle kurulan Kadın ve Kız Çocukları Güvenli Alanları da yine önemli bir politika değişikliğine ve analitik çerçeve bakımından ikinci derece bir politik değişikliğine işaret etmektedir. Bu alan birinci basamak sağlık hizmetleri alanı ile araçsallık bakımından karşılaştırıldığında mevcut muhafazakâr toplumsal

cinsiyet politikaları sebebiyle burada nüfus artış hızını azaltmaya yönelik ve aile planlamasını ön planda tutan bir sağlık hizmeti sunumu modeliyle ilgili politik öğrenimin kısıtlı olacağı öngörülebilir. Türkiye'deki nüfus politikaları esasen tarihsel olarak üç farklı dönemde incelenebilir. 1960'lı yıllardan sonra sonra anti- natalist (nüfus artış hızını azaltmaya yönelik) bir politika izlemeye başlamış ve aile planlaması gibi konular özellikle birincil basamak sağlık hizmeti sağlanmasında önemli konu başlıkları haline gelmiştir. Özellikle Türkiye'de sağlık ocaklarının birincil basamak sağlık hizmetlerini sağladığı dönemlerde, ebeler aile planlaması ile ilgili hizmetlerin verilmesinde önemli rol oynamışlardır. Ancak özellikle 2007 sonrası pro- natalist yani doğumu teşvik eden nüfus politikalarına dönüldüğü görülmektedir. Bu sebeple burada gerçekleşecek bir politik değişiklik daha az talep edilebilir haldedir ve dolayısıyla politik öğrenme sürecinin daha az olması beklenebilir diyebiliriz. Oysaki tezin bulguları buradaki politika öğreniminin de yüksek olduğunu göstermektedir.

Öncelikle Türkiye'deki doğumları teşvik eden mevcut politikalar, tam anlamıyla mülteci nüfusu hedeflememektedir. İkinci olarak mültecilere ilişkin mevcut demografik verilerin incelenmesi, buradaki sorunların da politika değişimlerini teşvik edebilecek kadar önemli olduğunu göstermektedir. Tez içinde tartışılan verilerle, Suriyeli kadınlar için doğurganlık oranlarının, "baby-boom" denen ve doğum oranlarının yüksekliğine işaret eden bir durumda olduğu gösterilmiştir. Bu anlamda, cinsel ve üreme sağlığı hizmetleri sağlanırken aile planlaması gibi konuları önemli kılabilecek nüfus göstergeleri mevcuttur. Ayrıca kadına karşı şiddet verileri hem ev sahibi topluluk hem de mülteci topluluk için oldukça yüksek verilere işaret etmektedir. Bu anlamda Kadın ve Kız Çocukları Güvenli Alanları'nda mülteci kadınlara verilen cinsel ve üreme sağlığı hizmet sunumuna toplumsal cinsiyete bağlı şiddetle mücadele bileşenlerinin eklenmesiyle oldukça önemli bir rol üstlenilmiştir diyebiliriz.

Burada BM Nüfus Fonu'nun tez boyunca incelenen analitik, operasyonel ve siyasi politika kapasiteleri bu öğrenme sürecini önemli ölçüde şekillendirmiş ve BM Nüfus Fonu burada bir savunuculuk rolü de üstlenmiş bulunmaktadır. Sivil toplum ve devlet kuruluşları arasındaki koordinasyon uzmanlığını kullanan kuruluş, teknik

bilginin aktarımı için analitik politika kapasitelerini de kullanmış aynı zamanda siyasi politika kapasitesini de etkin bir şekilde kullanmıştır. Özellikle acil durumlarda uygulanması için hazırlanan Asgari Sağlık Hizmet Paketi (Minimum Initial Service Package) gibi kurumsal kılavuzlar, mülteciler için cinsel ve üreme sağlığı hizmetlerinin savaş sonrası acil durumda da kesintisiz sağlanması için gerekli bir altyapı oluşturmuştur. BM Nüfus Fonu'nun bunu eğitimler yoluyla kamu ve sivil toplum kuruluşlarına aktarması önemli bir analitik kapasiteye işaret etmektedir. Ayrıca uygulama partnerlerinin mülteci kadınların sağlık ve toplumsal cinsiyete bağlı göstergelere dair yaptığı araştırmalar ve yayınları da yine BM Nüfus Fonu tarafından desteklenmiş ve bu anlamda politika değişikliği için de ampirik veriye dayalı bir uzmanlık sağlamış ve dönüştürücü bir etki yaratmıştır. BM Nüfus Fonu, da en az Dünya Sağlık Örgütü kadar güçlü koordinasyon uzmanlığı sağlamıştır ve bu anlamda da siyasi politika kapasitesini aktif olarak kullanmıştır. Son olarak merkezlerde istihdam edilen Suriyeli mülteci kadınlar, kendi dillerinde mülteci kadınlara ulaşarak önemli bir erişim faaliyeti üstlenmişlerdir ve bu da önemli bir operasyonel kapasite oluşturmuştur. Bu anlamda BM Nüfus Fonu, bu merkezler aracılığıyla hem analitik ve operasyonel politika kapasitesini hem de uygulama partnerleri ve kamu kurumları arasında kurduğu koordinasyon faaliyetleri ile siyasi politik kapasitesini etkin bir şekilde kullanarak ikincil derece olarak değerlendirilen bu politika değişikliğine katkı sağlamıştır.

Türkiye'nin BM Uluslararası Çocuklara Acil Yardım Fonu ve Dünya Sağlık Örgütü iş birliği ile yaptığı ve mülteci çocukların tüm çocukluk aşılarını tamamlaması ile tam bağışıklamasını hedeflediği 2017 Ulusal Aşı Kampanyası ise bu üç alan içinde en zayıf politika değişikliğini oluşturmaktadır. Buradaki zayıf politika değişikliği, kampanyanın etkilerinin zayıf olmasını değil ancak bir politika değişikliği yaratabilecek bir politika aracının oluşturulmamasını ifade etmektedir. Dolayısıyla bu ortak ulusal kampanya, yeni bir politika aracı oluşturmadan 1981 yılından beri Türkiye'de uygulanmakta olan mevcut Ulusal Aşı Kampanyası'na yabancı fonlar ile destek verilmesi şeklinde gerçekleştirilmiştir. Kısıtlı bir süreyi ifade etmesi bakımından uzun dönem bir politika değişikliği gerçekleşmediğinden birinci derece politika değişikliği olarak değerlendirilmiştir.

Türkiye bazı çocukluk aşılarının (DTP3 örneği) tamamlanması bakımından en iyi örneklerden birini oluşturmaktadır. 1981 yılından beri de aktif olarak ulusal bağışıklama kampanyasını yürütür durumdadır. Bu bakımdan veriler, bağışıklama hizmetlerinin sağlanması açısından güçlü bir altyapıya ve donanımlı teknik personele sahip olduğunu göstermektedir. Ancak özellikle son yıllardaki Nufüs Araştırması verilerinin karşılaştırmalı okuması, tüm aşıların tamamlanması oranında düşüşler olduğunu göstermektedir. Tez içinde de tartışıldığı üzere bunu 2003'ten beri değişmekte olan sağlık sistemine bağlayan araştırmalar bulunmaktadır. Ancak yine de bağışıklama hizmetlerinin Aile Sağlığı Merkezleri'nde ücretsiz ve erişilebilir olduğunu söylemek mümkündür. Ancak ebeveyn reddi son yıllarda önemli bir risk olarak karşımıza çıkmaktadır. Mültecilerin bağışıklama hizmetlerine ulaşabiliyor olması ise hem çok elzem bir konudur, ancak bazı zorluklar da içerebilir. Tartışıldığı üzere, göç sonrası genelde kötüleşen yaşam koşulları mülteci nüfusu bulaşıcı hastalıklara karşı daha kırılgan hale getirebilmektedir. Bu anlamda mülteciler yaygın kanının aksine bulaşıcı risk taşıyıcısı değildir ancak göç koşulları kendilerini oldukça kırılgan hale getirmektedir. Yine de diğer iki vakaya kıyasla bu alandaki sorunlar geniş çaplı bir bulaşıcı salgın olmaması sebeiyle çok yoğun durumda değildir. Bu anlamda, 2013 yılında meydana gelen çok yaygın olmayan bir kızamık salgını dışında ciddi bir bulaşıcı hastalık riski gözlenmemiştir.

Tez içinde de tartışılan göç ve göç koşullarının, genelde kötüye giden yaşam koşullarının mültecileri bulaşıcı hastalıklara yakalanma konusunda daha hassas hale getirmesi buradaki en büyük risk faktörünü oluşturmaktadır. Ancak tüm bu riskler büyük çaplı bir salgına dönüşmediği için de ciddi bir politika değişikliği öngörülmemiş olabilir. Bu anlamda bu politika sektörü araçsallık bakımından da önemli bir talebi içermemektedir. Bu sebeple de Suriyeli mülteci çocukların tam bağışıklığının sağlanması için yeni bir politika aracı oluşturulmamış ve 2017 yılında Dünya Sağlık Örgütü, BM Uluslararası Çocuklara Acil Yardım Fonu ve Türkiye Cumhuriyeti Sağlık Bakanlığı iş birliğiyle mülteci çocukların bağışıklığını hedefleyen zaman açısından kısıtlı bir aşı kampanyası uygulanmıştır. Bu kampanya ile mültecilerin yoğun olarak yaşadığı 20 ilde beş yaşın altındaki 376000 mülteci çocuğa aşı yapılmıştır.

Bu bağlamda bağışıklık hizmetlerinin sağlanmasında BM Uluslararası Çocuklara Acil Yardım Fonu hem operasyonel hem de analitik kapasitesini değerlendirmiştir. Ancak uzun dönemli bir program oluşturulmadığından, burada diğer iki örnekte olduğu gibi sivil toplumla uzun dönem bir operasyonel iş birliği yapılmamış, bu anlamda da koordinasyon uzmanlığı çok yoğun kullanılmamıştır. Göç yönetişiminde BM Uluslararası Çocuklara Acil Yardım Fonu'nun siyasi politik kapasitesi daha çok eğitim alanına yoğunlaşmış ve uluslararası fonlar özellikle de AB fonları bu alan odaklanmıştır. Özellikle mülakat verileri, bunun sebeplerinden birinin Türkiye'nin mevcut bağışıklama hizmetlerini sağlama kapasitesinin zaten iyi durumda olması olabileceğini göstermektedir. Burada önemli olan nokta, daha zayıf bir politika değişikliğinde BM Uluslararası Çocuklara Acil Yardım Fonu'nun politika kapasitesini çok da bu alanda kullanmamış olmamasıdır. Bu da tartışılan politika kapasiteleri içinde siyasi politika kapasitesinin göreceli az olmasının, politika öğrenimini de azaltabileceğini düşündürmektedir.

Yine de BM Uluslararası Çocuklara Acil Yardım Fonu, mültecilerin aşılanmasına yönelik yaptığı araştırmalar veriye dayalı bir uzmanlığa işaret etmektedir ve 2017 kampanyasının oluşturulmasında önemli olmuştur diyebiliriz. Ayrıca kuruluşun küresel bağışıklama veriseti de önemli bir analitik politika kapasitesine işaret etmektedir. Bunun dışında BM Uluslararası Çocuklara Acil Yardım Fonu'nun erişim uzmanlığı uyguladığı ve bazı eğitimler ve aşı lojistiğinde soğuk zincir yönetimine katkı sağlayarak operasyonel uzmanlık da sağladığını söyleyebiliriz. Bu anlamda sivil toplum koordinasyonu kısa süreliğine aşı kampanyasının aşı erişimini arttırmak için kullanılmış olduğundan ve yine fonlar da sınırlı olarak bu alanda kullanıldığından siyasi politik kapasite diğer iki vaka ile karşılaştırıldığında daha az kullanılmıştır. Ancak bu durum eğitim gibi başka politika alanları incelendiğinde farklılık gösterecektir. Bu üç vakanın karşılaştırmalı analizi aşağıdaki ampirik ve teorik bulguları vermektedir.

Bu tez, Birleşmiş Milletler kuruluşlarının önemli politika değişikliklerine katkı sağlayabilecek ve teknik uzmanlıklarıyla ve tartışılan politika kapasiteleriyle politika öğrenme sürecinde önemli roller alabilecek aktörler olduklarını tartışmıştır. Ancak bu kuruluşların süreci ne kadar yönlendirebilecekleri söz konusu politik sektörde bir

politika değişikliğinin ev sahibi ülke tarafından ne derecede talep edildiğiyle yakından ilgilidir. Ancak söz konusu politika değişikliğine yönelik önemli bir talebin bulunmaması durumunda dahi göç sürecinde politika alanında oluşan sorunlar ve riskler de politika değişikliğine dair bir talep yaratabilir ve iş birliğini destekleyebilir. Politika değişikliğinin derecesinden (birinci, ikinci, üçüncü derece politika değişimleri) bağımsız olarak siyasi politika kapasitesinin, operasyonel ve analitik kapasitelere göre politik öğrenme sürecinde daha kritik bir rol oynadığı söylenebilir. İncelenen tüm örneklerde her üç BM kuruluşu da operasyonel ve analitik kapasitelerini kullanmışlardır. Ancak bağışıklık hizmetlerinin sağlanmasına yönelik 2017 kampanyasında donör ve sivil toplum/ devlet kurumları koordinasyon uzmanlıklarının oluşturduğu siyasi politika kapasitesinin diğer iki vaka çalışmasına göre daha az kullanıldığı söylenebilir. Bu alanın güçlü olduğu BM Nüfus Fonu örneğinde politik sektörün çok araçsal bir alan olmaması halinde dahi etkin bir öğrenme süreci gerçekleşmiştir. Bu anlamda donör ve sivil toplum ilişkileri politik öğrenme süreci için önemli bir kapasiteyi işaret etmektedir. İncelenen üç ayrı politika kapasitesinin (analitik, operasyonel ve siyasi politika kapasiteleri) bu nokta dışında birbirine hiyerarşik bir üstünlüğü bulunmamaktadır. Ancak siyasi politika kapasitesinin çok aktif kullanılmadığı durumlarda politik öğrenme sürecinde daha az aktif bir rol üstlenilebilir ve bu da daha zayıf bir politik değişikliği getirebilir. Ancak aynı durum operasyonel ve analitik kapasitelerin eksikliği durumunda da ortaya çıkabilir. Tezin sonuçları bu kısma ışık tutmasa da yine de operasyonel ve analitik kapasitelerdeki eksikliğin bir diğerinin daha etkin kullanılmasıyla aktif bir politika öğrenme sürecinin olabileceğini öngörebiliriz. İleride yapılabilecek başka ampirik çalışmalar bu noktaya da ışık tutabilir. Devretme, erişim, ampirik ve koordinasyon başlıkları altında incelenen uzmanlık alanları ayrı ayrı öğrenme sürecinde önemli kapasiteler sağlamaktadır. Bu durumda tezin önemli bazı teorik bulguları da bulunmaktadır.

BM kuruluşunun faaliyet gösterdiği politik sektör BM kuruluşunun politik öğrenme sürecinde alacağı rol için oldukça önemlidir. Sağlık sektörünün teknik kapasitesinin arttırılması (sağlık personeli istihdamı gibi) gibi konularda politik öğrenme daha kolay gerçekleşebilir. Bazı kültürel ve sosyal etmenlerden dolayı üreme ve cinsel sağlık ya toplumsal cinsiyete bağlı şiddetin önlenmesine yönelik hizmetler gibi bazı

politika sektörleri, öğrenmeye daha fazla direnç gösterebilirler. Ancak burada göç gibi toplumsal ve politik alanın birçok yönünü etkileyen bir konunun ilgili politika sektörüne getirdiği bazı zorluklar sebebiyle de öğrenme tetiklenebilir. Böyle bir durumda BM kuruluşlarının yukarıda detaylıca tartışılan kapasite ve uzmanlıkları da yine politik öğrenme konusunda oldukça işlevsel hale gelebilir ve bir savunuculuk rolü üstlenebilir. Ancak, BM kuruluşları yine böyle çok araçsal olarak değerlendirilemeyecek bazı politika sektörlerinde, BM Uluslararası Çocuklara Acil Yardım Fonu gibi mevcut politika araçlarını destekleme yönünde de rol alabilirler ve bu durumda aldıkları rol savunuculuktan çok teknik bir rol olarak değerlendirilebilecektir.

İncelenen veri ve analizinin de gösterdiği üzere BM kuruluşları için sürdürülebilir fon ve sivil toplum ile iş birliği operasyonel ve siyasi kapasiteleri arttırması bakımından çok önemli durumdadır. Bu sebeple literatürde de epeyce yer bulmuş olan finansal sürdürülebilirlik sorunu BM kuruluşları için önemli bir risk olarak karşımıza çıkmaktadır. Ancak sivil toplumla iş birliği de erişimi arttırması bakımından politika öğrenme sürecinde önemli bir yere sahiptir ve bu bakımdan da program yapım aşamasında muhakkak dikkatle incelenmelidir. Bu şekilde BM kuruluşları özellikle göç yönetişimi alanında mültecilerin incelenen sağlık sektörü örneğinde olduğu gibi sosyal hak ve hizmetleri erişiminin kolaylaştırılması ve özellikle göçten etkilenen misafir ülkelerin de sosyal hizmet sistemlerinin dayanıklılığını arttırılması ve güçlendirilmesi anlamında önemli görevler üstlenebilirler. Nitekim gerek Göçmen Sağlığı Merkezlerinin kuruluşu gerek mülteci sağlık personelinin istihdamı ve de kadın ve çocukların ihtiyaçlarına yönelik sağlık hizmetlerinin sağlanması konusunda Türkiye'deki Suriyeli mültecilere sağlık hizmetleri verilmesi konusunda BM kuruluşları oldukça önemli roller almış durumdadırlar.

Burada Türkiye'nin mültecilerin sağlık hizmetlerine tam erişebilmesi için ayırdığı kaynak ve politik kararlılık da istisnai örnekler arasındadır. Yine de her mültecinin sağlık hakkına tam erişebildiği ve hiçbir mültecinin geride bırakılmadığı bir dünyanın, devletlerin ve diğer aktörlerin eşit sorumluluk paylaşımı ve iş birliğine dayalı bir şekilde mültecilerin uluslararası korumadan kaynaklanan geri

gönderilmeme haklarına saygı duyarak izleyecekleri bir göç yönetimi ile mümkün olduğu unutulmamalıdır. Bu anlamda Türkiye örneğinde olduğu gibi iş birlikleri, mültecilerin sosyal hizmetlere ulaşabilmesini kolaylaştırabilir. Ancak uluslararası hukuktan kaynaklanan haklara tam erişim sadece devletleri değil siyasette rol alan tüm uluslararası aktörleri ilgilendirmektedir. Bu sebeple tüm aktörlerin uluslararası hukukun tam uygulanabilmesi için birlikte hareket etmesi gerekmektedir. Bundan daha önemlisi ise göçün temel kaynağı olan savaşların ve çatışmaların bitmesi ve hiç kimsenin mülteci konumuna düşmeyeceği bir dünyanın yaratılmasıdır.

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