EXPERIENCES OF SYRIAN REFUGEES REGARDING HEALTHCARE ACCESS IN ANKARA

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ABSTRACT

EXPERIENCES OF SYRIAN REFUGEES REGARDING HEALTHCARE ACCESS IN ANKARA

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This thesis attempts to provide a picture of the accessibility of healthcare services for Syrian migrants in Ankara along with the barriers to access they might be encountering when seeking healthcare. The framework that is used in this dissertation encompasses a wide array of barriers and groups them into economic and socio-cultural, cognitive and structural barriers. Since migration is a "human process", the study is enriched through human experience, perception and engagement. Hence, to gain further insight into the experiences of refugees and to highlight their agency, semi structured interviews were conducted with twenty two Syrian refugees living in Ankara, and five hospital visits with refugees were conducted. The findings from the study indicated that while access to healthcare was deemed easy, the refugees regarded the lack or inadequacy of translation services, the language barrier, complicated referrals, doctors' lack of communication, long procedures and waiting lines, number of tests and transportation as the most prominent challenges they face when seeking healthcare services in Ankara. Through accompanying refugees to hospital, digitalization, lack

of information and lack of social networks also appeared to pose challenges when accessing healthcare.

Keywords: Syrian Refugees, Healthcare Access, Access Barriers, Ankara

ÖZ

ANKARA'DA YAŞAYAN SURİYELİ SIĞINMACILARIN SAĞLIK HİZMETLERİNE ERİŞİM DENEYİMLERİ

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Bu çalışma, Ankara'da yaşayan Suriyeli sığınmacılar için sağlık hizmetlerine erişilebilirliğin ve sağlık hizmeti ararken karşılaşabilecekleri engellerin bir resmini sunmaya amaçlamaktadır. Bu tezde kullanılan çerçeve çeşitli erişim engellerini kapsamakta ve bunları ekonomik ve sosyo-kültürel, bilişsel ve yapısal engeller olarak gruplandırmaktadır. Göç bir "insan süreci" olduğundan, bu çalışma insan deneyimi, algısı ve katılımı ile zenginleştirilmiştir. Sığınmacıların deneyimleri hakkında daha fazla bilgi edinmek ve eylemliliklerini vurgulamak için Ankara'da yaşayan yirmi iki Suriyeli mülteci ile yarı yapılandırılmış görüşmeler yapılmış ve mültecilerle beş hastane ziyareti gerçekleştirilmiştir. Araştırmadan elde edilen bulgular, sağlık hizmetlerine erişimin kolay görüldüğünü gösterirken, mültecilerin çeviri hizmetlerinin eksikliği veya yetersizliği, dil engeli, hastane yönlendirmelerinin karmaşıklığı, doktorların iletişim eksikliği, uzun prosedürler ve hastane sıraları, test sayısı ve ulaşımın Ankara'da sağlık hizmetlerine başvururken karşılaştıkları en önemli zorluklar olduğunu göstermiştir. Hastane ziyaretleri ile

dijitalleşme, bilgi eksikliği ve sosyal ağların eksikliği gibi etkenlerin de sağlık hizmetlerine erişirken zorluklar yarattığı ortaya çıktı.

Anahtar Kelimeler: Suriyeli Sığınmacılar, Sağlık Hizmetlerine Erişim, Erişim Engelleri, Ankara

To My Dear Family,

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Finally, praise be to Allah for pulling me through.

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

TABLES

FIGURES

LIST OF ABBREVIATIONS

AFAD	Disaster and Emergency Management Presidency
ASAM	Association for Solidarity with Asylum Seekers and Migrants
ASOB	The Ankara Syrian Student Association
CEDAW	Convention on Elimination of All Forms of Discrimination Against Women
CRC	Convention on Rights of the Child
DGMM	Directorate General of Migration Management
ESSN	Emergency Social Safety
EU	European Union
HCAB	Health Care Access Barriers
HTP	Health Transformation Program
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
INGO	International Non-Governmental Organization
LFIP	Law on Foreigners and International Protection
MERNIS	Central Registration Administration System
MoH	Ministry of Health
MoNE	Ministry of National Education
MRI	Magnetic Resonance Imaging
MSF	Doctors Without Borders / Medecins Sans Frontiers
NGO	Non-Governmental Organization
SUT	Health Budget Law
SuTP	Syrians Under Temporary Protection
TL	Turkish Lira

TPR	Temporary Protection Regulation
UK	United Kingdom
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

"Just to claim asylum means that you believe now that you are not going back to your home…just to have this feeling that you don't have the hope to come back…at the same time you feel you are in a safe place and you try to live your normal life" (Waad Al-Kataeb, 2019). These are the words of Waad Al-Kataeb a Syrian woman who stayed in Syria during the worst times of the conflict with her husband Hamza Al-Kataeb who was a doctor and set up a clinic to tend to the sick and wounded. During their stay Waad took to her camera and filmed everything she could, especially in the clinic her husband set up, the footage was the sowing the seeds for the film "For Sama" released in 2019. These words were uttered during an interview on Channel 4, when she was talking about seeking asylum with her husband in the UK. The experiences of people fleeing war and conflict, leaving their homeland, their houses, their loved ones behind are not ones easily captured nor reflected. There are many images, words, interviews, articles, social media posts on refugees, and yet the most powerful ones are always those that spill from their own mouths or hands. Especially in terms of understanding challenges, barriers and needs these experiences play a vital role in situating these experiences and developing a response plan.

On the scheme of things, the scheme of a refugee crisis, the scheme of lives lost, the scheme of challenges that remain, the scheme of integration, the scheme of new beginnings, the scheme of rights and liberties this dissertation has a very miniscule and humble aim indeed: it's an attempt to paint a picture of the experiences of Syrian refugees accessing healthcare in Ankara. Yet the methodology employed is one that aims to present the challenges and experiences through refugees' own

narration of their own challenges, as, how does one touch upon displacement without the words of the displaced.

1.1. The Backdrop

> Displacement is like death. One thinks it happens only to other people. From the summer of '67 I became that displaced stranger whom I had always thought was someone else. The stranger is the person who renews his Residence Permit. He fills out forms and buys the stamps for them. He has to constantly come up with evidence and proofs. (Barghouti, 2003)

Numbers and figures are ubiquitous in any study or paper on refugees, especially in introductions, so this paper shall follow suit. The first number to be mentioned is "755,400", the number of refugees residing within the borders of the Syrian Arab Republic that placed it as the third largest refugee hosting country worldwide in 2011, according to the 2011 Global Trend Report published by the UNHCR. The Syrian civil war that broke out towards the end of 2011 tipped the balance in just the course of one year and Syria found itself listed as one of the top refugee producing countries with 728,218 refugees fleeing Syria (UNHCR,2012). 8 years on into the unrelenting civil war there are 5.6 million Syrian refugees across the globe mainly residing in Turkey, Lebanon and Jordan (UNHCR, 2019).

Turning to Turkey, there are now over 3.6 million Syrian refugees (UNHCR,2019) registered and estimates are that there is a vast number of unregistered Syrian refugees as well. It began with a mere 250 people who crossed the border from Latakia into Antakya in April 2011 (Dağtaş, 2018) and then reached 10,000 in the summer of the same year. In the nascent years of the crisis Turkey adopted an open-door policy for its neighbours fleeing the violent crackdown of the government in Syria that claimed the lives of many. Numbers continued to escalate, though in the first few years of the crisis the situation was regarded as one of a temporary nature (Memişoğlu, 2018; Kirişçi, 2015; İçduygu,2017). This is also evident in the terming

of Syrian refugees as the *misafirs* (guests) of Turkey (İçduygu, 2017; Dağtaş,2018), which implied that they would be in the country for a short time or at least until the violence had ended in Syria. Alongside the term guest, the government employed the use of the Islamic term *muhacir* (the Muslim people who migrated from Mecca to Medina in 622) when referring to the refugees and dubbed the local community as the *ensar* (Medina's local people who welcomed the *muhacir*) to the guests/brethren from across the border. Thus, the discourse was more or less formulated on the axis of temporality and on religious responsibility instead of the law or universal human rights values (Memişoğlu & Ilgıt, 2017).

Thus, during the first years, Turkey's response to the "guests" was centred on ad-hoc policies and humanitarian assistance (Memişoğlu, 2018). As Bilecen and Yurtseven have promptly put it "Syrians in Turkey were seen as an emergency just as an earthquake would be. Therefore, the Disaster and Emergency Management Presidency (AFAD) was held responsible and was the main authority regulating all services provided to Syrians – thus suggesting that unexpected population flows should be dealt with according to crisis management logic" (2018, p.117). Little was it known that the crisis would not abate, and continue on for eight years. Between the years of 2013-2015 the number of refugees inundating the country leapt from 224,665 in 2013 to 1.519.286 in 2014; and from the latter to 2.503.549 in the summer of 2015 (DGMM, July 2019). Furthermore over 90% of this number were living in urban settings. It was during this period that Turkey passed the Law on Foreigners and International Protection (LFIP) in 2013 establishing the Directorate General for Migration Management (DGMM). The following year witnessed the issuing of the temporary protection regulation which granted Syrian refugees temporary protection status in October 2014 and outlined service provision regulations.

In mid March of 2015 numbers had reached 1.7 million which was triple the numbers of December 2013 (İçduygu & Şimşek, 2016). Thus, especially in 2015

when numbers escalated and there were no signs of the conflict abating in Syria, Turkey began to realize that the guests were "Not Likely to Go Home", in his 2015 article with the same title Kirişçi stated that "one of the most striking aspects of the situation today in comparison with October 2013 is the broad consensus that exists in Turkey among academics, officials and civil society activists that the refugees are here to stay and that measures are urgently needed to help with their integration" (Kirişçi, 2015). 2015 also demarked the year of the "European refugee crisis", with numbers having reached record numbers and the summer that witnessed hundreds of refugees drown in the Mediterranean on their way to Europe (İçduygu & Şimşek, 2016). The number of refugees flooding into Europe seeking protection rose from 138,000 in 2014 to nearly 500,000 in late 2015 (2016, p. 61). Much to Turkey's dismay international responsibility sharing had remained scant and the Turkish government was largely left to its own devices in shouldering the responsibility of hosting the Syrian refugees (Kirişçi, 2015; Memişoğlu & Ilgıt, 2017), however with the reality of the refugee crisis sinking in, the EU signed a Refugee Deal with Turkey in March with a promise of 3 billion euros of financial aid to be spent on housing, food, employment, education, and healthcare for Syrian refugees (İçduygu et al., 2017). The policy of the Turkish government had begun to shift from ad hoc policies to band aid the crisis until the conflict died down in Syria, and started moving in the direction of integration and harmonization. The issuing of work permits to refugees who'd been in Turkey for longer than 6 months in June 2016 is one example of such a shift (İçduygu & Şimşek, 2016), as is the announcement of the Ministry of National Education to close the Temporary Education Centres that had been established for Syrian children, to facilitate the gradual integration of Syrian children into the national education system via their transition into Turkish public schools. (MoNE, September 2016). Thus, since 2015 and 2016 policies and perceptions have slowly departed from their temporary nature.

Looking at the past eight years there have been many practices and policies to be commended, as it is no easy task to absorb such a large number of refugees.

Especially considering that only a mere 3,02% of the 3.6 million Syrian refugees reside in the seven Temporary Accommodation Centres i.e. camps in five provinces (DGMM, November 2019). The bulk of Syrians under Temporary protection reside in cities and are among the local population every single day. Over 2.2 million of them are concentrated in six cities: İstanbul, Gaziantep, Şanlıurfa, Hatay, Adana and Mersin (DGMM, November 2019). Hence, services including health services in İstanbul and provinces along the border in the Southeast of Turkey are severely overburdened. To provide statistical information according to AFAD 34,501,808 policlinic services across primary, secondary and tertiary healthcare facilities have been provided to Syrian refugees between 2011 and 2018 (AFAD, April 2018). Furthermore, the economic burden has also been immense, as Turkey has spent over $30 billion on services for Syrian refugees, of which an estimated $10 billion alone has been allotted to health services (Alawa et al., 2019). Turkey has had to respond to the health needs of a population which has increased gradually but also in bursts, and with shifting policies of temporality to a more integrated approach.

Although all Syrian refugees are entitled to free access to primary and secondary health-care facilities as long as they are officially registered (Ekmekçi, 2016), the situation of those living in non-camp settings is far worse than those living in camps (Kirişçi, 2014; Yavuz, 2015; Uzun, 2015; Akgül, 2015). A myriad of challenges impeding access to healthcare are underlined in the literature ranging from structural barriers, cultural barriers, socio-economic barriers, systemic barriers. The most prevalent challenges include; lack of information/misinformation, language barriers, discrimination, registration issues, lack of mental healthcare and reproductive healthcare services, not being able to navigate the healthcare system and capacity problems. However, the literature surrounding Syrian refugee's healthcare access in Turkey, especially those that employ qualitative methods, is far from rife, with the exception of a few studies conducted in İstanbul and border provinces. Since health is a fundamental right and lack of it can result in dire consequences, I'd like to focus on this area and provide a picture of the accessibility of healthcare services for

Syrian migrants along with the barriers to access they might be encountering when seeking healthcare.

1.2. Scope and Objectives of the Study

As it was previously underlined the bulk of the literature on access to health barriers in Turkey does not include a qualitative component and hence falls short in providing a holistic picture of the existing bottlenecks and gaps. Thus, the main objective of this study is to provide an exploratory description of the situation of healthcare access in Turkey by looking into the experiences of urban refugees accessing healthcare in Ankara with an emphasis on the access barriers that they encounter. In other words, it aims to excavate the challenges faced by refugees accessing healthcare in urban settings, to explore the nature of the difficulties they are facing, to understand their opinion of the Turkish healthcare system and its accessibility as well as to inquire about what they think would improve healthcare access for themselves. Another aim is to cluster the access barriers to understand whether the barriers are systemic, provider level or patient level; economic, structural or cognitive; as the intersections are to be explored to identify responses and incorporate what the refugees think can be done to improve their own access. Thus, to this end the study employs qualitative methods; twenty-two semi-structured in-depth interviews were conducted with Syrian refugees residing in Ankara, along with five hospital visits where Syrian refugees were accompanied to hospitals.

In line with the aforementioned objectives, this dissertation attempts to shed light on the following research questions; What are the most pressing challenges refugees face when accessing healthcare in Ankara? What are the cognitive, socio cultural, economic and structural access barriers to healthcare? How do refugees regard healthcare accessibility in Ankara? Based on the suggestions of the respondents what steps can be taken to improve the accessibility of healthcare?

The scope of this study is a limited one indeed, as it focuses on Syrian refugees living in Ankara, a city which is not densely populated with Syrian refugees, as it only hosts a mere 95,000 in its population of 5.5 million (DGMM, 2019). Furthermore, Ankara is one of the cities with lesser tensions compared to border cities. The reason Ankara was selected as a city, was due to the existing access I had to the refugee community in Ankara through various volunteer groups I had been part of. Had the research been conducted in another province I would not have had the access or the trust that I did for this study. Thus, the aim is not to make unequivocal statements or generalisations but to explore and reflect the experiences of refugee access to healthcare, to explore what would be revealed through hospital visits and to cluster the access barriers alongside identifying possible responses. Furthermore, the study aims to point out how interviews coupled with ethnographic methods may enrich refugee studies and help gain a better understanding which would hopefully in turn lead to better tailoring of policies and responses.

1.3. Significance of this Study

Regarding the significance of healthcare access for refugees, healthcare is a service of vital importance for any person. In her list of capabilities Martha Nussbaum lists "bodily health" as one of the central human capabilities that are essential to lead a decent life (2000, p.78). The accessibility of healthcare services is thus of paramount importance to ensure the continuity of a healthy life. However, in cases of displacement, due to the changing landscape and challenges that ensue, healthcare access can become jeopardised. The health condition of refugees tends to deteriorate, as they may face poor living conditions and nutrition, coupled with exposure to loss, insecurities and trauma (Torun et al., 2016; Bilecen & Yurtseven, 2017; Alawa, Zarei & Khoshnood, 2019). Furthermore, various chronic conditions require sustained treatment, and as refugees struggle to resettle in a new country and acquaint themselves with a new health system, the delay of care and lapses of treatment can have adverse effects on the state of their health (Alawa et al., 2019).

Thus, addressing the healthcare needs and ensuring that refugees have access to healthcare services is of vital importance for any host country. Especially in the case of Turkey as it is catering to the healthcare needs of over 3.6 million Syrian refugees.

As it was mentioned previously; while access barriers to health have been delineated in the literature, an experiential narrative from the refugees' point of view doesn't seem to have been presented. While major barriers such as the language barrier, difficulties navigating the Turkish healthcare system, financial constraints, discrimination, misinformation, limited reproductive and mental healthcare services have been underlined several times; more cognitive or cultural barriers do not seem to appear in the literature as much. While attesting to the prevalence of the barriers in the existing literature, this micro study reveals in its own small way the perspective of refugees and other challenges they deem significant. Thus, other perhaps "softer" dimensions came to light such as lack of social networks, difficulties with digitalization, doctor-patient communication and the strong dislike of the test-based nature of the Turkish healthcare system. This small study also asked refugees what they would like to change and how they think their healthcare access could be improved.

The culmination of the study is to identify gaps and bottlenecks, to group them and cluster them in a way that would present the experiences and challenges of refugees from their perspective, and also help pinpoint nodes of intervention at varying levels (civil society, NGO, government, individuals) to ameliorate access to healthcare. Furthermore, as it was mentioned above, this study also to a small extent shows how ethnographic methods can enrich the understanding of challenges, reveal new challenges and aid in the processes of responding to those challenges. As Eastmond asserts "stories are reconstitutive in the way they organize experience, give it unity and meaning, but they also, in a more pragmatic perspective, form part of purposive and meaningful action to influence the outcome." (2007, p.251). Thus, the narratives

presented by refugees are also key sites to pave the way forward when it comes to devising suggestions and solutions.

1.4. Roadmap of the Study

The following chapter prescribes various definitions of access to healthcare and then proceeds to contextualize it within the refugee crisis. Then the chapter provides a framework for healthcare access and explores certain healthcare access barrier models. Upon which a lose framework is drawn up to group the access barriers that have been identified in the literature and from the fieldwork in later chapters. Drawing from the literature the main access barrier groups shall be cognitive, structural, and socio-cultural and economic barriers across personal, provider and system level.

Chapter 3 is another literature review which details the healthcare access of Syrian refugees in Turkey through the legal framework for Syrian refugees and the implications on their access to healthcare, the healthcare reforms to explain the current healthcare system and the means of healthcare provision to refugees, and the access barriers that they are facing. At the end of this chapter a vague classification of the identified barriers is provided.

Chapter 4 focuses on the methodology of the study and the reasons behind employing both semi-structured in-depth interviews and ethnographic work. The sampling of the study, characteristics of respondents, challenges encountered, limitations, design of the interview questions and use of ethnographic vignettes shall be explained. Furthermore, this chapter will also lend focus to the significance of qualitative methods, particularly ethnographic work, in refugee studies, by referring to the importance of highlighting refugee agency and experiences.

The actual fieldwork and interviews are presented in Chapter 5. The interviews aimed to elicit the challenges and experiences of Syrian refugees regarding access to healthcare. Based on the interviews, factors that complicated ease of access to healthcare services mentioned were; the language barrier, lack of translators, long waiting times, crowdedness, the lack of information provided by doctors to patients, navigating the healthcare system, transportation, lack of information, the test-based nature of diagnosis in public hospitals, stigma towards seeking mental healthcare. The ethnographic visits on the other hand, revealed similar challenges with the addition of lack of social networks, difficulties with digitalization and also how lack of information and not being able to navigate the healthcare system lead to "limited potential for agency in decision making and self-management of health" for refugees (Lloyd, 2014).

The final section centres around a discussion on what can be done, what has been suggested by the literature, and endeavours to delineate future study areas that would contribute to ameliorating certain challenges and addressing the existing gaps.

CHAPTER 2

CONCEPTUALIZING REFUGEE ACCESS TO HEALTHCARE

This chapter delineates the framework of access for the study and then provides various access barrier models which are then merged into one model to suit the data in this study.

2.1. Defining Access to Healthcare

Amartya Sen asserts that "health is among the most important conditions of human life and a critically significant constituent of human capabilities which we have reason to value." (2002, p.660). Access to healthcare has been defined in countless ways across the literature, it seems that rather than the definitions themselves the dimensions that these definitions pertain to or encompass would be more of service in this study when delineating various barriers to accessing health. To note some of the most widely referred to definitions in the literature, access has been defined as "the fit between patients and the health system." (Penchansky & Thomas, 1981); "providing the right services at the right time in the right place" (Rogers qtd. in Norredam & Krasnik, 2011); "the opportunity to consume health goods and services." (Haddad & Mohindra, 2002).

A highly comprehensive approach is adopted by Levesque et al. as they conceptualise access in the interface of systems and populations and have devised a highly comprehensive and multifaceted patient centred conceptual framework of access to healthcare. They define access as "the opportunity to reach and obtain appropriate health care services in situations of perceived need for care" (Levesque et al, 2013). More poignantly the framework provides a supply and demand slant on

accessibility without neglecting processual factors, since access is regarded as resulting from the "interface between the characteristics of persons, households, social and physical environments and the characteristics of health systems, organisations and providers" (2013, p.4). Furthermore, the model doesn't ignore elements such as perception, values, culture, gender and empowerment. The paper provides a highly succinct and encompassing framework from a supply and demand side. Five dimensions of accessibility of the supply side (health systems, organisations, institutions, providers) are given as approachability, acceptability, availability/accommodation, affordability and appropriateness. Then there are five corresponding abilities of the demand side (populations, households, communities, individuals) are provided as the ability to perceive, ability to seek, ability to reach, ability to pay and ability to engage (2013, p.5). These are all framed within their patient-centred access model that conceptualises access at the interface of health systems and populations.

This framework is utilized in this dissertation when determining barriers and accessibility to healthcare for Syrian migrants and affords a great deal of flexibility and fluidity, due to the breadth of the categories it provides such as the ability to perceive, acceptability, appropriateness, availability and the ability to engage . Levesque et al.'s approach is also reminiscent of Sen's approach to health, as he distinguishes "between the achievement and capability, on the one side, and the facilities socially offered for health care on the other." (2013, p.660) just as Levesque et al. distinguish between five dimensions of accessibility and five corresponding abilities of populations.

2.2. Factors Influencing Refugee Access to Healthcare

When it comes to refugees' access to healthcare several components have been taken into consideration. Language and culture are the two most salient factors that have been cited in the literature (Young et al., 1987; Ingleby, 2011; Norredam and

Krasnik, 2011; Ager,2014). There are also distinctions between factors affecting the accessibility of healthcare such as formal/informal, structural/cognitive/financial (Norredam & Krasnik, 2011; Carillo et al., 2011; Ay et al.,2016). For instance, regarding health services themselves; the location and cost of health services, the availability of transportation, the services' capacity are key (Ingleby, 2011). While factors relating to language, culture, affordability, capacity etc. have been covered extensively; more cognitive, perception based and behavioural factors seem to have received little attention. Norredam and Krasnik lend focus to these under a highly comprehensive list of several factors including self-perceived needs, health beliefs, health-seeking behaviour, health and socioeconomic status, legal restrictions on entitlement, healthcare costs, language barriers, gender, cultural differences, trauma and newness (Norredam & Krasnik, 2011). Structural barriers include barriers such as waiting time, transportation; healthcare costs and health coverage are among financial barriers and cognitive barriers encompass language, communication, trust, discrimination etc. (Carillo et al., 2011).

To provide a more concrete picture of refugee access to healthcare looking to other countries such as Jordan and Lebanon prove to be useful, as there have been several studies that delve into refugee access to healthcare for both countries. In 2015 Jordan is host to over 660,000 registered Syrian refugees (UNHCR, 2019). Doocy et al outline how at first healthcare was free of charge to all refugees, however due to the immense burden placed on the Jordanian health system, Syrian refugees now have to pay for health services as do uninsured Jordanians since November 2014 (Doocy et al, 2015). Thus, this severely impacted access to healthcare, as according to another study three out of ten families did not have access to healthcare when needed in the last six months, as they could not bear the costs (Akbulut et al., 2019). When it comes to healthcare access, Doocy et.al noted that long waiting times, lack of information on health services, poor staff treatment, and transportation prevented refugees from care-seeking (p.2).

Turning to Lebanon, the country hosting the most Syrian refugees per capita, it is estimated that there are over one million Syrian refugees residing in Lebanon (UNHCR, 2019). With regard to access to healthcare Syrian refugees are able to utilise public health centers, however these centers do not offer high quality healthcare services which are mostly provided by private healthcare centres (Akbulut et al., 2019). Parkinson and Behrouzan, drawing on two ethnographic encounters (a hospital and a refugee camp) among Syrian refugees in Lebanon, they demonstrate "how interactions surrounding the clinical encounter reveal the social, political, and logistical complexities of healthcare access" (2015, p.324). They demonstrate the politics of access to healthcare through ethnographic vignettes. For instance, one encounter reveals how refugees are sensitive to cost considerations and how knowledge of facilities affects their decisions with regard to health care seeking, while another provides insight into how running the risk of encountering security forces affects decisions. In the words of Parkinson and Behrouzan "these ethnographic vignettes shed light on the intersecting socioeconomic, political, and bureaucratic dynamics that shape healthcare access for refugees from Syria in Lebanon" (2015, p.328). Lebanon, unlike Jordan, has no essential health care package even for its own population and its health care system is fragmented, privatized and not coordinated. As, there has been no clear policy or plan by the government regarding refugee health response, accommodating another 1.1 million people is no easy task for the health sector and the most influential barrier preventing Syrian refugees from accessing healthcare is the high healthcare expenditure (Parkinson & Behrouzan, 2015; El-Jardali et al., 2014).

2.3. Healthcare Access Barrier Models

When devising how to approach the subject of access barriers the use of three aspects of three studies on access to healthcare barriers are employed to provide an outline by making reference to Levesque et al.'s framework. The use of categories (cognitive, socio-economic and cultural, structural) of Carillo et al. has been

adapted, the concept of informal barriers from Norredam and Krasnik's study has been incorporated and finally from Scheppers et al. the notion of using levels have been tailored to suit the classification provided at the end.

2.3.1. The Health Care Access Barriers (HCAB) Model

Carillo et al. worked with a large community of Latino immigrants in Washington Heights Inwood when devising their HCAB model. The model "targets modifiable health care access barriers in order to serve as a practical tool for root-cause analysis and community-based interventions" (Carillo et al., 2011). They proposed three categories of health care access barriers; financial barriers (cost of care and health insurance status barriers such as no health insurance), structural barriers (institutional and organizational barriers such as waiting time, transportation, multiple locations for tests and specialists, continuity of care, operating hours), cognitive barriers (knowledge and communication barriers such as the availability of interpreter services, awareness of health resources, language, health literacy, availability of cross-cultural communication, understanding of treatment, racial/ethnic concordance of provider). The limitation of the model is that it does not "capture the overlap among multiple health care determinants of disparities" (2011,p.570) . Ay et al. adopted this model in their study entitled "The Perceived Barriers of Access to Health Care Among a Group of Non-camp Syrian Refugees in Jordan" where they conducted 196 surveys. Ay et al. make a distinction between financial, structural and cognitive barriers to healthcare. The most pressing structural barriers they identified were long waiting lines, long procedures, long distances, late appointment dates complex referral systems and multiple tests. Financial barriers were listed as the most prevalent ones and encompassed high cost of transportation, medicine and health services. Finally, the cognitive barriers underlined were discrimination, not knowing where to go and not trusting doctors other barriers (Ay et al., 2016). It must be noted that cognitive barriers, those relating to trust, discrimination, preferences, were not that common in the research

in contrast with other barriers. This outcome is most likely related to cost being a more important challenge as it was indicated in the literature, however it could also possibly be due to the narrow scope of cognitive barriers in the HCAB model. Thus, Norredom and Krasnik's further elaboration on informal barriers could prove to be useful.

2.3.2. Migrants' Access to Health Services

Norredam and Krasnik highlight the differences between access barriers for migrants and non-migrants seeking healthcare. Hence, they lend focus to a wide array of barriers pertaining specifically to migrants. The informal barriers encompass factors such as language, communication, sociocultural factors, "newness", lack of comprehensible information, lack of skilled interpreters, gaps in the training of staff, stigmatization, doctors' biological, psychological and social approaches, loss of social networks, cultural differences, health and socioeconomic status, self-perceived needs, health beliefs, health-seeking behaviour, trauma etc. While the formal barriers pertain to health policies and the organization of health systems, as well as legal restrictions and financial barriers, such as legal restrictions on entitlement and healthcare costs (Norredam & Krasnik, 2011).

Norredam & Krasnik look at intangible factors and go beyond the language barrier when looking at communication. They focus on stigmatization, the "biological, psychological and social approaches" of practitioners and assert how these can poorly affect treatment through misunderstandings, mistreatment and mis referrals . They also elucidate barriers that can be particular to refugees such as social marginalization and loss of social networks. Furthermore, concepts such as newness are regarded as factors that can inhibit access to healthcare, as acclimatizing oneself to a new healthcare system is no easy ordeal (2011).

As it can be seen Norredam and Krasnik have devised a highly comprehensive list of several factors especially under informal barriers.

2.3.3 Potential Barriers to the Use of Health Services Among Ethnic Minorities

Scheppers et al. also provide a highly comprehensive list of barriers and state that the potential barriers occur at three different levels: patient level, provider level and system level. A levelled analysis is useful in the sense that it helps identify which barrier is occurring where (2006). Barriers at patient level pertain to demographic variables, social structure variables, health beliefs and attitudes, personal enabling resources, community enabling resources, perceived illness and personal health practices. These have been further exemplified as lifestyle, socio-economic status, family and social support, values concerning health and illness, traditional remedies and self-treatment, local language skills, culture, education, perceptions and attitudes towards health services and personnel. Barriers at provider level are related to the provider characteristics such as sex, skills and attitudes. Examples of such barriers are client approach, cultural knowledge, translation, skills, religion, medical procedures and practices. Finally, barriers at system level deal with the organisation of the health care system, policies, organizational factors, structural factors, such as translation, intake procedures and opening hours, waiting time, referral systems. The idea of incorporating levels provides a more wholistic picture (2006, p.329).

They then classify access barriers from the literature that they have reviewed into these categories. For instance, for a 2002 study conducted in Australia among Thai women the barriers at patient level were noted as language skills, translation services, perceptions and attitudes towards healthcare personnel; barriers at provider level were listed as practitioner behaviour and style of information provision; and finally the referral system and printed forms of information dissemination were listed under system level barriers (Scheppers et al., 2006).

2.4. A Conceptual Framework for Barriers to Accessing Healthcare for Syrian Migrants in Turkey

Since the research focuses on the experiences of refugees from their perspective Levesque et al.'s framework is well suited to this purpose as it is patient centric and "provides clues into what are the dimensions that relate to various abilities of patients that healthcare services characteristics interact with in providing access to care along the continuum of health care-seeking" (Levesque et al., 2013) . Furthermore, the framework focuses on "the actual process of seeking care, including the various stages that a patient has to go through to actually receive the needed care" (p.7) and is based on "the experiences and resistances faced by individuals", thus it offers a suitable framework for this study.

As mentioned before a preliminary conceptual framework has been devised by combining various aspects of the abovementioned models to frame the access barriers in this research. A comprehensive framework (Table 1) which encompasses a wide array of barriers as Norredam and Krasnik have used has been developed and the barriers have been grouped into structural, cognitive, socio-cultural and economic barriers as Carillo et al. have done. Cognitive barriers pertain to perceptual barriers, values, norms and communication, such as a doctors' biological, psychological and social approaches. It can also be said that these barriers also correspond to Levesque et al.'s the ability to perceive, ability to seek and ability to engage. Structural barriers are related to institutional, organizational and systemic barriers, such as the legal status of refugees and hospital appointments. These barriers are more related to the demand side in Levesque's framework such as availability/accommodation, affordability of healthcare services. Finally, socio-cultural and economic barriers have been grouped together and are barriers pertaining to social status, financial issues, living conditions, cultural considerations and other socio-economic factors, such as loss of social networks and indirect costs. The reason the term socio- cultural and economic has been used is that culture is

enmeshed with social considerations as well, and various social considerations relate to economic issues as well. For instance, child care and the labour market also have linkages as it will be revealed below. The aspect of women taking care of children, not being able to leave them to go to hospital and their husbands not being able to take time off work to support them constitutes one example. The cultural barriers can be linked to approachability, acceptability and appropriateness in Levesque's framework, while economic and social barriers can be linked to affordability, ability to seek, ability to reach, ability to pay and ability to engage.

Moreover, it is key to note how the literature focuses on how access is affected by a complex interaction between all factors and levels. None of the themes or levels are as clear cut as they are presented on paper, however the focus of this study is not to devise a model but to explore the experiences of Syrian migrants regarding access to healthcare, so while the interaction among themes and levels shall be acknowledged it will not be expounded on here but will be elucidated through the interviews. Furthermore, as Carillo et al. state "one can never capture a complex system with one model or taxonomy; much depends on the questions one wants to ask" (2011,p.571). Thus, this model does not encapsulate everything but is in line with the questions this dissertation wishes to answer.

The three levels, personal, provide and system, have been incorporated into the framework by weaving them into the categories further along in the study. After the field work and the barriers have been identified a levelled categorization shall be provided.

Table 1

Thematic Classification of Access Barriers

Cognitive	*Socio-cultural and economic*	*Structural*
Health beliefs	Cultural differences	Legal status of migrants
Awareness of available health resources	Loss of social networks	Transportation
Religious reasons	Indirect costs	Waiting times
Gender	Availability of child care	Hospital Capacity
Language	Levels of education and literacy	Appointment availability
Self-perceived needs	Traditional remedies and self-care	Lack of translators
Doctor approaches	Working hours of refugees	Gap in staff training
Discrimination/Stigmatization		Referral Systems
Fear of deportation		Continuity of care
Low prioritization of health care		Navigating the healthcare system
Newness		
Recognizing mental illness and somatization		

CHAPTER 3

THE SITUATION OF REFUGEE HEALTH CARE ACCESS IN TURKEY

> We lost our home, which means the familiarity of daily life. We lost our occupation, which means the confidence that we are of some use in this world. We lost our language, which means the naturalness of reactions, the simplicity of gestures, the unaffected expression of feelings. (Arendt, 1976)

3.1. Legal Review on Healthcare for Syrians under Temporary Protection in Turkey

Sen placed health as a central feature of social equity based on "the ubiquity of health as a social consideration" (2002, p.659). It seems obvious that everyone would give importance to health, and notions such as health being regarded as a "moral entitlement" or moral right (Venkatapuram, 2011) seem unequivocal. Nevertheless, the concept of the legal right to health or right to healthcare is greeted with ambivalence in the literature. Furthermore, when it comes to standards, requirements, and details pertaining to health and healthcare, these seem to be rather elusive in the existing international legislation (Toebes, 1999; Hunt,2016). The case is no different regarding the legal framework of the health rights and access of migrants, refugees and asylum seekers (Cole,2009; Willen, 2011). Hence, in the case of the legal framework that organises the health rights and health access of Syrian refugees living in Turkey, the main focus shall be on national legislation which has been specifically tailored to the situation of Syrian refugees in Turkey.

3.1.1 International Legislation

Turkey is party to several international conventions, including the United Nations' Universal Declaration of Human Rights which delineates the right to health in article 25 by stipulating that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care…" (UN General Assembly, 1948). Similarly, the right to health is also enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) which Turkey ratified in 1976. It states that: ''The States Parties to the Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (UN General Assembly, 1966). Other treaties Turkey is party to, pertaining to health can be listed as follows; International Covenant on Civil and Political Rights (ICCPR) in 1966, ratified by Turkey in 2003, the International Convention on Elimination of All Forms of Racial Discrimination (ICERD) in 1965, ratified by Turkey in 2002, the Convention on Elimination of All Forms of Discrimination against Women (CEDAW) in 1979, ratified by Turkey in 1985, Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) in 1984, ratified by Turkey 1998 and the Convention on Rights of the Child (CRC) in 1990, ratified by Turkey in 1995 (Mardin, 2017). These conventions and treaties are also in the same vain as the UN Declaration of Human Rights and the ICESC in the sense that they refer to healthcare as a right in the broadest sense and do not contain any specific provisions regarding the right to health of refugees, asylum seekers or migrants, as the key word in all of these international treaties and conventions is "everyone". Furthermore, international law is not entirely settled on the matter of recognizing healthcare as a right for refugees, migrants and asylum seekers (Ekmekci, 2017).

3.1.2. National Legislation

Before moving on to national legislation, there is one particularity concerning Turkey's migration legislation that should be mentioned. Although Turkey is party to the 1951 Refugee Convention and to the 1967 additional New York Protocol, it has a geographical limitation when it comes to refugees and only recognizes asylum seekers coming into Turkey from Europe as refugees. However, due to the magnitude of non-European asylum seekers entering the country and for the purpose of filling the gap in the legislation, *Regulation No. 1994/6169 on the Procedures and Principles related to Possible Population Movements and Aliens Arriving in Turkey either as Individuals or in Groups Wishing to Seek Asylum either from Turkey or Requesting Residence Permission in order to Seek Asylum From Another Country* was put into force in 1994 (Çallı, 2016; Yavuz, 2015). Hence Syrians fleeing from the unrelenting conflict in Syria and seeking asylum in Turkey, are not considered "refugees" and constitute a unique situation. The term asylum seeker has no place in the Turkish legal system either, and only in 2014 were such concepts regulated (Assi et al., 2019). Consequently Turkey had dubbed the refugees inundating the country as "guests" upon its adoption of an open-door policy in 2011. Selin Dağtaş clearly demonstrates the ambiguity surrounding the status of Syrian refugees in Turkey:

> Deriving from the root safar (travel), misafir in Arabic (mus¯afir) means "one who is traveling," as opposed to the Arabic term d.ayf (guest). The way it is used in Turkish, however, prioritizes the perspective of those who host travellers and translates into English directly as "guest." Even though it is this second meaning that informs the official declaration of welcome, in a bilingual (Turkish-Arabic) border context such as Antakya these two meanings converge and address guesthood as a matter of both hospitality and mobility. The misafir as a traveling guest, then, signifies a relative position that cannot easily be pinned down to a particular group of people, property, or entity" (2017, pp. 663).

The “travelling guests” were granted temporary protection status in line with article 91 of the Law on Foreigners and International Protection in 2013 and the consequent Temporary Protection Regulation that entered into force in 2014 (Dinç, 2017; Ineli-Ciger, 2017). The former established the Directorate General of Migration Management (DGMM) (Dağtaş, 2017), and introduced four statuses of international protection: refugee; conditional refugee; subsidiary protection; and temporary protection (Akçapar, 2017). While these highly comprehensive laws delineate a plethora of rights, entitlements and clarifications pertaining to Syrians under temporary protection ranging from access to education to access to social services, from temporary accommodation centres to referral centres, from family residence permits to work permits, this chapter shall maintain its focus on healthcare and shall further expound on this legislation in light of access to healthcare in Turkey.

The right to health in Turkey which is embedded in the constitution is not based on citizenship but is recognised as a right for all who inhabit the country (Mardin, 2017). When it comes to refugees and stateless persons, Article 60 of the Law No:5510 on Social Security and General Health Insurance (2006) deems them holders of universal health insurance and thus includes them in Turkey’s general health insurance scheme (Çallı, 2016). However, as mentioned before since Syrians do not have refugee status according to Turkish law, the right to free healthcare access and the framework within which this access is provided to Syrian refugees is enshrined in several legal documents of national legislation that have been enacted in recent years. During the more nascent years of the influx of Syrian refugees, only Syrians living in camps were entitled to free medical care within the camps, then in 2013 as numbers began to escalate AFAD issued two memorandums numbered 2013/1 and 2013/8, extending the scope of access to free healthcare to encompass those living outside of camps. These memorandums stipulate that Syrians living outside of camps can resort to health clinics or hospitals for free, granted that they are registered with AFAD (Çallı, 2016; Dinç, 2017).

The primary legislations that are currently in use are the Law on Foreigners and International Protection (LFIP) published April 2013, the Temporary Protection Regulation (TPR) published October 2014, the Circulation about Conducting Health Services for Foreigners under Temporary Protection in Regulation 2015/8 published in 2015 and the protocol between AFAD and Ministry of Health on the procurement of health services based on a lump sum price which has been renewed each year between 2014 and 2018. However, as per the amendments to the TPR (March 16, 2018), the responsibility of dealing with the provision of healthcare is now shouldered by the DGMM (Cloeters and Osseiran, 2019).

3.1.2.1 The Law on Foreigners and International Protection

Turning to specific articles pertaining to health, article 89 of the highly comprehensive Law No. 6458 on Foreigners and International Protection (2013) consisting of 126 articles, provides that applicants of international protection and international protection beneficiaries who "are not covered with any medical insurance and do not have financial means [to afford medical services] provisions of the Social Security and Universal Health Insurance Law № 5510 of 31/05/2006 shall apply". Hence, this law fills a gap in the legislation as it ensures the inclusion of asylum seekers and applicants of asylum in the general health insurance scheme, along with refugees and stateless persons who are covered by general health insurance as prescribed in Article 60 of Law No: 5510 on Social Security and Universal Health Insurance. However, the primary legislation that clearly prescribes the rights and status of Syrian refugees along with the services accessible to them is Regulation No.29153 on Temporary Protection (2014) that was issued on the basis of Article 91 of the LFIP. Upon the enactment of the TPR Syrians were provided with temporary protection identity documents which include an identification number, akin to the Turkish identification numbers that all Turkish citizens have.

The temporary protection identity cards and the identification numbers would now constitute the basis of accessing key services such as health, and education. (Erdoğan, 2015).

3.1.2.2. The Temporary Protection Regulation

Article 27, entitled *Health Services,* of the Temporary Protection Regulation stipulates the nature of the healthcare services for persons under temporary protection inside and outside temporary accommodation centres (camps). The article again makes a distinction between those who are registered by the Directorate General of Migration Management (DGMM) and those who are not, stating that the former are entitled to free "primary and emergency health services and the respective treatment and medication" while the later shall be provided with health services "in emergency situations and when they are crossing the border for the first time" (TPR, 2014). The article also relinquishes the patient of the obligation to pay a contribution fee by stating that a "patient contribution fee shall not be collected for primary and emergency health services and the respective treatment and medication. The cost of health services, including second and third step health services, shall not exceed the costs in the Health Budget Law (SUT) determined by the Presidency of Social Security Institution for beneficiaries of general health insurance" (TPR, 2014). The article underlines that Syrian refugees cannot directly seek healthcare in private hospitals. Furthermore, the article also provides that the Ministry of Health shall take measures pertaining to the delivery of vaccinations, scanning activities and protective health services; continuity of supporting activities pertaining to reproductive health; transfers to health institutions for people with drug addictions or psychological problems; and the provision of psycho social support. The article also promises that "competent personnel shall provide information and conduct support activities about reproductive health" and that assistance to Syrians in accessing healthcare services will be carried out under the coordination of the MoH, (TPR, 2014).

Regarding temporary accommodation centres, the MoH will ensure that the environments are in line with health considerations and will ensure that the necessary and appropriate physical equipment is installed. Right to interpretation services free of charge is also enshrined in article 31 of the TPR and in Article 26. It is important to mention that in article 26 of the TPR "Provision of services by the relevant ministries and public institutions and organizations under this Regulation shall be carried out in coordination with AFAD" (TPR, 2014), however as per an amendment (March 2018) to the TPR the DGMM is now responsible for the provision of services instead of AFAD. As the TPR had placed the responsibility with AFAD between the years of 2014-2018, AFAD had issued two circulars, one on services to foreigners under temporary protection in 2014 and the other on health services to foreigners under temporary protection in 2015. Furthermore, the procurement of healthcare services was carried out by AFAD as per the Protocol between AFAD and Ministry of Health on the procurement of health services based on a lump sum price that was signed in 2014 and was renewed each year until the amendment in March 2018.

3.1.2.3. Circulation about Conducting Health Services for Foreigners under Temporary Protection

The Circulation about Conducting Health Services for Foreigners under Temporary Protection in Regulation 2015/8 which was issued by the Ministry of Health in November 2015, further elucidates the governance, delivery, accessibility, scope and other specifications of the healthcare services that are provided to Syrian refugees. The highly detailed legislation consists of 4 separate parts. The first section outlines the scope, purpose and definitions, the second part which is the main focus covers beneficiaries, service providers and terms of service, first level healthcare, and the procurement of healthcare services, the third is centered around volunteer health clinics, the fourth part encompasses other provisions such as regulating healthcare services and circumstances that constitute exceptions. The

focus here will be on the second part of the legislation which begins with Article 5. This article distinguishes between accessible healthcare services to those who have registered with the DGMM and possess a temporary protection identity card, those who have not yet registered. Unregistered persons can only benefit from emergency services, preventive healthcare and in the event of communicable diseases and epidemics they can benefit from first level healthcare. Registered persons with identity cards can benefit from all the healthcare services under the General Health Insurance. Healthcare facilities that they can benefit from are delineated as: migrant healthcare centers, university hospitals, private hospitals, volunteer clinics, however not all these services are free of charge. The protocol between the ministry of health, AFAD and the DGMM determines which services are accessible for free and where. A salient article in the Regulation 2015/8 is article 6 which states that beneficiaries of temporary protection are only able to benefit from healthcare services in the province they have been registered in, unless they are referred to another province or in the case of emergencies and communicable diseases. In such cases where treatment is not available for the patient in the province they are registered in, they are referred to the nearest province where the patient can receive treatment. Article 6 also states that persons under temporary protection have to go to primary/first level health care facilities first and only upon referral can they resort to secondary and tertiary healthcare services. According to Article 8, first level healthcare covers diagnostics, screening against communicable diseases and vaccinations, vaccination, health and reproductive services that are granted to women in Turkey, the identification of those who suffer from substance abuse and psychological issues. The billing and payment for healthcare services is outlined in Article 9, the price of the healthcare services cannot exceed the amount prescribed in the SUT.

3.1.2.4. Protocol Between AFAD, DGMM and the Ministry of Health

To further elaborate on the payment of healthcare services, the cost of services was covered by AFAD as per the Protocol between AFAD and Ministry of Health on the

procurement of health services based on a lump sum price that was signed in 2014 and was renewed each year until 2018 when this responsibility was transferred to the DGMM. Thus, as of March 2018 the billing is now done in the name of the DGMM and not the provincial governorate. The protocol with AFAD and the DGMM in 2018 prescribed that the procurement of healthcare services for 2018 as 800.000.000 TL for the year 2018, AFAD is to cover all payments that predate March 2018 and the DGMM is to cover the payments for the dates after March 2018. This sum doesn't cover organ transplants, prosthetic limbs, IVF, treatment abroad and any treatment not prescribed in the SUT (protocol, 2018). Regarding the cost of medication, all medication and tests covered under the SUT are reimbursed. (Article 8, protocol, 2018). MERNIS (central population administrative system) and the MEDULA (pharmacy provision system) online information systems are in use for persons under temporary protection and the electronic or manual prescriptions given by healthcare providers are accepted in pharmacies which have an agreement with SGK, the prescriptions are registered with the SGK information system MEDULA and the pharmacies are reimbursed by the DGMM (Prior to March 2018 they were reimbursed by AFAD) by up to 80 and 100 per cent of the cost (Bilecen & Yurtseven, 2017).

3.1.4. Uncertainty and Lack of Awareness Regarding Legal Status

In terms of healthcare access, the rights of Syrian refugees are almost akin to those of Turkish nationals. The government has ensured that Syrian refugees are legally able to access health care services for free and are to be provided with assistance when needed, on paper. In most comparative studies especially those that compare healthcare access in Jordan and Lebanon, Turkey receives high praise for its inclusion of Syrian refugees in its universal health coverage (Samari,2017; Saleh, 2018). However, it must be noted that the uncertainty that demarks the situation of refugees and their legal status is a source of ambiguity and discomfort for Syrians (Ekmekçi,2016; Mardin,2017; Memişoğlu,2018). Thus, although Syrians under

temporary protection seemingly enjoy a myriad of rights, they are not safeguarded by laws but mostly through regulations and circulars issued by the government. Namely the temporary protection status can be terminated by the Council of Ministers any time, thus as Memişoğlu states "the future legal status of Syrians in Turkey remains largely a matter of political discretion, rather than being solely based on the legal framework for refugee protection" (2018, pp.13). Furthermore, the fact that displaced Syrians do not have a status which has an equivalence in international law, can be echoed in Hannah Arendt's words "their plight is not that they are not equal before the law, but that no law exists for them" (1976, p.295). A Syrain refugee was also quoted by Memişoğu saying "We are grateful to Turkey, you embraced us so warmly. However, what if this warm welcome ends one day? Can we rely on this without a sufficient legal protection?" (2018, p. 13).

Another issue regarding rights is that there is a lack of awareness as to what these rights are and As Memişoğlu relays the statements of Syrians under temporary protection in a 2018 report, she asserts that "the common labeling of Syrians as 'guests' has nurtured their sense of uncertainty, making it difficult for refugees to comprehend the scope of their actual legal rights and obligations, especially for those benefiting from temporary protection. Second, the lack of general awareness among the public about refugee legal framework and temporary protection, frequent changes in procedures, and discrepancies between central-level policies and local-level implementation blur their sense of legal stability in Turkey" (Memişoğlu, 2018). This was also the case in terms of the awareness of refugees pertaining to their right to access health care. This will be further elaborated on in the chapter in the section dealing with challenges and access barriers.

3.2. Turkey's Healthcare System and the Means of Healthcare Provision for Refugees

This section shall start by providing the changes in the Turkish Healthcare system upon the Health Transformation Programme (HTP) and will then proceed to expound on the provision of healthcare to Syrian refugees through available public healthcare services, INGO and NGO's, migrant healthcare centres, healthcare services in camps and informal Syrian clinics.

3.2.1. The Turkish Healthcare System After the HTP and Improved Access

To fully comprehend the situation refugees are facing regarding accessing healthcare in Turkey, it is necessary to provide a picture of the current Turkish healthcare system. This will prove imperative in excavating the systemic access barriers hindering Syrian refugees from accessing healthcare. The current healthcare system is a product of the Health Transformation Programme initiated in 2003 and spanning across a decade, hence this section will focus on the HTP to elucidate the landscape of healthcare provision in Turkey today especially in terms of access. Starting in 2003 Turkey majorly reformed its healthcare system in order to provide "easily accessible, high-quality, efficient, and effective healthcare services for the population", as its previous healthcare system was "was characterized by its highly complex and fragmented provision and financing systems as well as inequalities in access to healthcare" (Jadoo et al., 2014). Thus, to remedy this situation and to ensure accessible, high-quality, equitable and efficient healthcare services for the entire population the Health Transformation Program (HTP) was set in motion in 2003 and would span across a decade. The HTP brought about the restructuring of the national healthcare system through "various institutional and structural changes, such as administrative and functional re-organization of the Ministry of Health, implementation of universal health insurance, instituting autonomous hospitals and redesigning the primary care system under the family medicine model", purchaser-

provider split (Fındıkoğlu, 2019, p.2); and was heralded for its success nationally and internationally and has been regarded as a "good practice" (Ökem & Çakar, 2014; Fındıkoğlu, 2019; Yardım & Üner, 2018; Jadoo et al. 2014; Atun et al., 2013). As Atun et al. have put it the "HTP rapidly expanded health insurance coverage and access to health-care services for all citizens, especially the poorest population groups" (Atun et al., 2013).

With the HTP reform process spanning across a decade several radical changes and restructurings were introduced such as "the introduction of compulsory social health insurance to achieve a financially sustainable and equitable social security system; the establishment of a purchaser–provider split and a redefinition of the role of the MoH from provision to planning and stewardship" (Ökem & Çakar, 2015). Other changes include the establishment of the family care practitioner scheme for primary care in 2010 , the establishment of health focused information systems such as Health-NET, Medula (General Health Insurance) and E-prescription (Demirel, 2017), the enforcement of a performance-based payment system in all hospitals and healthcare providers in 2004 (Jadoo et al., 2014), the promotion of private sector investments in health, the establishment of budget ceilings for hospitals and pharmaceuticals (Ökem & Çakar, 2015).

To attain universal health coverage and render health services accessible to all, the three distinct health insurance schemes that existed previously were united under a universal health insurance scheme (USI) through a succession of laws in 2006, 2008 and finally in 2012 when the unification was fully realized with the "Social Security Institution as the sole purchaser of health services for the public and the private sector" (Ökem & Çakar, 2015). Another significant change was that the role of the Ministry of Health was transformed to one of "planning and stewardship", as all public health facilities were gathered under the authority of the Ministry of Health. Accreditation and quality standards were introduced, plus through the enactment of the law on full time practice of University and Health Personnel and Amendments

introduced full- time work in public and university hospitals to reduce the shortage of doctors in public and university hospitals (Ökem and Çakar, 2015).). Another significant change that impacts the performance of healthcare personnel is that the payment system was changed, and payments are now made based on institutional performance criteria to boost motivation and productivity. Hence, now in public hospitals physicians are paid both by salary and through revolving funds according to their performance the previous month. The calculation is made based on various coefficients that have been determined for medical examinations, operations and diagnostic techniques depending on the duration and level of difficulty of each procedure. According to Ökem and Çakar a total of 5300 different medical procedures have been identified and have been assigned coefficients. In later years, a quality dimension along with an institutional performance evaluation system was added. Thus, "payments to health personnel have become closely associated with the hospital rating according to the hospital classification". These of course impact the way physicians work and their approach to patients.

In 2004 a Family medicine model was introduced to improve access and quality. MoH makes contracts with general practitioners (GPs) for preventive and primary care that is provided for free, but there are co-payments for medication in place. The remuneration of GPs also changed from salaries to a new method based on capitation and certain performance criteria, and the MoH makes contracts with GPs. The base capitation payment for family medicine personnel assigns higher weights to the care of pregnant women and children in order to motivate providers to improve access to care for these groups. GPs receive an additional performance-related payment linked to the provision of preventive services, such as vaccinations, reproductive and child health services in addition to curative services (Ökem & Çakar, 2015).

The literature asserts that the HTP greatly improved healthcare access (Atun et al, 2013; Yardım & Üner, 2018, Jadoo et.al., 2014, Ökem & Çakar, 2014). Atun et al.

state that the HTP introduced major changes to the system and in turn rendered healthcare accessible for all citizens including the poorest; increased equity and expanded benefits; greatly bolstered patient satisfaction levels; improved the supply side through the expansion of infrastructure, human resources and services (Atun et al.,2013). Looking at statistics "access to healthcare measured by the number of per capita visits to healthcare facilities rose from 3.2 in 2002 to 8.3 in 2015" (Fındıkoğlu, 2019), "the number of patients treated increased from 4.4 million in 2002 to 46.2 million in 2009 (Ökem & Çakar, 2015). Furthermore, several health-status indicators were improved (Jadoo, 2014) and the WHO and OECD have underlined this in their reports (Saleh et al., 2018) . Turkish society also perceived the changes as positive, as surveys and studies have shown that people believe there has been an improvement in access to health services and service quality (Yardım & Uner,2018; Ökem & Çakar, 2015; Jadoo et al., 2014). Turning to statistics "Patient surveys of the MoH revealed that the level of patient satisfaction improved from 39.5% in 2003 to 74.8% in 2012" (Ökem & Çakar, 2015). These may be regarded indeed as highly positive notes for Syrian refugees as well, considering the overall improvement in access, quality and in coverage. Furthermore, it constitutes the legal basis as well, as it was mentioned previously refugees are taken under the wing of the Law No: 5510 on Social Security and Universal Health Insurance and are covered by general health insurance.

Having said that, such deeply structural reforms have several ramifications for the healthcare system. In the literature there are those who are highly sceptical of the HTP reforms and have severely criticized them claiming that the "health sector has become more profit-orientated due to competition among providers created by the HTP implementations. This might jeopardize access to health services" (Ökem & Cakar, 2015). Fındıkoğlu presents the gaps in the current system and the drawbacks especially regarding the Family Medicine System, the immense workload of physicians and lack of harmonization across care levels. She asserts that many people from disadvantaged groups, are not fully served by the family medicine

system and that 40-60% of citizens do not apply to family doctors as their primary contact, despite the fact that they are assigned to one. This is also the case for Syrian refugees as well. Awareness on family medicine services remains rather low. Another criticism is that the referral chains are not in place across care levels, as patients do not refer to family doctors first but go directly to secondary or tertiary care levels. Thus, patients are resorting to specialized services for the simplest of health problems that should be treated in primary care facilities. In turn there is a waste of resources and overburdening of secondary and tertiary level health care. This has also exacerbated the immense workload of physicians in Turkey. Fındıkoğlu states that patient visits per day vary between 40-70 and this in turn means that physicians are only able to devote limited time to their patients. The fact that performance criteria for physicians lack qualitative indicators, such as quality of care or patient satisfaction does not help the situation either. Finally, Fındıkoğlu states that the health information systems used at the three care levels are not integrated either, further compounding the situation as the patients info on previous diagnosis and treatment, or health history is not available across institutions (2019, pp. 4-6).

Above a brief account of the Turkish healthcare system has been provided and thus the foundation of the medium for healthcare provision to Syrians under temporary protection has been laid down. One would not be mistaken in claiming that the reforms were rather timely considering the lack of universal health care coverage prior to the HTP. Not only in terms of quality but also in terms of accessibility, as it is hard to imagine where and under which coverage the Syrian refugees would've fallen in terms of healthcare provision, funding and access, prior to the HTP. Although the Turkish healthcare system is highly accommodating to Syrian refugees (Saleh et al., 2018; Akbulut,2019; Kirişçi,2015) , certain ramifications in the system underpin systemic access barriers for Syrian refugees. The issues Fındıkoğlu has vehemently expressed the increased workload of physicians, the lack of awareness regarding family medical services, the ineffective referral chain and lack of

harmonization across care levels; also impact refugee access to healthcare and are part of systemic access barriers. This will be further elucidated in the following section under access barriers to health, while this next sub-section shall outline the situation and service provision for Syrian Refugees in Turkey.

3.2.2 Healthcare Provision for Syrian Refugees in the Turkish Healthcare System

When it comes to the protracted refugee crisis as Doocy states, it "necessitates health responses focused on greater integration of refugees into host country systems rather than the establishment of parallel systems of refugee assistance" (Doocy et al. 2016). In the case of Turkey, due to the sheer number of Syrians under temporary protection, in many service provisions including health, harmonization and integration is sought and is mainly state managed (Saleh et al., 2018; Kirişçi, 2015; Samari, 2017). However, this has not always been the case, as it was underlined previously, the Syrian migrants were regarded as temporary guests thus integration was not the main policy that was sought. Only after 2015 was it realised that the temporary "guests" would have to extend their stay in Turkey. By this time numbers had also escalated to a staggering large number indeed. Integration has thus persisted as a significant challenge, especially regarding the integration of refugee children into the Turkish education system and the integration of refugees into the job market (Kirişçi, 2015). However, in the case of healthcare provision bar the first years 2011-2013 when refugees were mostly living in camps and AFAD was responsible for the health care provision within the camps (Bilecen & Yurtseven, 20) , system-wise Turkey did indeed opt for an integrated approach by granting free access to healthcare services that Turkish citizens were also benefitting from and placed the responsibility of delivering and regulating healthcare services for refugees with the MoH (Özçürümez & Yıldırım, 2017).

For Turkey healthcare provision to Syrian refugees began in Hatay in April 2011 with the first influx of Syrian refugees crossing the border from Latakia into Antakya (Hatay) (Tayfur et al., 2019). “Guest camps” were set up “This first group, hosted in “guest camps” and consisting of some 250 Syrian citizens, was labelled by the authorities as *misafir*s rather than as “refugees” or “asylum seekers”” (Dağtaş, 2017). AFAD was in charge of the provision for healthcare for the Syrian refugees who were mostly residing in camps, as the numbers did not even exceed 250,000. However, upon the surge of refugee numbers between 2013 and 2014 and the implosion of refugees in urban areas healthcare provision shifted outside of the camps (Ekmekçi, 2017; Kirişçi, 2015; İçduygu et al., 2017). These years also mark the years when Turkey realized that the refugees would not be returning home any time soon, and hence major developments in the legal system ensued such as the Law on Foreigners and International Protection (LFIP) published April 2013, the Temporary Protection Regulation (TPR) published October 2014 which were mentioned in the previous section (Kirişçi, 2015). Upon the shift from “guests” to “those under temporary protection” service provision also began to shift towards a more integrated approach, especially in terms of education and healthcare (Kirişçi, 2015). Starting from 2014 refugees living outside of camps could benefit from regular public health services and were granted free access to the full range of healthcare services at all public health facilities, and could benefit from tertiary level services upon referral, the only limitation being their province of residence (Bilecen & Yurtseven, 2017). For the sake of clarification, it is worth pointing out that in Turkey there are three hierarchical stages of healthcare institutions: Primary level healthcare institutions are comprised of small-scale clinics which provide preventative and protective outpatient services, such as mother–infant health clinics, family practitioner clinics, migrant health centres, tuberculosis control dispensaries, community health centres etc. Secondary level institutions are private and public hospitals and tertiary level institutions are training and research hospitals which are either attached to public or private universities or the MoH (Mardin, 2017; Bilecen & Yurtseven, 2017). Thus, all levels of healthcare services can be frequented by

Syrian refugees. However, now there are over 3.6 million refugees and 97% of them are living in urban areas, thus the strain on national health care services is highly visible and has resulted in a degree of discontentment among Turkish citizens (Ekmekçi, 2016; Akgül,2015; Uzun, 2015). Especially in border cities which are densely populated with refugees significant challenges are experienced both by refugees and by service providers. These will be further excavated in the following section on access barriers. But first the various service providers shall be explored to further outline accessibility of services:

3.2.2.1. INGO and NGO Health Services

One factor contributing to this is that there is no supplementary health support system that both locals and Syrian refugees could benefit from, as the Turkish government has a tight rein on the regulation and delivery of services to refugees and has given a wide berth to the direct involvement of NGO's and INGOs in managing the refugee crisis (Kirişçi, 2015; Chong,2018; Memişoğlu & Ilgıt, 2017). As Kirişçi puts it " INGOs with extensive experience in the provision of specialized health services to victims of civil wars and refugee movements have encountered difficulties in registering themselves to operate legally in Turkey" (Kirişçi,2015). Nevertheless, various INGOs and local NGOs have been providing services, examples include Doctors Without Borders (MSF), International Medical Corps, Doctors World Wide, International Blue Crescent Relief and Development ; ASAM (Association for Solidarity with Asylum Seekers and Migrants) and the Turkish Red Crescent, Support to Life (Yasin, 2016; Özçürümez & Yıldırım, 2017; Kutlu, 2015). Several UN agencies are also involved in supporting health care such as UNFPA, UNHCR and the WHO. Still healthcare provision from INGO's and NOGs is far from rife and the state, out of its own volition, is mostly alone in shouldering the patient load, consequently this creates specific difficulties especially in terms of addressing caveats in healthcare provision to refugees such as mental healthcare provision and women's reproductive health services (Cloeters & Ossarian, 2019;

Samari, 2016; Yasin, 2016) . NGO's are mostly providing support in these areas via clinics or centres that offer psycho-social support, women's health services particularly sexual and reproductive health services, and also in support related areas such as translation services and patient guide services (Yasin, 2016; Cloeters & Osseiran, 2019; Bilecen & Yurtseven, 2018). Thus, the role they serve is complementary to the MoH. For instance the UNFPA works in cooperation with the MoH and has a Women and Girls Safe Spaces (WGSS) program with close to 400 doctors, nurses, midwives, psychologists, social workers, and healthcare providers, to "ensure that women and girls have access to healthcare, particularly sexual and reproductive health services and rights, including prenatal care, safe birth, postnatal care, and family planning methods" (Cloeters & Osseiran, 2019). For mental health one example is the International Blue Crescent, under their Mental Health project in Akçakale they provide psychological support to those who have lost their relatives, rehabilitation for post-traumatic stress disorders and psychological support to children (Yasin, 2016). Thus, although the scope and reach of the NGO's is limited, their role in easing access to healthcare services cannot be overlooked, whether it's direct healthcare service provision, conducting needs assessments for Syrians, providing support with translation or info dissemination.

3.2.2.2. Migrant Healthcare Centres

As it was explained above NGO and INGO involvement remains limited, thus the MoH sought other means to deal with the sheer number of patients especially in border cities which are densely populated by Syrian refugees. In December 2016, in response to the overburdened healthcare system the MoH began the establishment of Migrant Health Care centres financed by the EU Commission under the EUR 300 Million project titled "SIHHAT" ('health' in Turkish) 'Improving the Health Status of the Syrian Population under Temporary Protection and Related Services Provided by Turkish Authorities' (Action Document for EU Trust Fund to be used for the decisions of the Operational Board). The centres that are staffed by Syrian

healthcare professionals are offering primary health care services to all refugees and migrants regardless of their nationality (Cloeters and Osseiran, 2019, p.32). The plan is to complete the establishment of 178 Migrant healthcare centres in 28 cities, by December 2019 to ease the burden of hospitals (MoH, 2019). The MoH also announced that in cities that are severely overburdened will be provided with Strengthened Migrant Health care centres which, in addition to primary care services will offer internal diseases, paediatrics, maternal-childbirth, oral-dental health and psychosocial support services; and will be equipped with imaging units and basic service laboratories, so as to improve access and reduce the burden on hospitals (Eğici, 2019). Under the project 790 doctors, 790 nurses, 84 technicians, 300 support staff and 960 patient guides who can speak Turkish and Arabic are to be hired. Thus, the project is a source of employment for Syrian refugees as well. The staff in the centres receive a training course by the MoH and the WHO, the aim is to train 2520 healthcare professionals. 165 centres have been established since (MoH, 2019). Furthermore 10 community mental health centres are to be established, reproductive services are to be given to 750,000 Syrian women and 600,000 Syrian men, 6.255.000 doses of vaccinations are to be given as well. The project also aims to strengthen secondary level healthcare as well via capacity strengthening and equipment (MoH, 2019).

Migrant Health Centres can also refer patients to public hospitals, and may also write prescriptions. However, they cannot issue specialist health reports, as they do not have authorization (Cloeters and Osseiran, 2019). Other issues elicited from the literature are that there are issues with the referral system from these clinics (Demir et al.,2016) and that they have not been "very functional" due to distance (Torun et al.,2018). On the other hand Migrant Health centres are unique in the sense that they can be accessed in any province regardless of the province of registration (Çolak, 2018). There is not much research dedicated to the utilization of these clinics, thus the impact they have had on the healthcare system and whether they have been able to alleviate the situation and improve access warrants further research. Nevertheless

a 2018 study based on outreach data in İstanbul (265 households and 1453 individuals) conducted by YUVA organization, revealed that: 67% of people who were in the registration process, 27% of those who had no registration and 50% of those registered in other provinces stated that they had access to healthcare. The study mostly attributed this access to the existence of migrant healthcare centres (Çolak, 2018). Thus at least in İstanbul it can be said that they have contributed to improved access.

3.2.2.3. Healthcare Services in Camps

Healthcare provision in the camps is managed by AFAD. Currently there are 11 Temporary Accommodation Centres i.e. camps in 8 provinces hosting only 3% of the Syrian refugees (DGMM, July 2019), as people have mostly moved to cities. However, in the early years of the crisis camps were the providers of healthcare and were heralded for their services. According to a 2018 Ombudsman report on Syrian refugees, Syrians who were interviewed stated that "they were very satisfied with the current healthcare services, ambulances were immediately ready in case of emergency, and patients were referred to hospitals in the city centers when required" (2018, p.89). According to an AFAD survey in 2017, 97.20 of Syrians residing in temporary accommodation centres stated that they had access to health care and 93.3% of them stated that they were "very satisfied" (48.8%), or "satisfied" (44.5%) with healthcare services in camps in camps (AFAD, 2017, p.85). According to the Ombudsman report the health units in camps are well equipped, there are no issues with medication or supplies, there is a sufficient number of healthcare personnel (p.149). However, issues in camps were the lack of medical expertise and psychological support services (Vatansever, 2016)

3.2.2.4. Informal Syrian Clinics

Finally, there are informal Syrian Clinics or "volunteer clinics" that were decided upon by the MoH in 2015 and are included in part 3 of the Circular on The Fundamentals of Health Services to be delivered to those under Temporary Protection. Syrian doctors are allowed to provide free medical care to Syrians in "volunteer clinics" that are managed by Turkish doctors. Various foundations, associations and local governments have established such clinics with Syrian healthcare providers (Dedeoğlu, 2016) . The circular necessitates that the license for these clinics is given for a period of 6 months and is renewed biannually. Cloeters and Osseiran point out that many of the clinics are operating without a license due to demand, and that the Turkish government regarded the clinics as problematic due to their informality and lack of oversight (2019, p.31).

3.3. Challenges Refugees Face in Accessing Healthcare in Turkey

Syrian refugees face many challenges and although the literature on factors impeding access to healthcare is not rife, there is still a considerable amount of studies that have been carried out in Turkey. A myriad of issues are underlined in the literature ranging from structural barriers, cultural barriers, socio-economic barriers, systemic barriers. The most prevalent challenges include: lack of information/misinformation, language barriers, discrimination, lack of registration, lack of mental healthcare and reproductive healthcare services, not being able to navigate the healthcare system and capacity problems. This section shall begin with an overview of the literature which provides a wholistic picture of access barriers. Then the identified access barriers will be further elaborated on and grouped under specific barriers to make for an easier read.

Gabriele Cloeters and Souad Osseiran compiled a workshop report titled "Healthcare Access for Syrian Refugees in İstanbul: A Gender-Sensitive

Perspective. The comprehensive workshop included prominent academics, Syrian and Turkish NGO members, medical professionals and public health experts working in İstanbul. İstanbul hosts the largest number of refugees at 546,296 according to the DGMM (June 2019). Participants identified several challenges: language barriers, insufficient mental health services, registration under temporary protection, lack of knowledge of the Turkish healthcare system, health literacy, lack of coordination among NGOs, Funding and sustainability of projects, slow emergency response, gender-based violence, discrimination, misinformation, integration of reproductive health services, health literacy, government and NGO relations. (Cloeters & Osseiran, 2019, p.33). Perihan Torun et al. also provide a comprehensive list of access barriers upon their qualitative research carried out in İstanbul with Syrian women. Torun et al. identify, language barriers, long waiting times, complexity of the appointment system, lack of knowledge on where to go for certain services, distrust of Turkish doctors, capacity issues and the overburdening of the healthcare system, lack of awareness on rights and entitlements, not being able to opt for a female doctor, problems with registration, lack of understanding how to access health services, complexity of referrals and the health system in general, and difficulties in accessing mental health services (Torun et al., 2017). Saleh et al. noted that financial barriers, cross-cultural communication and limited cultural awareness on country of asylum impacted refugee access to healthcare (Saleh et al., 2018); Demir et al. include distance, discriminatory attitudes on part of health workers, exerting pressure on the existing capacity, lack of translators and psychologists among significant challenges impeding access (Demir et al., p.63, 2016). Kirişçi states the accessibility of health services for refugees living outside of camps is even more problematic, despite that the government has granted free healthcare access in all public hospitals. Challenges are delineated as overburdened hospitals, lack of awareness on behalf of healthcare personnel, the language barrier and the follow up of patients with chronic illnesses (Kirişçi, 2015). Yurtseven and Bilecen stress that “guaranteeing full access to the healthcare services through legal regulations does not necessarily indicate equity in access due to the practical

challenges in Turkey" (2018, p. 119) and identify 3 main barriers that impede refugee access: registration, navigation of the healthcare system and language barriers.

Turning to reports from the literature which reflect the responses of refugees themselves , the AFAD field survey that was previously mentioned underlines 4 reasons conveyed by refugees: 42 % stated that they had never felt the need for healthcare services; 29% (28% of men, 34% of women) stated that they did not know where to go; 15 % stated that they did not have the right to do so; 13 % stated that they did not have the financial capability (2017, p.85.). Another key report is a 2018 outreach report compiled by Özlem Çolak from YUVA, which provides in detail the data from 265 household visits and 1453 individuals. The report underlines 7 access barriers reported by refuges. 42% of them stated that "bureaucratic barriers" such as lack of registration or issues with the referral system constituted the greatest difficulty in accessing healthcare. It is surprising that in comparison to 42% for the former challenge only 23% reported the language barrier as a significant challenge. The third major challenge was identified as difficulties in navigating the Turkish healthcare system (appointments, referrals etc.) by 21% of the participants. The remaining 4 challenges voiced by refugees were: Not having anyone to accompany them (7%), discrimination/mistreatment (3.5%), services are not free (2%) and lastly transportation difficulties (1.5 %) (Çolak, 2018).

Factors impeding access to healthcare as not as clear cut nor as neat and tidy, as they have been presented above. As Özçürümez and Yıldırım have stated

> the social determinants of health (gender, economic status, education levels, working conditions, etc.), culture, traditions, cultural interaction, life conditions (climate, sanitation, accommodation conditions, nutrition, etc.), health services, access to social services, access to education, the presence of social support networks, discrimination, language barriers, the approach of health care providers toward refugees, and the awareness of health care providers about the needs of refugee populations all impact in different ways health service accessibility (2017, pp.110).

Thus, exploring the healthcare access of refugees is a multifaceted endeavour with overlapping layers as well. The following section will try to further elaborate on each access barrier.

3.3.1. Registration: Healthcare Providers as "Gatekeepers"

As mentioned before Syrians cannot receive the full breadth of primary or secondary healthcare services without registration with the DGMM, and are only entitled to emergency services. Furthermore, the access of those who are registered is tightly bound to the province in which they are registered. Thus, whether refugees have no prior registration at all or have changed provinces, they end up with the same legal hindrance when accessing healthcare services. Lack of registration has been listed as a salient access barrier in the literature (Cloeters & Osseiran, 2019; Mardin, 2017; Akbulut et al., 2019; Türkay, 2016; Bilecen & Yurtseven, 2018; Assi et al., 2019).

Starting from the end of 2017, in various crowded cities such as İstanbul and Ankara registration has come to a standstill, due to the escalating number of refugees moving to urban areas with the aim of reuniting with their families or in search of better living conditions and employment opportunities (Cloeters & Osseiran, 2019). Mardin exclaims that people under temporary protection were "pushed" to larger cities due to lack of employment (2017, p.5). Akbulut et al also

states that some refugees deliberately sidestepped the registration process in Turkey with hopes of getting to Europe (2019, p.4).

Without registration refugees are only entitled to access Migrant Health Centres and emergency services free of charge. Refugees are not able to transfer their registration to the cities which are no longer accepting registration such as Ankara and İstanbul, plus those who applied for temporary protection prior to the restrictions on registration have to wait for long periods of time before they can obtain temporary protection status and these in turn severely hinder their access to healthcare (Cloeters & Osseiran, 2019; Bilecen & Yurtseven, 2018). Mardin asserts that, lack of registration is the second major access barrier after the language barrier. She also exclaims that "the health coverage and health care providers should not have the role of a gate keeper to restrict the travel conditions of a person or to report a person in the case he or she is not in the city where registered" (2017, p.6).

Assi et al. and Demir et al. also point out that the high mobility of refugees renders service delivery difficult, as this mobility interrupts preventive healthcare services and treatment for those with chronic diseases, rehabilitation needs and those who are pregnant. (Demir et al., 2016; Assi et al., 2019).

3.3.2. Language Barriers and Lack of Translation Services

The language barrier and lack of translation services constitute the most predominant challenges not only for refugees but also for healthcare providers (Yıldız, 2013; Kirişçi, 2015; Mardin, 2017; Bilecen & Yurtseven, 2018; Kaya & Kıraç, 2016; Cloeters & Osseiran, 2019; Assi et al., 2019; Samari, 2017; Savaş et al., 2016; Vatansever, 2016). The language barrier not only affects the communication between the healthcare provider and the patient but also impedes the ability to navigate the healthcare system; furthermore, appointment making, following referrals and dealing with paperwork also become highly complicated

when one doesn't speak the language. According to Savaş et al.'s study in Hatay 92.4% of the health workers had difficulty in communicating with refugee patients, and only 13 % employed the use of an official translator (2016, p.18286).

The Turkish government has employed translators, through the EU funded SIHHAT programme, in several hospitals, however they are also insufficient at times (Assi et al.,2019). Furthermore, NGO's are providing translation services and patient guides to lend a hand to refugees when seeking healthcare due to the lack of language support compared to demand (Torun et al., 2017; AIDA, 2018, Ozcurumez and Yildirim, 2017). The quality of translation is imperative especially when it comes to healthcare, as it can lead to misdiagnosis and misunderstandings. As Yıldız relays a Syrian refugee woman's plight in a 2013 study: "We are struggling communicating with communication and we can't explain what's wrong with us to the doctor. One doctor gave me birth control pills, due to mistranslation, instead of the flu medicine that I'd asked for. I only realized this later" (2013, p.158). Nevertheless, the quality of translation services has improved since especially with the appointment of bilingual translators in hospitals, although there are still issues especially with regard to mental healthcare. In this case, instead of translators, Arabic speaking psychologists and psychiatrists are preferred (Samari, 2017; Cloeters & Osseiran, 2019). Furthermore, as Cloeters and Osseiran point out providing therapy in the patients mother tongue greatly improves the quality of mental healthcare that is provided (2019, p.32).

Torun et al. also underline that the language barrier has resulted in distrust towards Turkish doctors and this in turn has led some patients to resort to illegal Syrian clinics where they can find "doctors" who can understand them (2017, p.604). In addition to hiring translators in hospitals, the decision of the MoH to establish Migrant Health Centres was also to remedy this situation by training and then employing Syrian healthcare professionals to deliver healthcare services to Syrian refugees in their mother tongue (Bilecen & Yurtseven, 2018).

3.3.3. Burden on the Turkish Healthcare System

Another salient challenge listed as one of the major challenges in the literature is the overburdening of the Turkish healthcare system (Kirişçi,2015; Ekmekçi,2017; Savaş et al.,2016; Demir et al., 2016; Torun et al., 2017; Assi et al., 2019; Cloeters & Osseiran, 2019) with an addition of over 3.5 million potential patients aggravating the system. Health workers, especially those working in border provinces which are reported to be allocating 30-40% of their capacities to Syrian refugees (Ekmekçi,2017) , are stating that their workload has suffered a dramatic increase. Doctors have reported that they have reached their upper limit of patients with 4,000 registered patients (Demir et al., 2016, p.13). According to a 2015 study conducted in Hatay with 210 health workers (doctors, nurses and health technicians), 85% of them stated that their workload had increased and 46% exclaimed that the time they could allot to each patient had decreased; 67% stated that working hours had increased, with the arrival of Syrian patients (Savaş et al., 2016, p. 18284). When asked about capacity, 92% of the respondents stated that the number of health care workers, "68% stated that the number of beds and 76% stated the capacity of intensive care were insufficient" (2016, p.18286).

The sheer burden on hospitals is partially attributed to the lack of primary care utilization on part of refugees (Torun et al., 2017; Assi et al., 2019; Akbulut et al., 2019). Lack of knowledge on where to seek healthcare can also be listed as reasons refugees resort to public hospitals. Furthermore, issues with referrals also lead to increased hospital use. The burden on the Turkish health system not only affects healthcare personnel but also in turn affects patients as well, in terms of crowdedness, long waiting times, less time dedicated by doctors and at times mistreatment from doctors and also local patients towards refugees. The long working hours and immense workload of doctors are affecting the treatment towards refugee patients, especially when compounded by the language barrier; while the long waiting times and crowdedness is aggravating the local patients (Cloeters &

Ossarian, 2019; Kirişçi, 2015). Thus, as a result of the overburdening of the system refugees are subjected to mistreatment, faced with long waiting times, crowdedness and less time allocated to them which all contribute to patient dissatisfaction. This issue constitutes a systemic barrier which is impacted by the Turkish healthcare system as mentioned under the section on the HTP.

3.3.4. Navigating the Turkish Healthcare System

The Turkish healthcare system is not akin to the Syrian healthcare system, this implies that refugees have had to familiarize themselves with the various health departments, the appointment system, the different levels of care and their respective services. The literature denotes navigating the Turkish healthcare system as a significant challenge (Savas et al.,2016; Cloeters & Osseiran, 2019; Demir et al., 2016; Torun, 2017; Bilecen & Yurtseven, 2018). Challenges mentioned were: using the hospital appointment system, refugees orienting themselves in the hospital system bureaucracy, lack of information on where to go, comprehending the referral system, challenges in making appointments. Navigation inside the hospital proves to be difficult as well, from desk to desk; or knowing which department to go to for which ailment, or even which hospital to go to, as every country has a "particular logic of operation" that takes time to get accustomed to, thus this is another area where NGOs are trying to fill the gap through providing patient guides (Bilecen & Yurtesever, 2018).

The study conducted by YUVA posits the claim that the duration of the refugees stay in İstanbul has a correlation with their healthcare access, as 70% of refugees who'd been living in İstanbul for less than a month stated that they couldn't access healthcare, while a mere 9% of refugees who'd been living in İstanbul for 4 years or more stated that they couldn't access healthcare services (Çolak,Ö., 2018). In Torun et al.'s study that was conducted with Syrian refugee women in İstanbul, not knowing how to access healthcare was the second most frequently mentioned

barrier (2017, p. 604). Moreover, in Savas et al.'s study, 46% of the participants relayed that refugees' lack of information about health care constituted the second impediment to communication with patients following the language barrier (2016, p. 18283).

Thus, adjusting to the healthcare system and getting to know ones way around it or how to access it, is also a matter of time. Furthermore, as Cloeters and Osserian point out it is not that Syrian refugees "have no knowledge about the healthcare system, but rather the fact that people do not know how to orient themselves, where to go and [how to] reach [services], when people go to the hospital" (2019, p.16).

3.3.5. Different Health Cultures

Disparities between patient cultures in Turkey and Syria are also listed in the literature among the challenges in accessing healthcare (Mardin,2017 ; Cloeters & Osseiran, 2019, Demir et al.,2016; Assi et al., 2019; Akbulut et al.,2018; Dedeoğlu, 2016). Mardin asserts that "due to differences in patient culture, many refugee patients complain that they were unable to understand the diagnosis properly or do not trust the diagnosis… Differences in patient culture influence patients' health literacy, their trust in physicians as medical authorities, and their willingness to commit to prescribed medical treatment" (Cloeters & Osseiran, 2019). In their study in Hatay, Savas et al. reveal that 45% of the participants relayed cultural differences as a major hindrance to communicating with patients (2016, p.18283).

Another issue to be touched upon here is the female physician preference of Syrian refugee women. The qualitative interviews in Torun et al.'s study elicited the dissatisfaction with health services of refugee women due to the unavailability of female healthcare providers (2017, p.604). A Syrian woman relays this dissatisfaction by saying: "We have a problem with healthcare provision, as there are no female doctors. It is against our beliefs to be seen by a male doctor" (Yıldız,

2013). Thus, patient culture, doctor preference, trust in physicians constitutes a cognitive barrier and affects refugee access to healthcare.

3.3.6. Lack of NGO and INGO Presence

Considering the sheer number of Syrian refugees residing in Turkey, answering to all their needs is a mammoth task for the government indeed. Although the government has been exerting an increased effort to provide healthcare services to refugees, the role of NGOs and civil society is imperative in improving access, quality and in filling in the gaps in the healthcare system (Bilecen & Yurtseven, 2018; Özçürümez & Yıldırım, 2017; Torun et al., 2017; Samari, 2017). As it was previously mentioned lack of NGO involvement in health is due to the tight restrictions on NGOs and INGOs operating in Turkey, and the centralized approach of the MoH (Memişoğlu & Ilgıt, 2018; Chong,2018, Assi et al., 2019, Özçürümez & Yıldırım, 2017). Thus, in comparison to Jordan and Lebanon the number of NGOs operating to deliver healthcare to refugees is rather low (Samari, 2017).

Lack of NGO presence especially poses challenges in specialized services especially in reproductive health and mental healthcare (Torun et al., 2017; Samari, 2017; Demir et al., 2016; Yasin, 2016; AIDA, 2018). Torun et al. state that many queries were posed by respondents on how to access specific healthcare services such a psychological support and breast cancer screenings, and that NGO presence was especially needed in these areas (2017, p.604). Samari asserts that the delayed involvement of NGO's in Turkey resulted in women's reproductive health issues not being assessed (2017, p.264). Demir et al. state that treatment and rehabilitation of trauma caused by experiencing armed conflict is given to refugees by NGOs, as public healthcare services do not provide such services (2016, p.62). Some of the NGOs providing psycho social support are ASAM , Support to Life and the Turkish

Red Crescent (AIDA, 2018). Another gap where NGO's prove highly useful is translation services and patient guidance, however the extent still remains limited (Bilecen & Yurtseven, 2018).

3.3.7. Discrimination and Local Perceptions

"We pay taxes, they get the jobs, the money, and now we pay for their health care" this is the unsavoury remark of a Turkish person quoted in Nielsen's study (2016, p.103). Unfortunately, refugees are faced with discrimination not only from healthcare providers but also from patients as well. Nielsen asserts that the local patients are aggravated as they believe that "their own rights are being infringed" (2016, p.103). Cloeters and Osseiran state that racism is a major problem that affects refugee access to basic rights, they also assert that there are negative perceptions that they burden the health system and bring illnesses (2019, p.18). According to Savas et al.'s study in Hatay 65% of respondents stated that the number of Turkish patients visiting the hospital had declined and 54% reported a drop in the number of medical students who wanted to train at the hospital, upon the increasing numbers of Syrian patients. (2016, p.18284)

On part of healthcare providers, discrimination occurs in the form of mistreatment, harassment, refusal to register and other forms of discriminatory behaviour. (Demir et al., 2016; Cloeters & Osseiran, 2019; Torun et al.,2017). For instance, Türkay states that there are reports of family doctors not registering refugees in Bursa (2016, p.54). The discriminatory attitude of healthcare providers is also ascribed to lack of training for medical professionals on dealing with refugees (Demir et al.,2016). Demir et al. state that many healthcare professionals have reported that they haven't received any training pertaining to healthcare in emergencies or on how to deal with refugee patients (2016, p.64). Support and in-service training are crucial for healthcare workers in terms of understanding refugee behaviour and knowing how to respond to the needs of refugees (p.62). Torun et al. assert that the

situation is conflated with the language barrier and the overburdening of the Turkish healthcare system, especially regarding overworked doctors, as these factors lead to "friction between Turkish doctors and Syrian patients, which seems to have led to perceptions of mistreatment" (2017, p.604).

3.3.8. Knowledge on Rights

According to a 2017 AFAD field survey conducted with 10,838 people in 9 provinces, approximately 36 % of the Syrians didn't have any knowledge on the rights granted under temporary protection (2017, p.101). Based on the study conducted in İstanbul with refugee women, Torun et al. convey that nearly half the women (49.6%) in İstanbul were not aware they had the right to free health care. Those who were cognizant of this right, knew about it from their friend, neighbor or relative (57.8%) and 28 % used social media to learn about their rights for services (Torun et al., 2017). Kutlu also identified lack of knowledge on right to access healthcare as an access barrier (2015, p.10) It seems this is connected to the lack of a rights based approach, as Mardin has also underlined the governments approach to refugees revolves more around a humanitarian axis rather than a rights based one.

3.3.9. Access to Mental Healthcare

Access to mental healthcare for refugees is a multifaceted one indeed as it is impacted by elements such as negative connotations surrounding seeking mental healthcare, availability of services, the language barrier and the lack of Arabic speaking mental healthcare professionals and interpreters etc. The need for mental healthcare is prevalent among Syrian refugees not only due to their experience of war and armed conflict but also due to displacement that has brought about difficult living conditions and as Şimşek et al. state "persistent existential concerns of safety, trust, coherence of identity, social role, and society" (2017, p.12). Mardin also makes reference to the structural uncertainty that refugees are faced with and how it

has adverse effects on mental health (Cloeters & Osseiran, 2019). Regarding numbers, Samari states "55% of refugees are in need of psychological services, and close to half of the Syrian refugees think they or their family members need psychological support" (2017, p.264). Again, according to Şimşek et al's study of Syrian refugee women in Şanlıurfa, a staggering percentage of almost 90% of the women reported at least two mental health symptoms, especially emotional distress (depressive symptoms, prolonged grief disorder, posttraumatic stress disorder, anxiety) (2017, p.12).

Cloeters and Osseiran point out that there are no Arabic speaking psychologists or psychiatrists available in İstanbul to tend to Syrian refugees and that the hospitals dedicated to psychiatric care in İstanbul do not offer translation services, thus NGOs are endeavouring to fill this gap however they are also very few in numbers (2019, p. 19). The limited mental healthcare services are mentioned several times in the literature (Torun et al., 2017, Demir et al.,2016; AIDA,2018; Cloeters & Osseiran, 2019; Bilecen & Yurtseven, 2018). Furthermore, the perception of refugees regarding mental healthcare also affects access due to social stigma. Çolak states that seeking mental healthcare is not a priority for refugees and only a mere 12% of those who stated they had mental health issues sought mental health care (2018, p.30). Çolak was quoted in a report stating that refugees do not seek psycho-social support since it's regarded as "culturally inappropriate" and that refugees do not attempt to access psycho-support as they are not aware of mental health problems or where to access the services. She exclaims that "it is necessary to have knowledge [of mental health symptoms] to define a problem as a problem firstly" (Cloeters & Osseiran, 2019). In the same report Mardin also underlines that "non-perceived needs" need to be addressed (p. 20).

3.3.10. Reproductive Healthcare

For reproductive health the story is rather reminiscent of mental healthcare. Availability of such services and access to the services remains low and NGOs are mostly providing these services (Torun et al.,2017; Özgülnar, 2016; Samari, 2017; Şimşek et al., 2017; Cloeters & Osseiran, 2019). Şimşek et al.'s study on Syrian refugee women's health reports "16% of the women were pregnant; nearly half of the respondents had had a miscarriage or stillbirth; about 38 % of respondents reported unmet contraceptive needs, and half of the women had a gynaecologic infection (2016, p.11). While the study in İstanbul conducted by Torun et al.'s demonstrates that 60% of the pregnant women received antenatal care, but experienced difficulties due to the language barrier (2017, p. 603). Çolak stated that 48% of the interviewed women in their study had not undergone any check-ups during their pregnancies (2018, p.26). Furthermore, there is a lack of counselling services on reproductive health and family planning, these services are highly salient issues for refugee women and their well-being (Şimşek et al., 2017; Samari, 2017; Cloeters & Osseiran, 2019). As Cloeters and Osseiran point out "not receiving medical care during pregnancy may endanger the lives of mothers and unborn infants. In this regard, it is critically important to raise awareness and ensure refugee women's access to comprehensive prenatal service" (2019, p. 22).

3.3.11. Access to Medication

Although certain medication (those specified under the Health Law Budget) is provided free of charge by pharmacies who have an agreement with the SGK, difficulties remain in obtaining medication. Torun et al. mentions that qualitative interviews revealed that there were challenges in getting medicine (2017, p.604). According to the 2017 AFAD survey 58% of Syrian refugees (57% living outside of camps and 78% living in camps) stated that they could access medication when needed (2017, p.86). Çolak underlined that when interviewees with chronic illnesses

were asked about access to medication around half of the respondents said they had difficulties (2017, p.25). When asked about the reasons 43% of participants conveyed that "bureaucratic reasons" i.e. registration or referrals impeded their access to medication, followed by lack of knowledge on the health system and how to obtain medication (32%) (p.25).

3.4. Verdict on Healthcare Provision

To sum up Turkey is providing free healthcare access at primary and secondary levels to 3.6 million Syrian refugees registered within its borders. Furthermore, the economic burden has also been immense, as Turkey has spent over $30 billion on services for Syrian refugees, of which $10 billion alone has been spent on health services (Alawa et al., 2019). Regardless of the immense burden and despite several challenges, Turkey has integrated the refugees into its own health system and has given coverage under the general health insurance. Means of delivering healthcare are limited to public facilities along with Migrant healthcare centres and very limited NGO and INGO healthcare providers. Especially in comparison to Jordan and Lebanon, the healthcare system in Turkey is particularly accommodating to Syrians under temporary protection (Saleh et al., 2018, Akbulut,2019, Kirişçi,2015). In Lebanon patients are required to pay 25% of the total cost of healthcare services, as the state only subsidizes up to 75 % of medical expenses, while in Jordan only refugees living in camps are entitled to free healthcare and those residing outside of camps have to pay the full price of services received (Saleh et al.,2018).

Turning to statistics of health care service utilization in Turkey, the most recent statistics available, according to a 2018 AFAD information note, indicate that from 2011 up until February 2018 there have been 34.501.808 policlinic services, 918.964 hospital referrals, 1.423.844 in-patients, and 1.188.606 operations (AFAD, 2018). Regarding the number of births in Turkey, according to a statement issued by the Ministry of Interior in November 2018, over 400,000 Syrian babies have been

born in Turkey in the past 8 years. Regarding vaccinations "Between 2011 and 2016, 1,804,574 refugees were vaccinated." (Tayfur et al., 2019), as vaccinations of Syrian children are covered under the scope of the Turkish immunisation programme (Assi et al., 2019).

Regarding satisfaction levels health appears to be the service that refugees are most content with. According to an AFAD Field study conducted in 2017 with 10,838 people (1,221 people from the camps and 9,617 people from non-camp settings) in 9 cities, "Sixty six percent of the participants mentioned that they utilized the health services offered by Turkey. The rate of satisfaction with regards to the health services was 83 percent." To further break it down: "95.60 percent of men and 89.20 percent of women living in camps and 82.20 percent of men and 78.80 percent of women living in non-camp settings stated that they were "very satisfied" or "satisfied" with the health services (AFAD, 2017). According to Murat Erdoğan's 2017 Syrian Barometer which surveyed 1,235 Syrian households, "the most positive service field for the Syrians seems to be the healthcare by 68.2%. The Syrians in Turkey are very satisfied with the healthcare services in Turkey" (p.34). Furthermore, Syrians rated Turkey's support to healthcare services 72.8 out of 100, this was the highest score among the services – education, accommodation, financial support (Erdoğan, 2017). According to Torun et al's study only 3% of the participants mentioned having major problems accessing healthcare (2017, p.603). Another interesting access statistic is from Çolak's research in İstanbul conducted with 265 households and 1453 individuals also included access for those with physical or mental disabilities, when households with such cases were asked whether they could access treatment opportunities in Turkey 76% stated they could (2018, p. 25).Beyond statistical data, the literature doesn't offer ample sources in terms of qualitative data reflecting the experiences and opinions of refugees regarding healthcare access.

Turning to the literature, one common statement echoed is that the Turkish healthcare system was not prepared for the sheer influx of refugees but still its efforts are commendable and the health system has shown resilience without encountering any severe problems in healthcare provision or cases of epidemics (Tayfur et al.,2019; Cloeters & Osseiran, 2019; Saleh et al.,2018; Özçürümez & Yıldırım, 2017; Assi et al.,2019). As Özçürümez and Yıldırım have succinctly put it:

> The scale of the mass influx, which amounts to differentiated needs of almost three million SuTP and other refugees, would challenge any system immensely. However, the health system in Turkey so far has been resilient in different ways, including having prevented any major epidemics or major difficulties in health service delivery to the whole population, including SuTP. While SuTP are concentrated in cities near the border with Syria, the health services continue to a relatively appropriate degree. (2017, pp.117)

Nevertheless, in all sources it is clearly stated that challenges remain persistent. Thus "access is not always as straightforward and simple as the government makes it out to be" (Kirişçi, 2015) and there are several access barriers all with a different nature be it systemic, cognitive, cultural, socio-economic or structural that impede refugee access to healthcare services. Furthermore, Mardin explains that the "healthcare system is designed for people who understand the system, live in a permanent accommodation, and are able to communicate their needs in the country's language. Living conditions, working conditions, access and right to work" (2019, p.17). Thus mobility, language, understanding the system, employment all impact access to healthcare and whether or not you will be excluded, this is also termed "intersectional patterns of discrimination" (Cloeters and Osseiran, 2019).

CHAPTER 4

DESIGNING THE STUDY

> Forced population movements have extraordinarily diverse historical and political causes and involve people who, while all displaced, find themselves in qualitatively different situations and predicaments. Thus, it would seem that the term refugee has analytical usefulness not as a label for a special, generalizable "kind" or "type" of person or situation, but only as a broad legal or descriptive rubric that includes within it a world of different socioeconomic statuses, personal histories, and psychological or spiritual situations. (Malkki, 1995)

The previous two chapters provided a literature review encompassing a conceptual framework for access to healthcare followed by a literature review of access to healthcare for refugees residing in Turkey, to lay the ground before presenting the study. This chapter firstly underlines the importance of a qualitative component in the study, then proceeds to expound on the methodology, design of the study, sampling and characteristics of the respondents and finally the challenges and limitations.

As it was emphasised in the introduction, the primary questions the study engages with is to comprehend the access barriers Syrian refugees are faced with when accessing health care in urban settings, to elucidate the nature of the difficulties they are facing, to understand opinions of the Turkish healthcare system and its accessibility as well as their suggestions to improve healthcare access for refugees. The aim is not to make unequivocal generalisations, just to get a glimpse of the experiences of Syrian refugees access to healthcare. Thus, a mixed-methods approach was adopted, consisting of semi-structured interviews and limited participant observations. These methods revealed the experiences of refugees

accessing healthcare, through their own words and actions. The in-depth interviews were semi-structured and consisted of open-ended questions to allow for more discussion. The limited participant observation was a key component of the research and is presented through four ethnographic vignettes in Chapter 5. The reason Ankara was selected as a city, was due to the existing access I had to the refugee community in Ankara through various volunteer groups I had been part of. Had the research been conducted in another province I would not have had the access or the trust that I did for this study. The main target group was refugees, not health workers or NGO workers engaged in refugee health related work, as the aim of the study was to focus on the experiences of Syrian refugees from their perspectives. Furthermore throughout the methodology, Levesque et al.'s conceptualization of access was considered as the interview questions and the limited participant observation were along the lines of the five dimensions of accessibility: i.e. approachability; acceptability; availability and accommodation; affordability; appropriateness; and ore specifically the five corresponding abilities of populations ability to perceive; ability to seek; ability to reach; ability to pay; ability to engage.

4.1. The Significance of Qualitative Component

A strong qualitative component is essential for this research, as it shall provide a deeper understanding of the intricate processes, experiences and perceptions regarding Syrian refugees and their access to healthcare. As it was outlined in the literature, there are several elements and intertwining processes that influence refugees regarding their access to and attitude towards healthcare in their host country. Culture, perception, experience, language, proximity, socio-economic status, occupation etc. all come together in various processes. The assessment of these elements and processes is essential in understanding the accessibility of healthcare. As Evans states migration is a "human process" hence it is key to describe the individual's involvement with human networks and the institutions sustaining them." (Evans, 1987). Hence, qualitative research would best suit the

purpose of presenting a picture which demonstrates several dimensions of refugees' healthcare access. Though unfortunately, the nascent literature on the healthcare access of Syrian migrants largely consists of quantitative research, as the subject is covered mostly by public health journals. Hence, this research endeavours to provide a more qualitative picture by going beyond a survey and actually talking to the refugees themselves and accompanying them on a trip to the hospital.

> Why are the perspectives of migrants important Different forced migrants, however they are categorized, have different areas of choice, different alternatives, available to them, depending not just on external constraining factors but also on such factors as their sex, age, wealth, connections, networks etc. This means that we have to understand the point of view and experiences of the people making the decision to move … We have to see them as agents, however limited, in a physical sense, their room for manoeuvre may be. (IOM report, 2018, p.173)

Since migration is a "human process", it seems plausible to argue that its study can be deeply enriched through human experience, interpretation, perception and engagement. This is where the notion of agency proves to be a crucial element in migration studies, as Essed et al. state in *Refugees, Agency and Social Transformation*, agency conceptualises people as "social actors who process their own experiences and those of others while acting upon these experiences" (Essed et al., 2004). Furthermore, agency implies "a certain knowledgeability, whereby experiences and desires are reflexively interpreted and internalised (consciously or otherwise), and the capability to command relevant skills, access to material and non-material resources and engage in particular organising practices" (Essed et al., 2004). Hence, there is much to be said for the use of ethnographic methods in migration studies. By relaying the personal narratives of refugees, the uniqueness of each experience is highlighted and generalizations are unpacked, as Eastmond states "from personal accounts we may also glean the diversity behind over-generalized notions of 'the refugee experience'" (2007, p.249).

4.2. Semi-Structured Interviews

The main focus of the interviews was to garner the experiences, struggles and suggestions of Syrian refugees living in Ankara. Another intention with semi-structured interviews was to reveal the additional barriers that perhaps are not mentioned in surveys, to tap into more cultural and cognitive barriers, permit as much leeway as possible for the expression of experiences, challenges and perceptions without being led on to respond. Thus, semi-structured interviews were conducted with 22 respondents consisting of 13 women and 9 men from May 2018 up until September 2018, for them to express in their own words, their experiences accessing healthcare. The required permission was obtained from the Middle East Technical University Human Subjects Ethics Committee. Moreover, an informed consent form which was translated and read to the participants was prepared. Before each interview the aim of the study was briefly explained and the duration of the interview was given as roughly 25 minutes, then the consent form was translated to them and their consent was obtained. The interviewees were also informed that their voices would be recorded using a voice recorder and their consent was taken for that as well. Each interview was then transcribed the same day. There were three group interviews: two women a mosque was helping, three students and three women at a hospital. The remaining fifteen interviews were conducted individually.

Due to my limited knowledge of Arabic, thirteen of the interviews were conducted with the help of a translator while the other nine were conducted with people who could either speak English (2) or Turkish (7). Translators were from among my Palestinian and Syrian friends who volunteered to translate. The questions were sent to them and we would go over them together before any of the interviews were conducted. The fact that they were also native Arabic speakers truly helped, as their presence, approach and way of talking (not classical Arabic, but *amiyah* the colloquial language) seemed to make people feel more at ease. Especially when the translators would refer to the respondents as *khaaltee* (my aunty) or *oukhtee* (my

sister) or other terms of kinship. For a more relaxed approach interviews were mostly conducted in cafes as well as public areas, private homes, in stores with store owners. Some respondents invited us into their homes, so interviews took place there. With others I tried to invite the respondents to have coffee or tea together. The aim was to create a more laid back atmosphere so people felt like they were having a chat rather than being interrogated and could open up about their experiences and challenges they were facing. I always kept the voice recorder on my lap or held it down low instead of keeping it on the table or anywhere close to their mouths so people could feel more comfortable.

4.2.1. Interview Questions

First of all a topic guide was prepared in light of the literature review and upon this topic guide the questions were formulated again by referring to the literature, namely Ay et al.'s survey that was used in their 2016 study titled "The Perceived Barriers of Access to Health Care Among a Group of Non-camp Syrian Refugees in Jordan", as it employed the use of a comprehensive survey containing access barriers and also aimed to elicit perceptions as well. The questions were open ended to enable as much discussion as possible. The questions asked to the respondents, evolved as they were talking about their experiences, and while the topic guide and questions anchored the discussions, for many respondents especially in the case of key informants many questions emerged during the course of the interview. The primary questions anchoring the discussions were as follows:

- Are you content with the healthcare services?
- Have you experienced any difficulties at the hospital?
- How is your experience in seeking healthcare in Turkey different from in Syria?

- Have there been any instances in which you decided against seeking care even though you were in need of it?
- Are you aware that you are entitled to free primary and secondary care at public hospitals?
- What is your opinion of Turkish hospitals, doctors?
- What are the major challenges for people accessing healthcare?
- What do you think needs to be changed or improved to make healthcare access easier for refugees?

4.2.2. Sampling and Respondents

Gaining access to the Syrian refugee community in Ankara was less of a challenge, as I have been working voluntarily with refugees in Ankara through civil society initiatives. I did not want to ask the families that we had been helping directly throughout the years, as I did not want them to feel obliged to participate in the study. However, other Syrian friends who I had been volunteering with helped me a great deal as one of them frequently volunteered as a translator at hospitals. She introduced me to other key informants who had ample experience accompanying Syrian refugees in hospitals.

22 people, 13 women and 9 men, were interviewed using snowballing and flow populations due to ease of access between May 2018 and September 2018. The characteristics of the respondents have been provided in Table 2. The target group of the study were Syrian refugees residing in Ankara. The first refugees I interviewed I found through a local mosque in Kızılay who helps refugees, others were found through the volunteer group I was part of and through my Yemeni, Palestinian and Syrian friends who directed me to people who would be willing to do interviews. They were then contacted by phone and asked if they would be available to meet at a café for coffee. In addition to this, four Syrian women with

very low income were reached through the imam of a mosque who was helping refugees. The women were contacted and asked if interviews could be conducted with them and they all asked that I come to their house to conduct the interviews. To achieve a random sample I also went to Önder Mahallesi, a neighbourhood densely populated by Syrian refugees, with a Syrian friend and went into Syrian stores to ask if they would be willing to conduct interviews. The Ankara Syrian Student Association (ASOB) was contacted to ask if any students would be interested in being interviewed on their experiences with access to healthcare. The association put me in touch with three students, of which one was a key informant as she had volunteered as a translator in hospitals in Ankara. The other three key informants were identified through two of my friends who accompanied refugees to hospitals for translation and assistance. Thus, the aim was to reach respondents from different socio-economic backgrounds and age groups, to help paint a picture reflecting the various experiences and perceptions of people. A specific population was not studied, for instance the research did not prioritise or target Syrian refugees who regularly sought healthcare or who had a chronic disease. Such a focus would've required increased access and more resources, thus the study focused on Syrian refugees living in Ankara and did not employ any criteria pertaining to health conditions or frequency of seeking healthcare.

The respondents were residing in the districts of Keçiören-Yeşilöz, Siteler, Cebeci, Öveçler, Kurtuluş and Dışkapı in Ankara which are densely populated by Syrian refugees. They were mostly from Aleppo with a few from Damascus, Homs and Raqqa. The average number of years the respondents had lived in Turkey was 2.8, varying between 1 year and 4.5 years. Their ages varied between 20 and 67, while the average age of the respondents amounted to 33.5. Most of the interviewees had been to hospitals often while only one had never been. Some respondents had lived in other provinces such as Gaziantep or Mersin prior to moving to Ankara, thus although the interview questions were directed towards Ankara, they also talked about their experiences in Gaziantep or Mersin. These were also specified.

Regarding their socio-economic situation, 6 respondents mentioned they were receiving the monthly assistance of 120 TL granted to vulnerable refugee families through the Emergency Social Safety Net (ESSN) program Turkish Red Crescent card (Kızılay card) backed by the UN. Some of the respondents were relatively well off, such as store owners, cleaners, and some of the students. 5 out of all respondents lead more comfortable lives with higher salaries, as they were formally employed or were students with well-off parents. 13 respondents stated that they sought healthcare often; three mothers stated they went mostly for their new born babies and for regular check-ups; others stated that they themselves or one of their family members had a chronic disease such as a heart condition or diabetes. Among those who frequented hospital, there were 4 key informants (Syrian students/translators) who had ample experience working or volunteering as translators in hospitals in Ankara. Thus, their inputs proved to be invaluable as they were able to relay the experiences they had had with different patients, hospitals and hospital staff.

To respect the privacy of the respondents deidentification has been employed throughout the study and respondents have been referred to by their first initials and ages. The key informants have been denoted with a * before their initials.

Table 2

Demographic Information of the Respondents

Name	*Age*	*Gender*	*Occupation*	*Years in Turkey*	*Goes to hospital*	*Speaks Turkish*
E	23	F	Housewife	1	often	no
R	24	F	Housewife	2.5	often	no
H	35	F	Housewife	4	often	no
S	36	F	Housewife	1.5	often	no
*R	21	F	Student/translator	3	often	yes
*W	26	F	Student/translator	3	often	yes
O	23	M	Student	5	never	yes
*M	21	F	Student/translator	2.5	often	yes
J	20	F	Student	1	never	no
R	21	F	Student	2	twice	yes
N	24	M	Student	4	once	yes
B	62	M	Retired	2	once	no
S	44	M	Store Owner	3	seldom	no
K	63	M	Retired	4	often	no
W	67	M	Salesman	5	twice	no
M	22	M	Workman	2	once	no
D	30	F	Cleaner	2	often	no
*M	24	M	Student/translator	3	often	yes
A	58	F	Housewife	2	often	no
F	30	F	Housewife	2	often	no
H	33	F	Housewife	3	often	no
Y	31	M	NGO Worker	4.5	seldom	a little

4.3. Limited Participant Observation

The next component of the study was limited participant observation, where I accompanied Syrian refugees to hospitals. The reason this was conducted was to attempt to experience the actual process refugees go through when seeking healthcare whether it's arranging a translator, finding and getting to the hospital, making an appointment, navigating the health system, the treatment from hospital staff and other patients, getting tests done. I wanted to see what a trip to the hospital entails for a Syrian refugee living in Ankara.

As the interviews were only conducted with Syrian refugees, this component would also provide some insight into how doctors, patients and hospital staff fit into the picture. Furthermore, this limited participant observation would enable me to glean insight into their experience when seeking health care. This could be a few glances from nurses, a couple of remarks from nationals at the hospital or even a mere expression that crosses their faces for a split second. Since I do not speak or understand Arabic very well, this kind of fieldwork which also involves non-verbal cues and sheer observation would add to the research. Relying on the use of ethnographic methods would enable "to show process in fine-grained detail and to open black boxes to show mechanisms causally linking independent and dependent variables" (Fitzgerald, 2006).

4.3.1. Point of Entry

As it was previously mentioned I'd been part of a Facebook group (a platform of volunteers) working with vulnerable refugee families in Ankara. For the sake of anonymity details of the group will not be revealed. The group consists of NGO workers, teachers, locals, internationals, students, refugees basically anyone willing to volunteer and work with refugee families. Through this platform, households in the most vulnerable neighbourhoods of Ankara are visited primarily by Arabic

speakers, once needs are identified the group helps refugee families by delivering donations, paying bills, accompanying them to hospital, providing translation services, finding employment, registering new families, enrolling children in school etc. The needs are posted on the group and then the post awaits a volunteer's response. The group has been active since 2016, the families and refugees trust the group and have built strong relations with them through the years. Furthermore, the active engagement of many Syrian, Palestinian, Iraqi, Afghan volunteers who have also experienced being refugees, has garnered a lot of trust within the refugee community especially the Syrian community. Thus, my point of entry did not pose any struggles. Refugees in need of assistance going to hospitals would contact the admin of the group (a woman who has been working with refugees since 2014, visits the neighbourhoods on a weekly basis and knows the families personally) who would then post on the group to relay the message and mostly an Arabic speaking volunteer would respond to either help with translation or serve as a patient guide.

4.3.2. Hospital Visits

I'd never accompanied anyone to the hospital before as my Arabic was not up to scratch and I wouldn't be able to translate for them. So, I asked if I could tag along with one of my translator friends as she was to accompany three Syrian women to the eye doctor. I asked my friend to ask the consent of the women and if they would mind me joining as an observer. Thankfully they accepted and I was able to conduct the first limited participant observation with three women. I was able to watch their experience with a translator.

For the other trips to the hospital I went alone, as shortly after that visit, there was post on the group that an elderly Syrian woman needed someone to accompany her to hospital, and no one responded as none of our Arabic speaking volunteers were available. Since it was only for an MRI and I had a basic level of Arabic, I volunteered to accompany her more as a "patient-guide" rather than a translator.

After the first visit together we took quite a liking to each other so I began going with her each time to the hospital. This made me more comfortable about asking for her consent. Initially I was going to ask for her consent at the end of the trip to the hospital, as I didn't want it to put any pressure on her or disturb her especially when she was not feeling well and when no one else was available to go with her other than myself. Thus, after we became friends it was easier to ask her, to which she responded very positively and was quite excited about it too. Thus, I accompanied her three more times to hospital.

Thus, I was able to conduct five participant observations in four different hospitals, which will be presented in brief vignettes in chapter five. After each visit I would go and write detailed field notes for each instance while everything was fresh in my mind. Participant Observation revealed a lot that language cannot express and provided certain situations in which I was able to ask people how they were feeling and see what their reactions were. Walking together or the bus rides together even proved to be useful as people would open up more about their experiences, Malkki from her own fieldwork states that narratives emerge in countless circumstances during walks, lorry drives or while people are working "conversations in these diverse settings about everyday topics, personal circumstances, and immediate concerns often (indeed, usually) led to broader, historicizing reflections" (1995, p. 49).

I tried to employ processual ethnography "precisely because process conveys an analytic emphasis on continuous production and construction... Process is simply a time-oriented perspective on both continuity and change." (Moore, 1987). I endeavoured to focus on my own time-oriented perspective with each field visit. Plus, it gave me a chance to self-reflect, since I had a few expectations and predefined access barriers of my own regardless of my limited experience and knowledge of the area.

4.4. Challenges and Limitations

Due to the language barrier and the requirement of a translator, interviews with refugees proved to be quite a challenge. 7 out of the 22 interviewees could speak Turkish and 2 could speak English, hence for the remaining 13 the help of translators was employed. The translators who accompanied me were friends of mine and also refugees themselves (one Syrian, one Palestinian) with the exception of one Turkish national with Arab origins who was also the İmam of a mosque helping refugees. Using a translator proved to be highly challenging, as I wasn't able to engage with the respondents to the degree that I wanted to. The other issue was that people were tired of being interviewed, since many people have been conducted research on Syrian refugees. Furthermore, some were more reserved and cautious while answering and expressing their thoughts about their host country. It also occurred to me that being Turkish myself, perhaps some respondents didn't fully express their thoughts or any criticisms they had, as quite a few of them expressed their thanks to Turkey but perhaps this was due to being interviewed by someone Turkish who was also recording their voices. Torun et al. stated that in their research in İstanbul which also involved interviews, the interviews were conducted by Syrian interviewers/interpreters and students from the UK to ensure that the respondents would freely "express their concerns and problems freely to a non-Turkish person" (2018, p.606).

Even though all were ensured that their names, where they lived and any other details would remain confidential, some were wary of the voice recorder. Before each interview I would ask if they minded me recording their voices, one woman refused and said I could take notes but I couldn't record her voice. Again, three men did not want to give their names but wanted to participate anonymously. To be honest it seemed to be better this way as the three men who did not give their names were rather vocal about the problems and issues they were facing. However, this is indicative of a certain fear perhaps of criticising the host country.

Another hindrance the language barrier engendered was that I could not prompt as much as I would've liked to. Sometimes there were time constraints or conditions were not favourable to continue the interviews so many issues were left untouched. With four interviewees the presence of the translator (an imam helping them financially) may have affected their responses, as they had no complaints at all. As Eastmond has stated that what is shared is "also situational, shaped not least through the contingencies of the encounter between narrator and listener and the power relationship between them." (2007, p. 249). However, I must mention that the three women lived very close to a hospital and apparently that hospital is one of the best hospitals for refugees to go to (R, a key informant, told me this later on).

During the participant observation with the Syrian woman W, since she wasn't feeling very well and there were very long queues and a lot of going and coming to various parts of the hospitals, I asked her to sit in the waiting rooms while I waited in the queues or went to various parts of the hospitals. Thus, during those visits I was worried that it was more my experience than hers. However, even this experience revealed the importance of social networks and also pointed out to me just how difficult things could be even for a Turkish citizen. Hence, although at some points I felt it was not reflecting W's experience, these visits did reveal certain aspects of the hospital environments and how difficult it was to navigate hospitals if one is not well acquainted with the system. This also pointed out how lack of familiarity lead to limited agency as well. These points will be further excavated in the following chapter.

My own biases were also challenging, as when I went to hospitals with the Syrian women fully covered in black niqabs I was constantly looking around to see if people were looking at them differently or talking about them. Even with hospital staff my senses were a bit too fine-tuned at first and ready to perceive any impatience as an act of discrimination. Thus, it was also an experience for me to self-reflect and try to put aside my own biases and preconceptions. It was not easy

to conduct limited participant observation or to interview refugees, as I am not a refugee and am alien to their experiences. In my mind I was endeavouring to adopt Bourdieu's methodological reflexivity, as it was mentioned by Loic Wacquant, Bourdieu's methodological reflexivity "requires the relentless self-questioning of method itself in the very movement whereby it is implemented. (2006, P.5). Thus, I was also trying to question myself as well in the field.

Regarding limitations, the scope of the study was underlined in the introduction, this study has the modest aim of exploring the experiences of Syrian refugees living in Ankara. Ankara was selected due to the ease of access to the Syrian refugee community. Although when compared with the literature the study did indeed cover and confirm almost all of the barriers that were mentioned and revealed additional ones. Perhaps, due to the low number of Syrian refugees in Ankara and the fact that it is more cosmopolitan compared to border provinces, the contentment level with ease of access to healthcare appeared to be higher compared to border cities such as Gaziantep, and reports of discrimination were marginal. This was also mentioned by some of the interviewees, as they had also been to hospitals in Gaziantep and Mersin. They had stated that Ankara fared better in terms of treatment of hospital staff and locals.

CHAPTER 5

FIELD WORK IN ANKARA

This chapter consists of two sections, the first section provides the experiences of Syrian refugees accessing healthcare in Ankara through 22 semi-structured interviews, while the second section provides 5 vignettes of hospital visits. The aim of the interviews was to reflect the experiences of Syrian refugees' access to healthcare, while the aim with the vignettes is to provide a picture of what a trip to the hospital looks like for a Syrian refugee in Ankara.

5.1. Semi-Structured Interviews

As it was mentioned in the previous chapter semi structured in depth interviews were conducted with 22 Syrian refugees in Ankara. The questions mostly revolved around their experiences in accessing healthcare, the challenges they have faced and what they thought would render access easier. Overall, they stated that they could access healthcare when they wanted to and that they were "content" with the healthcare services in Turkey. However, there were significant challenges that they mentioned that were in line with the challenges mentioned in the literature.

5.1.1. Refugee Experiences of Healthcare Accessibility and Contentment

Most people stated that they found it easy to access healthcare in Ankara. One key informant also mentioned that in terms of services provided to refugees healthcare was the best by far in comparison to education and employment. Respondents indeed mostly said that accessing healthcare was easy and that they didn't have difficulties besides the language. So even if they had mentioned the difficulties, they

didn't state all of them as difficulties when asked about difficulties. So, perception seems to come into play a lot in this question and also in the question asking about whether it was easy to access healthcare in Ankara, or people feel they have already explained themselves.

Regarding Turkish hospitals, 22 out of 22 interviewees stated that the facilities and hospitals were "good", especially when compared with Syria. They namely mentioned hospital facilities, medical advancements and the organised systems. More than 10 interviewees stated they were happy with services. No one expressed that they were unhappy with all hospitals. To sum up what was mentioned throughout the interviews: Not speaking the language was mentioned by 18 respondents, doctors not explaining things by 8 respondents, long procedures/lines/tests by 12 respondents, transportation by 6 and mistreatment by 4). 20 (including the 4 key informants) people said it was easy to access healthcare in Ankara and out of the remaining 2 interviewees, one didn't know about access the other didn't mention that it was easy. Some stated it was very easy, some said it was comfortable, some said there were no difficulties, some said it was easier in Syria, some mentioned that it was easy but transportation or language were a problem. 5 interviewees said there were no difficulties. Without going into specific challenges most stated that compared to other areas of service provision such as education healthcare faired a lot better.

> *I think the best service in Turkey for refugees is Health. There are major problems in other areas like education, unemployment but health is the best area. You can go get your medicine, get treatment. Even if you lose a day, you get a result. The other areas are not solvable in one day." (*M,24).*

> *I think the hospitals in Turkey are very good in fact they are better than just good. I'll give points, I give them 75 out of 100. It's very good, everything is organized but just people can be problematic (* M.,21)*

There were many positive remarks, as stated above. The 75 points M bestows upon the Turkish health care system actually echoes Murat Erdoğan's Syrian barometer as it was mentioned previously, among all services Syrians rated Turkey's support to healthcare services 72.8 out of 100 (2017, pp.34). Furthermore, respondents expressed a lot of praise for Turkey's response to their needs.

> *Things are good, praise be to God still things are good. There are so many of us (Syrians) and hospitals are already crowded so thanks to Turkey. (K.,63)*

> *If a child is ill whether its 1 lira or 1000 lira the government provides. (Ş.,35)*

Regarding the praise, perhaps the immense gratitude towards the Turkish government is indicative of Mardin's point that services seemed to be regarded as a "gift" rather than a right. However, when asked people did reveal the challenges that they were faced with.

> *When we go to hospital. It depends on the doctor if the doctor is good then great but if the doctor is bad then it's very bad. And thank you yes hospitals are good here. But I want to tell you about the bad things. We have difficulties. (S., 44)*

None of the interviewees had a particularly negative view of healthcare services, they conveyed that the healthcare services in Turkey were "good overall", but that there were challenges. The following section focuses on the access barriers that were mentioned during the interviews.

5.1.2 Access Barriers

Thirteen access barriers or rather challenging areas were identified during the interviews. They will then later be grouped under cognitive, structural, socio-cultural and economic barriers.

5.1.2.1 Navigating the Healthcare System

All of the key informants stated that navigating the Turkish healthcare system proved to be a challenge for people, especially since the Turkish healthcare system is very different compared to the one in Syria. Key informants relayed that the hospital departments, procedures in Turkey are very different from the ones in Syria. Difficulties with making appointments or not knowing where to go were also mentioned.

> *However, they don't know how to access healthcare. There are different departments here than there are in Syria. Procedures are also different, or they don't know about the specialization areas of Turkish hospitals. Like here most hospitals specialize in women's health departments. They (refugees) sometimes don't know about new procedures, new improvements or how to get appointments on the phone even though it's easy for them if they know a bit of Turkish but they don't know. (R.,21).*

> *Here hospitals are very big and there are lots of departments. In Syria hospitals aren't so big. Here people don't know where to go. So, it takes very long… Like in Dışkapı there is B block, D block so you have to go to the last block, but the person is sick. And they have to move and go to places. (W.,26)*

Such statements were reiterated by several interviewees, as they exclaimed that the healthcare system here was very different in comparison to the one in Syria. As it was mentioned in the preceding chapter navigating the healthcare system comes up as a significant barrier in the literature as well (Savas et al.,2016; Cloeters and Osseiran, 2019; Demir et al., 2016; Torun, 2017; Bilecen & Yurtseven, 2018). Refugees especially struggle with orienting themselves in the hospital system bureaucracy, or comprehending the referral system, as well as challenges in making appointments. Difficulties with navigating the healthcare system can be classified as a structural barrier which relate to institutional and organizational barriers, as difficulties in navigating the healthcare system pertain to the layout of the hospitals, referral systems and hospital bureaucracy.

5.1.2.2. The Language Barrier and Translators

Almost all interviewees who couldn't speak Turkish stated that language was the most prevalent challenge in accessing healthcare. Translators at hospitals were also mentioned as a major issue. Most of them stated there should be more translators and that translation services should be ameliorated. Among the interviewees most of them preferred to bring their own translators or go with relatives who can speak Turkish. Interviewees as well as key informants mentioned that, for the most part hospitals had translators but the number of translators allotted wasn't sufficient to respond to the demand. It was relayed that in some hospitals there would be only one translator trying to deal with six or seven patients at the same time. Other remarks included that translators were often short with people or were too busy to tend to patients seeking assistance. There is no fixed time for a patient, thus it becomes difficult perhaps to provide translators. Furthermore, when asked what could be done to make healthcare access easier most of the interviewees stated that translation services needed to be improved.

> *When I first went to hospital what I saw was that there are Syrians in hospital they were sitting waiting, they don't understand, they ask something in Arabic the hospital staff were telling them go there but they can't understand. When I see these, I get sad. I mean I speak Turkish so it's easy for me, but I felt sad for other Syrians." (*W.,26)*

The key informants, who have worked as volunteer translators, stated that Syrians ask for translation services on social media platforms (namely Facebook groups) and WhatsApp groups, then people volunteer to accompany them. The volunteers seem to be bearing the brunt of lack of translation services. Furthermore, people seem to be more at ease with people they know, as they are not sure what they will encounter at the hospital, this was the case for five of the interviewees, in fact two of them brought their own translators despite knowing that the hospital had its own translator. A translator is not solely needed in the doctor's office but also at desks as

well and also when making an appointment, thus when people bring their own translators they double up as a patient guide. Additionally, three interviewees stated that sometimes translators were not nice or helpful at all and that's why they resorted to bringing their own translators or phoning someone to translate over the phone.

> *People sometimes don't go because they know they will suffer when trying to explain or the translator might not be available for them. They say that the translators don't care too much. There would be two translators in the entire hospital. I once even heard that a translator working at a hospital charged them for money. But I only heard this I haven't witnessed it. (*R,21)*

> *For instance, I was at the hospital with my wife and I asked the doctor if I could phone a translator and he told me "get lost". I am an engineer for 46 years and he treats me like this. The next day I phoned a friend of mine to come to the hospital to translate for my wife. This happened 2 days ago. (K, 63).*

> *There are translators, but they don't help. The translators are always busy they are always working, they say we are busy. I think they either want to get money off us or they don't want to help us. Sometimes we go to hospital and we use our phones to call someone who can translate but doctors don't accept this. (S, 44)*

There was one interviewee who stated that there had been a mistranslation once, as she was promised that there was a way to treat her sons severe eye condition. However, in fact there was not and there had been a mistranslation.

As it will be explained further, language also underlies other barriers as well such as navigating the healthcare system, discrimination and seeking mental healthcare. Although the challenges are provided under separate headings here, they are intersectional and feed into each other. The language barrier can be classified as a cognitive barrier as it is a communication barrier.

5.1.2.3. Waiting Times, Lines and Crowdedness

Waiting times, lines and crowdedness are structural barriers that relate again to the hospital environment. People relayed that hospitals in Turkey were very crowded, especially compared to Syria, but most stated that it's due to the population or that "it's natural". Despite the lengthy queues and crowdedness they find the system to be organised and state that "you just take a number and wait for your turn". Waiting times, on the other hand appeared to constitute more of a problem, even though people who reported they had had to wait a lot (several hours) had gone without an appointment or had gone to the ER, some respondents who had made appointments also mentioned long waiting times.

> *Turkish hospitals are very crowded. We have to wait a long time. We don't make an appointment, but we go and wait there sometimes for 3 hours. But for my mother in law we phone and make an appointment. they say ok tomorrow at 8 but when we go, we still have to wait. (D.,30)*

> *My mum got very ill, her blood pressure was really high. They told my mum to wait for 1 hour. She was so frustrated, she didn't know what to do, just waiting, she was lying down getting up, she was feeling really bad. The line was long, and she had to wait. She said "I'll die at home but I won't go to hospital again!". (*M.,24)*

> *(In Syria) They tend to be more flexible. And with appointments there are no appointments in Syria there isn't even a queue. Whoever comes first enters just like a queue in the canteen. There are no papers either. So, everything is based on the time you come. The crowd there is much less than here, so it's easier. (F., 30)*

One of the key informants mentioned he'd gone with a 17 year old patient for an appointment at 8 o'clock in the morning but was only admitted into the doctors office at 3 o'clock in the afternoon. Long waiting times were mentioned by eight respondents and two key informants, as was crowdedness; and seven respondents plus two key informants mentioned long lines.

Hospitals are very crowded in Turkey, there is a lot of pressure on doctors. This affects translators too, there is only one translator in the hospital, each department needs a translator. We are all waiting for this one translator. When the translator is with us, he can't attend to the other people who are all waiting. (K., 63)

5.1.2.4 Referrals, Procedures and Tests

This was another prominent issue. Regarding referrals, procedures and tests several interviewees relayed that there were numerous procedures and tests at hospitals in Turkey compared to hospitals in Syria. Some expressed discontent with the lengthy procedures and found some tests to be unnecessary. One interviewee even stated that they paid for medication instead of going to the hospital each time his prescriptions needed renewed, because they didn't want to go through check-ups and tests. Others stated that there are lots of tests requested without a "proper" examination, or that tests are the first things doctors request. One interviewee stated "it's like we are machines and they are looking for the part that doesn't work.". Those familiar with hospitals in Syria stated that there weren't so many tests there. The interviewees mostly expressed discontent with regard to tests and procedures at Turkish hospitals. With procedures they were mostly referring to paperwork or other requests. People also commented on how they thought diagnosis was slower in Turkey compared to Syria. Six respondents and three key informants stated that there were too many procedures and that the system was highly test based.

Clinical diagnosis is much better in Syria. We diagnose the patient from symptoms, but in Turkey people diagnose based more on tests. Here they always send you to radiography or tests for everything. My friend went to hospital and they said go for a blood test and a urine test get your results and then come back. All this makes people not want to go to hospital. It's very arduous, if I go they will do this test and that test. I don't want to bother. Plus, in TR there are too many procedures. We don't have so many procedures in Syrian hospitals. And the diagnosis approach is very different. (O,23).

*In Turkey the patient comes, the doctor says "what's wrong" the patient says "my leg hurts" then the doctor says "go and get these tests done" the doctor doesn't do anything. But in Syria when the patient comes the doctor examines them thoroughly and then asks for tests. But in Turkey it's like go and get these tests, without explaining anything, go and get these tests done." (*M, 24).*

For referrals key informants stated that referrals and going from one hospital to another for different things was also difficult. One interviewee talked about her experience with her father who has a heart condition and how she had to go across four hospitals for treatment.

*They unnecessarily refer people to different hospitals. Sometimes for no reason. So, this leads people to not want to go to hospital. People start refraining from going to hospitals after they feel like they are being referred for no reason and going for no reason. (*R.,21)*

5.1.2.5 Mistreatment and Discrimination

On the subject of discrimination and mistreatment, there weren't many reports of it happening directly or having heard of it. Among the respondents two said that they had been mistreated, thirteen stated they hadn't experienced or witnessed any mistreatment or discrimination while seeking healthcare and six interviewees stated that they had been treated particularly nicely. The four key informants stated that it largely varies and is dependent on the person (healthcare personnel), and that they had witnessed some incidents. Incidents that were mentioned were: mistreatment from patients or nurses making snide remarks about Syrians getting free healthcare and medication or that they are taking up places of Turkish patients; doctors getting cross and telling refugees to go get a translator or doctors getting impatient with translators; pregnant women being mistreated in border provinces etc. However, all key informants also stated that it was contingent on the doctor and that they had also witnessed very nice treatment from healthcare professionals as well.

> *Doctors expect you to speak in their own languages. Once a doctor was asking me to translate something and I was directing them to the patient. But the doctor didn't even wait for me to translate she started shouting like very loud in Turkish to the patient, she said "what are your symptoms!!" "what are you saying!" she was yelling at the patient "can't you speak". But then I've met other doctors who are really patient and really nice. So, its fifty-fifty. (*R.,21)*

> *You know there are many Syrians here. Every day they come to hospital without a translator. They are coming and coming without appointments and the doctors are very busy. They say "go get a translator" they get cross. They are right sometimes because they are busy or tired and people are speaking Arabic with them. they don't understand either" (*M.,24).*

One respondent conveyed that he feared mistreatment and would either go to a private clinic or the health centre at his university and would not go to a hospital.

> *I don't have that good of an opinion of Turkish hospitals. Or of people. I think sometimes it's like a kind of discrimination act. My sister works part time at …. hospital and she's studying medicine at university. Once an old man came to hospital and my sister was going to take his pulse. But when he saw she was Syrian he started to shout, and he refused treatment from her and requested to be transferred to a Turkish doctor. I see the reverse side through my sister. (N.,24)*

Other issues were, the verbal mistreatment from local patients, as they voice their dismay regarding overcrowding or that Syrian refugees receive free healthcare and medication. Treatment from doctors was also mentioned.

> *One time a nurse was taking blood from someone and she got really angry with the patient. This was last year during the elections, she said: "you are voting aren't you". and then I came and said "what's the problem" and she said "you Syrians are here to vote for Erdoğan that's why he brought you here". (*W,26).*

One key informant mentioned that there were cases where doctors and hospital staff were highly pleasant. She talked about a little girl from Hatay, who's face was severely damaged due to a bomb in Syria. The girl had been brought to Ankara for

an operation. They reconstructed her face during several operations and the key informant relayed that they treated her so well in the hospital and that the head of the hospital would come and ask her if she wanted anything, people would come and play with her talk to her.

Snide remarks from locals were also mentioned, as people relayed how other patients would comment on Syrian refugees not paying for healthcare or for crowding up the hospitals.

> *Doctors are objective they treat us the same way as other patients. But the people in the hospital say "you get free treatment and you don't do anything, but we have to pay". Some say it directly to us or they look at us. In the hospital some people ask me just this and nothing else they just say "do you get this for free" or it's the first question. As though we are guilty because we get free medicine. (*M.,21)*

> *I've heard that for women it's very difficult, they are not treated well especially for pregnant women. Some people tell them to go and not have children. Or tell them "why are you making babies when there is war in your country!" (S, 44)*

Mistreatment seems to be happening on the lines of language, crowdedness and entitlement to free healthcare. As Cloeters and Osseiran stated there are indeed intersectional patterns of discrimination (2019, p.17). Discrimination can be classified as a cognitive and socio-cultural barrier, as discrimination pertains to perception, values, norms and communication. People did mention that awareness needed to be raised regarding Syrian refugees to prevent mistreatment on part of local patients and healthcare professionals.

5.1.2.6. Doctors' Lack of Explanation

Regarding doctors, the interviewees expressed mixed feelings, although one common thread was that doctors didn't give patients information or explain things to them. Four interviewees and four key informants expressed their dismay with the

lack of information provided to the patients. Eight interviewees plus one key informant stated they'd prefer a Syrian doctor mostly due to language, and because Syrian doctors explained more, for the remaining interviewees it didn't matter. Most respondents stated that in Syria doctors would sit down with patients and explain things to them and talk to them more, but in Turkey doctors didn't explain very much and that Turkish patients didn't ask many questions to doctors either. Another issue was the way doctors demanded tests and didn't interact with patients so much and that doctors treated them like "robots" (2 interviewees mentioned the words "machine" and "robot").

These issues affect locals as well. Explaining things less may be cultural, or less communication may be due to the change in the healthcare system (the focus on quantity hence less time per patient and digitalization).

> *The doctor is just writing, just prescribed me something, he didn't even examine me didn't look at me, he's just writing. But you are a doctor you should examine me. In Syria it's not like this. They don't use computers so much, they talk to you face to face and I think they deal with the patient more. But here we ask a lot but don't get a lot of answers. This I think is a major problem. Here, you go to hospital you have a small pain but they immediately give you serum. In Syria this is not how we use serums! The first time I ever had serum was here! (*W.,26).*

> *One big difference here is that in Syria our doctors tell us everything they explain things to the patient. But here they don't they just say "this is what we are going to do" and then I ask why they don't tell me anything. They don't seem to talk to patients. (*M.,21)*

> *Sometimes when you enter a hospital. They tell you to get some tests, blood tests but then send you home. They don't tell me anything. They say contact the medics or we will call you. What's the point they don't tell me what's my problem. They say nothing or say it's not your business. I have the right to know my problem. (S, 44)*

The issue of not explaining was relayed by several other people as well. This is perhaps more of a cognitive barrier on part of service providers and a result of disparities in care culture.

5.1.2.7. Lack of Information

For instance, when it comes to the right to free healthcare, everyone knows they can access free healthcare but do not know that they are entitled as a right. When asked about do you know you have the right to access free healthcare services, I had to rephrase the question and eliminate the word "right". It seems that, respondents do not regard it as a right but more as a "humanitarian provision of services", as many of them praised the Turkish government saying thank you to it or "God bless" . Furthermore, the respondents conveyed that they know about services from their relatives or neighbours. All four key informants also stated this. Some social media groups were mentioned that disseminate information, but there is no information package distributed to Syrians by the government or organisations. Key informants stated that NGO's mostly conducted such work.

Some don't know about transportation or which hospitals to go to. One interviewee didn't know whether the responsibility of finding a translator rested with her or the hospital. Syrian refugees mostly went to hospitals and not family health centres, or even migrant health centres (only one woman gone to Bab-I Şifa a migrant health centre in Ankara). Furthermore no one seems to have information about available psycho-social support services. Overall there doesn't seem to be a comprehensive information package regarding healthcare services in Ankara. A digital (apps, website) or non-digital (brochures) comprehensive information package could be developed in Arabic. Including health rights, which services they should benefit from (preventive care), how to make an appointment, health clinics and hospitals, perhaps important information on services such as family planning, transportation

networks, hospitals nearby, psycho-social support, even information on cultural and systemic differences could be noted and disseminated.

> *People are aware of free services through their relatives and friends, but not as like a right, but as a service, like if you get this id card you can go to the hospital for free. (Y.,31)*

The role of NGO's and civil society organizations is once more underlined as two key informants mention how information dissemination was conducted through organizations.

> *I worked for an organization and we used to inform people about things they can get and do with their temporary protection. (do people know about their rights?). No, they don't. Usually people know about things from people around them. But they know they can get free healthcare. But some don't know medication is for free, I know a family who pay for medication, they didn't know. (*W, 26)*

> *Refugees know. But not through the government, it's actually done through organisations. They had awareness stations and stuff. Or social media and groups. But before those they didn't know. The government doesn't tell you, you have the right to this this this. It's usually through other people. Like there was an organization …they worked really well and did a lot during the first years. I worked there as a volunteer too. But then it closed down. (*R,21)*

When it comes to lack of information many are still lacking information, as it has not been provided to them, on rights, where to access which services, transportation, how to navigate the system etc. As Lloyd argues that their local information landscapes have been disestablished, thus they have to adjust to and build new information landscapes in the context of health, and this takes time (2014, p. 48). This barrier is a cognitive barrier as it relates to knowledge and communication, and is a t system level, as the lack of information dissemination is systemic.

5.1.2.8. Female Doctor Preference

Regarding female male doctor preferences most of the respondents said “this is health, it doesn’t matter”, or ”as long as they are good doctors it doesn’t matter”. Men were asked if they would prefer a male doctor or if they would prefer their wives to be tended to by female doctors specifically. Only three women stated they’d prefer a female doctor, two women stated if they had to take their hijab off they would prefer a female doctor and one man stated he’d prefer a female doctor for his wife so she could be comfortable. Furthermore, two women stated they would prefer male doctors as they believed them to be more competent. Two key informants stated that sometimes women especially sought out female doctors.

> *If I don’t have to take my hijab off then I don’t mind. I went to the doctor about my period and it was a man, but I don’t mind. I mean it’s normal, it’s my health but if I have to take my hijab off I’d prefer a female doctor. 2 years ago, I had an operation in Gaziantep and the doctor who operated on me was a man and its ok for me it doesn’t matter. Its normal. (*W.,26)*

> *women sometimes ask a lot: can I choose my doctor. They want a female doctor sometimes, but they can’t find one because in that department there is only a male doctor especially in small hospitals. I personally would go to a male doctor. But some women go to hospitals that are far away just for a female doctor. And this takes time. (*M.,21)*

> *For female areas, like problems relating to womens health it should be female but for the other areas it doesn’t matter. (H.,33)*

Thus, female doctor preference did not come up as a major access barrier in the interviews. Although, as it was mentioned in the second chapter, female doctor preference was listed as an issue in previous studies i.e. Torun et al.’s study conducted in İstanbul (2017) and Yıldız’s study conducted in camps (2013), both studies elicited the dissatisfaction with health services of refugee women due to the unavailability of female healthcare providers. This barrier has been classified as a socio-cultural barrier.

5.1.2.9. Overuse of Public Hospitals

The interviews revealed that almost all respondents went to public hospitals instead of primary healthcare clinics. Although it was mentioned that they went to pharmacies as well by two key informants and one interviewee, as in Syria pharmacies also constituted places to receive healthcare.

> *In Syria we use pharmacies instead of doctors, for more than basic things, like if you have a fever or anything you go to the pharmacy. This is mostly due to the health coverage in Syria. In Turkey your insurance covers all but in Syria it doesn't. So, we use pharmacies. I phone my Syrian pharmacist friends when I get sick (Y.,31)*

> *My mum was a pharmacist. So, people in Syria go to pharmacists instead of doctors and they go to doctors for things that are more serious. Pharmacists can even know what goes around in the neighbourhood. Like this area has lack of this vitamin or something" (*R.,21)*

Furthermore, one of the key informants and one respondent mentioned that people consulted non-legalised Syrian doctors, nurses and clinics. Three interviewees and two key informants stated that they consulted their relatives who were doctors on the phone instead of going to hospital in Turkey, they said this was common in Syria as well.

> *I know a woman who is a nurse. She has migraines and she goes to someone who's not legalized. She gets injections from someone (*R.,21)*

> *I think we just prefer to talk to our known relatives or doctors that are known to us. This is something I think for Syrians. Even if our friends don't have doctor relatives they find a friend with doctor relatives. This is what we do instead of going to the hospital. (J.,20)*

Regarding migrant healthcare centres, only one respondent had gone to Bab-I Şifa the migrant health centre in Siteler. The respondents knew about the clinics but stated that they just went to the Turkish hospitals that were close to them. Three key

informants (one of them has a brother in law who works as a doctor there) mentioned how migrant health clinics were referring patients again to public hospitals or that they didn't have specialised services.

> *I went there (migrant health centre) but the Turkish hospital near me is better, they have better facilities. But if I want to explain more then I go to the clinic in Siteler by minibus. (H,36).*

> *I would prefer a Syrian doctor. I don't live in Siteler and I don't know many people in Siteler. But my sister in Antep always prefers the Syrian clinic there just because of the language because she can communicate with the people there. For me Siteler is too far so I wouldn't go, but if they were close to me, I would go to the Syrian clinic, because they would explain to me what's happening. But Turkish doctors don't explain." (*M.,21)*

Key informants touched upon how the migrant health centres offered limited services and thus people only opt for these centres if they have a minor ailment. For more serious issues they are mostly referred to other public hospitals.

> *Nowadays they prefer to go there (migrant health centre). Cause it's easier that way but most of the time they again send them to hospitals and refer them to hospitals for treatment. Or departments, if it's more serious. They especially refer people a lot because they don't have the authority to do so much. (*R.,21)*

> *They go there (migrant health centre) a lot now. But the clinic doesn't offer many services, they run tests or write prescriptions. They refer them to other hospitals. But the Syrians are happy that there is a clinic like that. It's just a small clinic my brother in law works there but it's for small things. They refer them usually. (*M.,24)*

When asked about family clinics, one key informant mentioned that some went there but were usually referred to hospitals. But went to these clinics for vaccinations with their vaccination cards. However, when respondents were asked, most of them went to hospitals and not clinics. Thus, the fact that Syrian refugees are not particularly opting for primary care or migrant health clinics is resulting in the overburdening of hospitals. This again constitutes an example of the

intersectional linkages between barriers. Again this was underlined in previous studies that were mentioned in preceding chapters (Torun et al., 2017; Assi et al., 2019; Akbulut et al., 2019).

5.1.2.10. Transportation

Transportation is classified as a structural barrier. The interviews revealed that expenses incurred, if any, seem to be from transportation (by taxi – 40-50 TL). It was reported to be an issue by two key informants and four interviewees. Either because they live far away from the hospital they need to go to, or they are not well acquainted with the transportation system or bus lines very well. In cases where the respondents' houses were far from hospitals they reported that they mostly opt for "taxis" that are essentially just cars owned by fellow Syrians who drive them for a cheaper price compared to regular taxis (Like a Syrian Uber). It usually costs 40-50 TL to go and come to hospitals by via these "taxis", among the interviewees five mentioned that they used these taxis to go to hospitals. They exclaimed that it takes a long time and is costly. The remaining interviewees, especially younger respondents, and respondents who lived near hospitals or had to go on a regular basis due to chronic illnesses relayed that transportation was not an issue and that they knew which buses or minibuses to take.

> *I went to Atatürk hospital for one month for my heart problem. And for the last three days I have been going there for my wife. We have to keep going and going this often is difficult when you are ill and its also expensive. I pay 40 TL to go by car by taxi. (K, 63)*

Two of the key informants mentioned that transportation was a major issue, as people did not know how to get around the city and that an app would prove to be useful.

> *To improve healthcare in Ankara I wouldn't say more translators, but I would say transportation. People need to know about transportation. This is a big issue. Ankara is a big city with 500 bus lines. Syria is not like this. Public transportation is not like this here. Actually, we wanted to develop something for Syrians like an app or a map with all the bus roots especially with a focus on buses to important places like hospitals. (R.,21)*

Transportation was mentioned as a challenge in the previous chapter as well, more in relation to indirect costs.

5.1.2.11. Paying for Medication

Two people mentioned that they had had to pay for medication (S out of choice, as her husband who was a diabetic didn't want to go each time for check-ups to get the report to get the medication, M regarding the nature of the medication and not being able to get it free coupled with the other medication she was buying). Furthermore, one key informant did mention that some Syrians did not know that they were entitled to free medication.

> *We have to go every 6 months. They give us a prescription for 3 boxes and each box lasts one and a half months. The pharmacy also knows. We go with a code, the pharmacist enters the code and gives us the medication. Just once I went to get 6 different medication but apparently there were two medications that you can't get for free at the same time so I had to pay but this just happened once (*M,21).*

5.1.2.12. Mental Healthcare

Mental healthcare was one of the trickiest subjects to touch upon. Especially with translators, the question had to be asked in at least two different ways. Most people gave very short answers and simply would say "no, I don't need it". However, younger respondent, namely students, were more open about mental healthcare and provided key insights into the stigma surrounding mental healthcare in Syria. 18

people stated they did not want or need psychological support, even ones who had lived through traumatic experiences said they didn't need it.

> *We don't need it…when we were fleeing Syria we came over dead bodies and through bombs. But Turkey opened its doors and we are safe. Praise be to Allah. (Ş.,35)*

> *I've never been. I don't need to go. (do you think people need to go?). It depends on the person for example there is nothing wrong with me, so I don't need to go. (W,67)*

The four key informants and four students who were interviewed shed some light on this issue and all of them relayed that psychological issues were a kind of taboo subject in Syria. They stated that mental illnesses were not considered illnesses in Syria, people would think you are "crazy" if you went to a psychologist. They said that it was cultural, and that people avoided defining these issues. One interviewee mentioned that her cousin had autism, but her family refused to even acknowledge it.

> *Even people who study psychology are not respected much. Bias towards psychology for instance if you get high points people don't want you to study psychology. I got high points and wanted to study psychology but people were like no don't do it. I know services are available in Ankara. There are psychiatrists in hospitals and other programs but people either don't know or don't want to go. (*R.,21)*

> *The perception towards mental health is very different in my country. If you seek psychological support then you are crazy. Or if you study psychology major then you are crazy. (N,24)*

Only four people, three were students, said they would like to receive psycho-social support. The student who wanted psychological support said she couldn't in Turkey due to the language (even though she speaks Turkish very well she wants someone who speaks her mother tongue for this issue) and perhaps not being able to find a good psychologist who speaks Arabic. When asked if she would seek psychological support if she were in Jordan, she said yes. She mentioned how NGOs were

providing this kind of support and how some had been shut down by the government. On her own personal note one issue she mentioned was the uncertainty in Turkey and how it affected how she felt, as Mardin had also pointed out the "strain that chronic uncertainty places on refugees' mental health" (2019, p.20). Uncertainty and liminality are truly affecting the mental health of Syrian refugees.

> *I didn't want this support when I first came but now its been 3-4 years…I don't know what my future is here… I want psychological support, my Turkish is good but for this I want an Arab doctor. I don't want another language. I used to work for an organisation in case management. They would help some families with special cases, if the father is dead or if they are very poor. Then they provide translators to go and help them at hospital. But then they closed it down. The organization was working under … but the government didn't give it permission to operate in Ankara. (*W.,26)*

> *The thing about at least myself…maybe this is why I need to see someone. I don't feel like I miss my country, I don't feel like I miss my family… I would like to go there for sure, I'd like to see my mum again, my room again like the red wall that I painted because I wanted a red wall in my sleeping room. I always tell my mum keep my things, don't disturb them, leave them the way I put them. I don't have the feelings that I want to come back to Syria. I'm not happy about these feelings. (Y.,31)*

Two key informants mentioned that some didn't know about such services. One in particular was quite knowledgeable about the situation, as her friend worked for a centre in Ankara offering psycho-social support specifically to refugees. She said that she knew of two such centres in Ankara and that people were going to these centres. She stated that her friend told her that people were changing, and their attitudes were changing towards psychological issues.

> *I asked my friend if people were coming and my friend told me that people have changed and they have changed their attitudes. Like they even come and say I think I might be going into depression. We Syrians, we don't talk about these things, we don't speak about it at all, if something is wrong even we don't say. But now people are talking about it here. People tell me, as I am studying psychological counselling that they will need me to work there. There are other centres too. (*M,21)*

As it can be seen there are multiple issues surrounding access to mental healthcare. For some it is about lack of knowledge on where to go, for some the lack of Arabic speaking psychologists but for most it is social stigma, or it is not perceived as a need. Thus, this barrier is both a cognitive and a socio-cultural barrier.

5.1.2.13. The Informal Labour Market

One interesting outcome of the in-depth interviews was how two key informants touched upon how lack of child care or the informal labour market impacted access as well. One key informant stated that for women with children it's harder to access healthcare, as they can't find the time to go and said that the woman is dependent on her children and on her husband who is in turn dependent on his job thus everything is connected. Respondents stated that men have to work under unfavourable conditions and are mostly only home one day and they do not use this day to go to hospital.

> *My aunts' husband, something happened to his knee, but he didn't get an appointment for a month and a half because of his job, but it got worse and then he needed an operation but maybe if he'd gotten the appointment before he could've gone to the doctor earlier and it wouldn't have gotten so bad. So, everything is connected. (*M,21).*

> *It's hard for people who are working to take time off, there was a woman who went to hospital but she wanted her husband with her to come, as she wanted him to accompany her but he couldn't get time off work to go with her. (*R.,21)*

Such challenges have been classified under socio-cultural and economic barriers.

5.1.3 Key Informant Remarks

The four key informants provided most of the information on the issue of reasons why refugees did not want to go to hospital:

- W and R said that there were many departments and specializations here in Turkey and people didn't know where to go.
- R expressed that transportation expenses was also an issue.
- Not being able to understand, language and translator problems were mentioned by all 4 key informants.
- 3 key informants mentioned that the lack of explanation on behalf of doctors constituted another reason as to why people didn't want to go to hospital (1 interviewee confirmed this).
- M and M stated that the way local patients treated Syrian patients could also affect people not wanting to go.
- M also noted that people couldn't find time to go, women because they are looking after children and men because they don't get time off work. She gave an example of her aunts husband. She stated that "The woman is dependent on her children and on her husband, he is dependent on his job, everything is connected". R mentioned that some women wanted their husbands to come beside them from work, because they didn't want to be alone.
- Two of them expressed that sometimes women wanted to go to female doctors. They look for a female doctor. It takes time.
- M mentioned lengthy procedures and waiting times and gave his mum as an example who said she'd rather die than go to hospital again, after waiting for an hour in the emergency room. 2 other key informants mentioned waiting times and procedures but not in this context, but 2 interviewees mentioned it in this context.

5.2. Ethnographic Vignettes

This section shall reveal four vignettes from the fieldwork. As it was mentioned in the previous chapter, the first visit was arranged by one of my translator friends,

where I accompanied them to the hospital. The other four visits were arranged through the Facebook group that was mentioned and I volunteered to be the patient guide. It was announced on the Facebook group helping refugees in Ankara, that a woman needed someone to accompany her to a hospital and to translate for her. As mentioned previously the group consists of volunteers who go and visit districts in Ankara that are rife with refugees. There are many Syrians and other Arabic speakers who volunteer, so with each visit the volunteers get to know the families and refugees and get their contact information (address and phone number). Then they help them with education (enrolling their children in schools, school supplies), health, paying bills, moving house, donations etc. The refugees text or call volunteers when they need something, and translators to accompany them to hospitals is a service they require on a regular basis.

5.2.1 "Jankal"

This vignette presents an encounter with three Syrian women H (33), F (30) and A (58), and H's two children in a hospital in Ankara. The women went to get their eyes checked. Their appointments had been made two weeks in advance by a Syrian translator/patient guide. This participant observation revealed various structural and socio-cultural and economic barriers. how some staff are still not au fait with the digital registration system or appointment system, how doctors were pleasant, how refugees prefer to bring their own translators instead of relying on the hospital for a translator, how transportation is an issue.

I met with my friend R (she's a student but volunteers for Syrians as a translator) who introduced me to H (33) and F (30). The women had come by "taxi" i.e. a Syrian uber, as they did not know how to get to the hospital, and it had costed them 50 TL. We went into the hospital and had no idea where to go and so the asking process began…R asks at the desk and we proceed "right then another right". We

arrived at the appointment desks, R went up to the free desk and asked about her appointment she had made for the Syrian women. The lady at the desk said she didn't know the system for Syrians and said we had to wait for her co-worker. I asked R: "how come they (Syrians) call you instead of the hospital translator?" she said: "Well usually there are only 1 or 2 at each hospital but they are busy mostly or people don't like them, so they call people they know to come with them and translate… we have Facebook or WhatsApp groups and stuff where people ask if anyone is available to translate. But usually they prefer to ask us and bring their own translators".

We waited for about 20 minutes. The appointments were for 14:30, 14:40 and 14:50. I asked R how people managed. She said "in big hospitals usually they know the process and procedure but in smaller ones the staff don't always know what to do when Syrian patients come.". I was looking around to see how people were looking at these 3 women in black burkas (you could only see F's eyes) speaking Arabic but no one seemed to even care. Then the same lady who asked us to wait called R to the desk over but the appointment time had passed. The lady opened the system to bring up their appointment details, but couldn't find F's appointment and said that the other two women could go ahead but F couldn't go through, saying "she can come another day she's not in the system.". R asked me to call 182 to inquire after F's appointment. I gave F's details to the operator and she told me that there was an appointment for 14:40 at X hospital. I went to the lady and said she has an appointment I'm on the phone with 182 could you please check again she said "no I don't see one on my screen, look it's blank" . I asked the operator if there was an appointment number or anything written that she could send us, but she said there wasn't and we could phone the ministry of health about it. R didn't have a message or email or anything about the appointment either. It was now 14:50 all their appointments had passed. R went to the lady at the next desk who asked her colleague to give her all the papers. This lady said "F, yes she has an appointment, its right here.". The lady who hadn't been able to bring it up on her screen was

shocked and started saying “it wouldn’t come up, how did you find it?” to which her colleague responded “it’s right here.”. The other lady offered no apology even though the 3 women had now been waiting for almost an hour.

The women didn’t understand what was going on and they were at the sitting area while we were at the desk so as not to crowd the desk. The two kids were hanging form the chairs playing. Finally, when we got all the stickers, we went to the eye check room. The two people in the eye check room were pleasant as they welcomed the three women in with their smiles. H and F went in first, then A came and the lady in the eye check room said “welcome aunty come come” and laughed together as A placed her face to the device used for an eye examination. We came to the doctor’s room but the numbers on the screen were way ahead of ours so I went in to the doctors room and said “Hi I’m sorry but there are 3 women here we were held up at the desk.” The doctor smiled and said “that’s ok all three are with me, no problem at all, I will bring their numbers up next. No problem.”. She brought up F’s number first. R and F went in. A and H were sitting chatting. F and R came out and R said “the doctor is really nice.”. Then H went in, followed by A.

A was called into the doctor’s room again and I sat and tried to chat with F and H, they laughed and said we could practice Arabic and I could talk to them. It was a pleasant 5 minutes just sitting in a waiting room. Talking with big hand gestures and a few words from Turkish and Arabic. I tried to talk to the kids Said (H’s son 9 years old) and Salim (F’s son 6 years old). A came out and the verdict was that she needed glasses. We left X hospital and they thanked R a lot. As we were crossing the road I had my hand on R’s shoulder, she then said let’s do “jankal” you know “jankal”? and she took my arm. I realised the word was just like the Turkish word “changal” which means clasp. So many small warm similarities. So, we jankalled and left.

5.2.2. Back and Forth

I accompanied W (a 54-year-old Syrian woman who lives alone) to hospital, since it was just for an MRI and I wouldn't need to translate much but just accompany her. This trip to the hospital revealed: how some staff are still not au fait with the digital registration system, how referrals across hospitals are not in place, even if someone has an appointment there is a lot that may go wrong, the crowdedness of hospitals and long waiting lines, the difficulties locals also face when they come to hospitals, difficulties with transportation if you do not know where you are going, how refugees prefer to bring their own translators instead of relying on the hospital for a translator, the long procedures of hospitals, the not so hands on approach of doctors examining a patient.

I had to see how to get there, plus I said that I'd pick her up, as she didn't speak any Turkish and didn't know how to get to the hospital. I looked up online and it seemed fairly straightforward. I went to Ulus to get a bus to her house, but the bus didn't come, when it finally arrived, to my surprise and dismay the bus driver said that it didn't go to Önder. I got off, the time of W's MRI was approaching, so I just got in a taxi picked W up and went to the hospital, at an agreed price of 70 TL with the taxi. It took one and a half hours to arrive at the hospital. W had been referred to Y Hospital from Z Hospital for an MRI. We'd arrived an hour early for her MRI appointment. The hospital was huge and was overflowing with patients. Lots of old people, young people, women with children... people running around saying "where do we go, what do we need". When we got to the information desk, they referred us downstairs to the MRI area, again with lots of people and long lines. The woman at the desk said the MRI form from Ankara university was no good here. Even though the referral paper (an official document) had been stamped and signed by the doctor at Ankara university. She told us to go upstairs and get an appointment. I asked W to sit down by the window and that I would go and ask what the problem was. I went up to the registration and appointment desk, waited for a while. There was a

woman carrying a young child accompanied by a girl who looked about 15 who was speaking to the woman at the desk in Turkish. The girl put their papers down, now I could see they were Syrian. The girl was asking where to go, but the woman at the desk was telling her they needed to be registered in the hospital system. Another example of people not using a translator. I thought it must be so much easier to have someone you know with you.

My turn came I handed the paper to the man at the desk along with W's papers and tried to explain what had happened and that we had an appointment for 3 o'clock that Ankara hospital had set up for W. He told me to go to the neurology policlinic. I went there and waited for the woman at the neurology desk and she was talking to two other people who had the exact same referral paper from Z hospital as I did. She told them, the paper had no validity here. But the two women were frustrated and exclaimed, "This is an official document from our doctor, we even have the appointment, how is this possible!" to which the woman replied, "we can't accept this, you need to be examined by a doctor here first to get an MRI done". The woman was adamant and said "This is ridiculous. We've been here for 2 hours now! We came a long way to bring my mother here just for this MRI". The women went back to the reception desk, so I followed them there as well. I gave the same man the documents, he started doing something on the computer. The man at the desk turned to me "there is an appointment but its overlapping with another appointment" and he sent me back to neurology again. The woman phoned the guy at the desk and then told me that he was going to register W. I thanked her and went back to the front desk. It was a marathon of back and forth. This time there was a woman who came with a piece of paper and said "bu, bu istiyor (this, want this)", she was also foreign. The woman at the desk said "ah you want a translator. Go up" and she pointed to the stairs, and then pointed up.

The man at the desk was looking at W's ID and then he phoned someone, and began to say "How do I register a Syrian, which part do I have to fill in?" He was asking on the phone how to register W. He followed the instructions and the registration was complete. Finally, I went down to get W she was just sitting by the window. I apologised and tried to tell her what happened upstairs, I asked her if she was ok waiting. She smiled and said "it's OK, I've waited a lot in hospitals" . We then went back to neurology and the woman told us we could go straight in. The doctor was nice, she asked me if I was the translator. I nodded and told her what was wrong to the best of my knowledge then she asked me to ask W where hurt, if she felt nauseous when she had a headache, she asked me to tell her to walk and then asked me to ask her if she was pregnant. It took 2 minutes… The doctor didn't get up just sat and asked 4 simple questions. Then she wrote a request for an MRI… I was shocked we had spent 1 hour in this hospital and they wouldn't recognise the referral paper from Ankara hospital where she had already been examined by a doctor. She had also given tests at y hospital and had been referred to x hospital for an MRI (with an appointment). But none of this mattered. 1 hour for 4 questions… The doctor said "geçmiş olsun" (get well soon) and we went down back to the MRI area again and this time there was a long line.

I asked W to sit down while I waited in line. I waited for about half an hour in line. I was watching people, an old man came and he had entered the hospital form the wrong place, he wasn't supposed to make an entry form the emergency room but from the main hospital area now because of this he had to go back and register from there. Then another came, people were coming with things missing or not knowing, just exactly as we had come without knowing, and the people at the desk were just referring them or telling them to bring this and that… It was our turn, I handed the woman the MRI request paper this time from the neurologist at Y hospital. She said "OK come on the 22nd at 16:30". I went to W and explained that we would come again in 13 days. It was now half 4, we'd spent 2 hours in the hospital just to get another appointment for a later date.

As we were leaving the hospital, I asked her about how it was in Syria and she said "these things are like this everywhere, it's more organised here, but there are lots of people here.". We started chatting again and she started showing me her grandchildren. I asked her if she was thirsty or hungry, she said she was fine and then brought out two little chocolate cakes from her bag and gave me one, then she offered me some water. She said she'd been in Turkey for 3 years and had been to hospital about 5 or 6 times. She said "not difficult, but tiring.". I asked her if anything bad had ever happened she said "no, no its good, it just takes long" and then told me the problems she was having with her head and her back.

Back and forth for the second time

Going the second time round was a lot easier, partially due to it being Sunday. This time we knew where to meet. We met at Ulus, W got off at her minibus stop and I met her there. We asked the minibus drivers which minibus to take to get to Y Hospital. This time transportation from Ulus took a mere 20 minutes and from Önder to Ulus it took W about half an hour, so the trip was now 50 minutes and not at all arduous. Since it was a Sunday, it was like a totally different place from last time, as there were very few people. We went straight downstairs to the MRI area. We went through, a young doctor smilingly greeted us and was very nice to W, he just told me to tell her that the machine would be loud and that there was nothing to be afraid of. W smiled and said "its ok I'm not scared.". Then he asked if she had anything metal on her. She went in the MRI and gave me her stuff, she took off her hijab, and some bobby pins out of her hair. I sat outside with her stuff and an old lady (74) came in and sat beside me, she was talking about how she always came to hospital and how it was like her second home because she was so ill. She said "some people don't know how to behave in hospitals but you have to be nice to each other. So, you can benefit from the care and so you make peoples life easier in the hospital. Some people are so rude.". W was out shortly, we were told the results

would be out on the 31st. This time everything was fairly easy as it was just an MRI, and we knew how to get to the hospital. It was a much easier ordeal.

5.2.3. Crash Boom

The following vignette reveals how some staff are still not au fait with the digital system and how one mishap can cause a lot of problems, translators are very busy at hospitals and their numbers are not enough, or appointment system, the crowdedness of hospitals and long waiting lines, the psychological issues that refugees have, the difficulties locals also face when they come to hospitals, difficulties navigating the hospitals, the difficulty of going to hospital alone and the importance of social networks

We made an appointment for W by phoning 182 for Thursday at Z hospital after we got her MRI result from Y Hospital. The problem with 182 is that you need to speak Turkish to be able to use it. So, refugees can't phone and make an appointment for themselves unless they can speak Turkish. We met at Z hospital Policlinic this time. She'd been here twice before so she knew exactly how to get there. She was in the translator's office when I got there. The translators office was on the ground floor, the translators room was easy to find and it had a sign above in Turkish and English but not Arabic. I met the translator he had three other patients waiting. He was very busy and I only saw him for a minute he just told us where to get W's blood test results.

The hospital was extremely crowded. The lines were very long and no one knew which line to stand in. We tried to figure out which queue it was. There were just masses of people in two discombobulated queues. Above one desk hung a sign that read "blood giving" and above the other it said "patient registration". People kept changing lines and telling others to stop cutting lines. Some people went up to the patient registration desk to ask questions which agitated other people in line.

Finally, we asked the lab section and she directed us to the blood giving line, but without asking, it was impossible to know where to go. It was our turn after half an hour, we gave W's ID card and got the results printed in about 5 seconds.

Since we had an appointment with the doctor, we were in straight away. The doctor was very nice, she smiled and said hello. We gave the results, and she gave them to the doctor sitting in front of the computer. The doctor opened up W's MRI results and the doctor asked a few questions, asked to see her medication, looked at her test results and the MRI result on the computer and said there was nothing wrong. She told us to go to physio therapy for W's back and neck and gave us a number and said go upstairs. "Her head is fine, she has high blood pressure so its normal for her head to hurt but for the chronic pain in her back and neck she needs to go to see the doctor in physio. She looked at W and me when she was talking so not just me because I was translating.

This was the 4th time for W in the hospital and still nothing. We were out of the doctors room when it was coming up to ten. We went upstairs and there were loads of people in front of physio. Little did we know that we would wait here for two and a half hours… I was trying to chat to W. I asked her what time she woke up this morning she said she got up at 5 in the morning and had gone to bed at 1. I asked why she said "I sleep very little since I came to Turkey". When I asked how long it had been, she said she'd come to Turkey in 2015. She said "the bombs I was very scared. I would sleep and Boom! Boom! Boom! Very scared…" I asked her if she was ok now, if she was scared… "I'm ok now. I don't sleep much anyway in Syria I used to sleep 5 hours. I raised 10 children" she said and laughed. I asked her how she came to Turkey. "I came to Afrin and I walked with my son… we walked over mountains… we walked a lot maybe 4 hours over mountains. It's hard, so hard…". We talked about her family. She opened her bag in which she carries every single document she's ever been given, she had photocopies of her kids' passports, her own passport, her bills… We'd been waiting quite some time, then an old man got

up and said enough and ripped his ticket and left the hospital. Others were tutting as to what was taking so long. It had now been an hour…An elderly woman next to me said "people are coming to the hospital for no reason and just crowding the place for no reason at all!". People were going in and out of the doctors room demanding an explanation, and coming out again. Another hour passed, kids were crying on the floor… more people gathered round the doctors room and the doctor finally came out and said "Stop! Enough! I'm human too. I'm doing my best. If anyone of you thinks they can do my job better than me, then go in and sit in my chair go ahead! You do it then! My computer is broken the system has crashed I can't fix it!". She looked very distressed. Some people sat down some just left. It had now been 2 hours… I translated in my broken Arabic what the doctor said, W raised her eyebrows and said "Let's come another day". We phoned 182 and made another appointment for the next day. The doctor was very distressed and there were lots of people that day. W said "hospitals everywhere are difficult, but here it's very crowded, you wait a lot, waiting, waiting a lot.".

In the hospital I saw 2 Afghanis a mother and son I think; 2 women presumably from an African country and their kids; 2 Syrian women and their kids. It seems people come together I recalled what H had said at X hospital "it's easier and something might go wrong so it's good to have someone". W had no one.

This trip to the hospital revealed: how some staff are still not au fait with the digital system and how one mishap can cause a lot of problems, translators are very busy at hospitals and their numbers are not enough, or appointment system, the crowdedness of hospitals and long waiting lines, the psychological issues that refugees have, the difficulties locals also face when they come to hospitals, difficulties navigating the hospitals, the difficulty of going to hospital alone and the importance of social networks .

5.2.4. A Not So Happy Eid

Alongside the not so hands on approach of doctors examining a patient, crowdedness and long waiting lines, this trip to the hospital revealed; how there are not enough translators, how translators struggle too, how refugees are afraid to go to hospital if they are not registered, how the informal labour market feeds into this issue, the impatience of doctors with non-Turkish speaking patients.

On the first day of Eid (21st of August) W vomited blood at 5 in the morning and went to the emergency room herself to D hospital. There was no one there to translate for her, since it was so early in the morning and it was Eid (a holiday). She sent messages to us with pictures she took of the forms they gave her. They gave her serum and apparently she was ok. R who volunteers to translate for refugees at hospitals took her to hospital. They arrived at the hospital at 08:30 but since they didn't have an appointment and had been referred, they had to wait a very long time. The ticket they got was number 32 and also said afternoon on it. I joined them in the afternoon, the hospital is huge, there are several blocks and again it was extremely busy, like most Turkish public hospitals.

We went to the gastrology department, there were a lot of people waiting to see the doctor. People who were over 65 were given priority so it took a very long time. People were waiting old and young, some with their kids, some on their own. While we were waiting a Syrian couple came and looked at the doctors door then they went away and came back with the hospital translator. He turned out to be R's friend, he was also Syrian. He said "it's so crowded today after Eid, I've tended to 35 patients today". I asked him: "How does it work?" He said: "Well they come and we give them a number and see where they have an appointment, or if they don't have one we make one. Then we tell them where to go and when it's their turn we go into the room with them.". When asked how many translators there were he said there were five but only three were active. He said he spoke English too so he also

tended to Russian, Somalian and other foreign patients too. He relayed that they worked full time very day of the week from 8:30 until 17:00. He smiled and said “it takes a lot of patience. Sometimes you tell people where to go but they go and just come straight back to you asking where to go again. It’s a tough job.”. I asked him “how many patients do you tend to in a day, like 35?”. He said that it wasn’t as much and was much less on other days. Then he got a call and he had to go to see a patient.

We continued to wait. W was tired since she’d been in the hospital since 08:30. Then I saw another translator with another couple, she was explaining something to them in Arabic and then she directed them somewhere and went. R told W “the people without doctors or nurses uniforms, but with a badge are translators”. It was now three o clock. People were getting restless and getting up to go into the doctors room to see what was taking so long. Finally, there were fewer and fewer people left. Again, I looked to see if anyone was looking at us since we were speaking a combination of Arabic and English but no one seemed to even care. The doctor finally called us in, the Syrian couple also went in and the translator came with them. There were 2 doctors, the Syrian couple went into the other room with the translator. We came in and the doctor asked the person beside him “are there no more Turkish patients?”, to which he said “no, they are the last ones.”. I asked “why does it make a difference?”. The doctor said “yes, I take Turkish people first, Syrians come without a translator I can’t be bothered with that, they come here, and they know nothing. They just sit across from me staring at me and I stare at them.”. I said “can you phone the hospital translator to come?”. He snapped and said “I can’t deal with that, it’s not up to me they should sort themselves out, am I gonna do that for them too! They should bring one or get one themselves. Let’s say I went to hospital in Germany what’s the doctor gonna do with me! I don’t speak German!”. I didn’t want to argue with him since he was going to examine W. I simply said “Well this woman does have a translator and has been waiting for a long time.”. He started asking about W, she had a rash on her neck and R asked about it, we thought

it might have something to do with the vomiting blood. The doctor said “that’s not my area, for that go to dermatology.”. He was very snappy and short with us. He asked how many times she’d vomited, how much she’d vomited and then asked whether they’d given her any medication for her stomach when she came on the 21st, whether she had taken any blood thinners. R translated and answered. Then he said “right go get an appointment for an endoscopy downstairs and then come back with the results, also go and give blood for these tests”. That was it. And gave a brochure with a list of foods on it. Again, W had waited 6 hours for 5 minutes of the doctors time, with no result. We left the doctors office, R took W to give blood and I went down stairs to make an appointment for the endoscopy which they gave for 2 days later. Then I went to join R and W who had now moved to a different block to give blood. If you don’t know the hospital it must be very difficult to navigate between departments and blocks especially if the signs in Turkish mean nothing to you. Again, people were running around with papers not knowing where to go. R got the stickers and we went to the area to give blood. They had 10 separate cubicles and 4 were open, there wasn’t a long queue, but people had come without getting their stickers, so the nurses were directing them to the front desk to get the stickers. The desk was near the entrance and it did say “blood tests” above the desk, but still people were coming directly to the area where they were taking blood. The nurses were very nice, they took W’s blood and that was it. We left the hospital, I asked are you tired? She said “yes very much, in hospitals you are always waiting waiting waiting.”.

After leaving W, R and I continued on, we went to a restaurant to grab some lunch. As we were eating and talking she mentioned that a Syrian guy she knew worked here and had dislocated his shoulder but would not go to hospital because he was not registered and was afraid that he would be sent out of Ankara. He had come here to find employment and couldn’t find it in a small city, so he went on working with a dislocated shoulder.

5.2.5. What the Ethnographic Fieldwork Revealed

The ethnographic work confirmed many of the challenges that were mentioned including the crowdedness, language barrier, long waiting times, referrals and transportation, doctors not being very hands on regarding examining patients, the test-based nature of examinations, transportation etc. However, it proved to reveal more: the importance of social networks, the way not being able to navigate the system renders the patient more passive, the struggles with digital systems, the gaps that civil society is filling, and how registration and employment impacted healthcare seeking behaviour.

5.2.5.1. Employment and Registration

Recalling Malkki's statement of how narratives emerge in countless circumstances during walks, or on the way (1995), the story that R told when we went to a restaurant about a Syrian waiter with a dislocated shoulder reveals another challenge. As he would not go to hospital because he was not registered and was afraid that he would be sent out of Ankara. He had come here to find employment and couldn't find it in a small city, so he went on working with a dislocated shoulder. This barrier is associated with socio-economic barriers at system level. This issue was also mentioned by Mardin as she stated that healthcare providers should not be gatekeepers when it comes to registration in a province, and as Cloeters and Osseiran pointed out how the informal labour market impacts health care access stated:

> The barriers associated with formal employment impact refugees' access to their labour rights, especially concerning work-related injuries and sick leave… refugees' integration into the informal labour market influences their access to health services. Refugees may delay seeking medical treatment for conditions because they fear losing their job if they take time off. (2019, p.18).

5.1.5.2. Translators

The interviews and the literature had already revealed that there are not enough translators. Key informants had stated that people seemed to be more comfortable with people they know because they are not sure what they will encounter at the hospital. This was the case in the hospital visits as well. Neither of the women I went with opted for a translator and from the people I encountered at the hospital most had brought people they know to accompany them. Furthermore, it was evident that a translator is not solely needed in the doctor's office but also at desks as well and also when making an appointment.

5.1.5.3. Treatment

People seem to be used to Syrians. No one looked or stared or said anything at this hospital. The doctors were nice more or less and so were the staff. There was no blatant mistreatment, people seemed to be used to foreign people in the hospital. No one was even glancing at the Syrian women donned in black attire. The staff were sometimes short with people in general, it was not specific to refugees, but they were short with locals as well. As it was mentioned in the literature and in interviews, the staff seem to have a tough day with the sheer number of patients that they had to tend to on a daily basis. However, it must be reiterated that these visits were conducted in Ankara, a city that is not densely populated with refugees. As it was mentioned in preceding chapters, the literature presents cases of mistreatment especially in border cities such as Gaziantep, Şanlıurfa and Hatay, where services are catering to numbers well-over their absorption capacities.

5.1.5.4. The Importance of Social Networks

Another thing that struck me was social networks, the three women at X hospital were more content together but W was on her own and had no support. Other refugees I saw in the hospital all had come with someone.

> *We go together, it's good to have someone to accompany you. Like even if we know the language, maybe something might happen or come up or bad news or something. (H,33)*

Bilecen and Yurtseven also underline this as "in addition to formal state rules and regulations, informal structures such as personal networks composed of kin and non-kin ties proved to play a crucial role in asylum-seekers' and refugees' access and use of healthcare services in the countries of residence. These informal structures might ease the access procedures as well as act as safety nets through the provision of social support" (2018, p.122).

5.1.5.5. Transportation

What I realised was that transportation is a major issue, if people don't know how to get to healthcare facilities, access becomes problematic. The ethnographic work attested to the issue that was mentioned in the interviews. The Syrian women from Keçiören had directly taken a "taxi" as they were not acquainted with the transportation system. With W we ended up having to take a taxi as we did know how to go either. But if one has been once or twice then it becomes easier, as it is just a matter of knowing which bus or minibus to take. In the literature the barrier of transportation was more related to cost, whereas here transportation constitutes a barrier dude to not knowing how to navigate the transportation system, as the key informants had previously. Thus, transportation can prove to be a salient structural barrier.

5.1.5.6. Referrals

The hospital visits with W demonstrated that referral systems were not in place. As the referral for the MRI from one hospital was not recognised by the other hospital even though both were public hospitals. We had to go through the process all over again just so W could be examined (asked 4 questions) by a doctor at Y hospital. And in the end, another MRI appointment for a different date was given. The second referral that was from neurology to physio also involved a two and a half hour wait and we didn't even see the doctor just got a new appointment. And the referral R got in D hospital cost R and W 6 hours of their time. This is a systemic barrier which was also mentioned in the interviews.

5.1.5.7. Digitalization

Hospital staff did not seem to be managing digital systems very well. At Y hospital the man at the desk didn't seem to even know how to register W. Again at X hospital eye hospital the woman couldn't find F's appointment. So even some of the staff aren't au fait with the system. Furthermore, at D hospital the system crashed in the doctors office and caused severe delays and distress to her and the patients. So even some of the staff aren't au fait with the system. The system seems to be a bit confusing for people (perhaps because they aren't used to it) and if the system doesn't work then things become very difficult especially if you don't speak the language. The staff or locals don't seem to be very well acquainted with the system either. It's also difficult for Syrians because they are used to a very different health care system which is not digitalised. Thus, this poses another systemic barrier.

5.1.5.8. Civil Society Filling the Gaps

Another issue was one that came up in the literature several times, how NGO's and civil society were filling gaps. The example here is the Facebook group that

provides a lot of support with accompanying patients to hospitals to translate for them. Many refugees resort to this group, as either they are not content with the translation services, or do not want to go alone.

5.1.5.9. Navigating the Healthcare System and Limited Agency

What became most evident for me through the ethnographic work was that Lloyd's assertion of various health access barriers, "impact on refugees' ability to connect with and navigate the complex and challenging health information environment. In particular, they limit refugees' ability to understand the structural and operational aspects of the health system, limiting the potential for agency in decision-making and self-management of health" (2014, p.48) rang quite true. Indeed, in most cases I was trying to navigate while W was with me, as it would have been very complicated and unnecessarily tiring for her. Furthermore, as it can be seen challenges are not only refugee specific as long waiting lines, crowdedness, digitalization pose challenges for locals as well. However, it is the "newness" that compounds these issues and renders access more difficult (Norredam & Krasnik, 2011; Lloyd, 2014).

5.1.5.10. The Focus on Syrian Refugees

Another issue that was striking to me was how other persons under international protection such as Afghans or Palestinians were navigating the health care system, as I encountered others in the hospitals. There is a lot of research conducted on Syrian refugees due to the imminent refugee crisis. However perhaps, refugees from other countries are slipping through the cracks. Thus, this is an area that requires more research perhaps.

CHAPTER 6

DISCUSSION AND CONCLUSION

The previous chapters have provided a literature review from previous studies conducted on refugee access to healthcare in Turkey and have underlined the various challenges they are faced with. The fieldwork presented has also voiced the experiences of refugees living in Ankara regarding their access to healthcare. This chapter shall attempt to thread the preceding chapters together, firstly it will classify the access barriers from the literature and from the field to be able to identify intervention points. Then the chapter will present suggestions from the literature and from the fieldwork and will finally mention further areas of study.

6.1. Classification of Access Barriers

As it was mentioned in the second chapter, deriving from the three models presented by Scheppers et al. (2006), Carillo et al. (2011) and Norredam and Krasnik (2011) the below table has been devised by compiling the barriers into cognitive barriers, socio-cultural and economic barriers, and finally structural barriers. Furthermore, identifying at which level the challenges are experienced paves the way to help identify areas of intervention to improve access. As Norredam and Krasnik assert at various levels of the health system refugee access is impacted differently and to improve access, "entitlements, health policies, structure and organization of services, and the characteristics of the clinical encounter between health professionals and migrants" need to be addressed (2011,p.72).

Cognitive barriers are those that refer to more perceptual, linguistic and non-tangible barriers such as language, doctor-patient communication, discrimination

disparate health cultures etc.; socio-cultural and economic barriers encompass hindrances stemming from cultural practices, social networks or lack thereof and financial or employment related issues such as the lack of female doctors, the cost of transportation, lack of social networks etc.; finally structural barriers include barriers that pertain to the healthcare system, hospital environment and existing services such as waiting times, navigating the healthcare system, lack of translation services, registration related issues.

The barriers shall also be grouped into levels; patient, provider and system, as they were in the study of Scheppers et al.. Barriers at patient level barriers were noted as those that are related to the five abilities that Levesque et al. outlined. The ability to perceive relates to health literacy, health beliefs and trust. The ability to engage pertains to empowerment and information. The ability to reach and ability to seek concern transportation, social support, mobility and personal values. Thus, patient level barriers were listed as newness, the language barrier, transportation, lack of social networks, stigma against mental healthcare and such. Barriers at provider level and system level, pertain more or less to the five dimensions of accessibility that Levesque outlined. Barriers at provider level relate to accessibility which entails professional values, culture and gender. Availability and accommodation relate to provider and system levels, as translation services are a means of accommodating a need at provider level, whereas lack of available mental healthcare services is a barrier at system level. Appropriateness corresponds to provider level, since it covers technical and interpersonal quality that affects doctor patient relations; adequacy that relates to lack of training for practitioners. However, this can also be taken as a systemic barrier since training staff is a problem to be tackled at system level. Figure 1 demonstrates how each access barrier fits in to the framework.

As Norredam and Krasnik have stated “access will often be affected by a complex interaction between all these factors” (2011, p.71). As it is evident from the classification there are several intersections and overlaps among barriers.

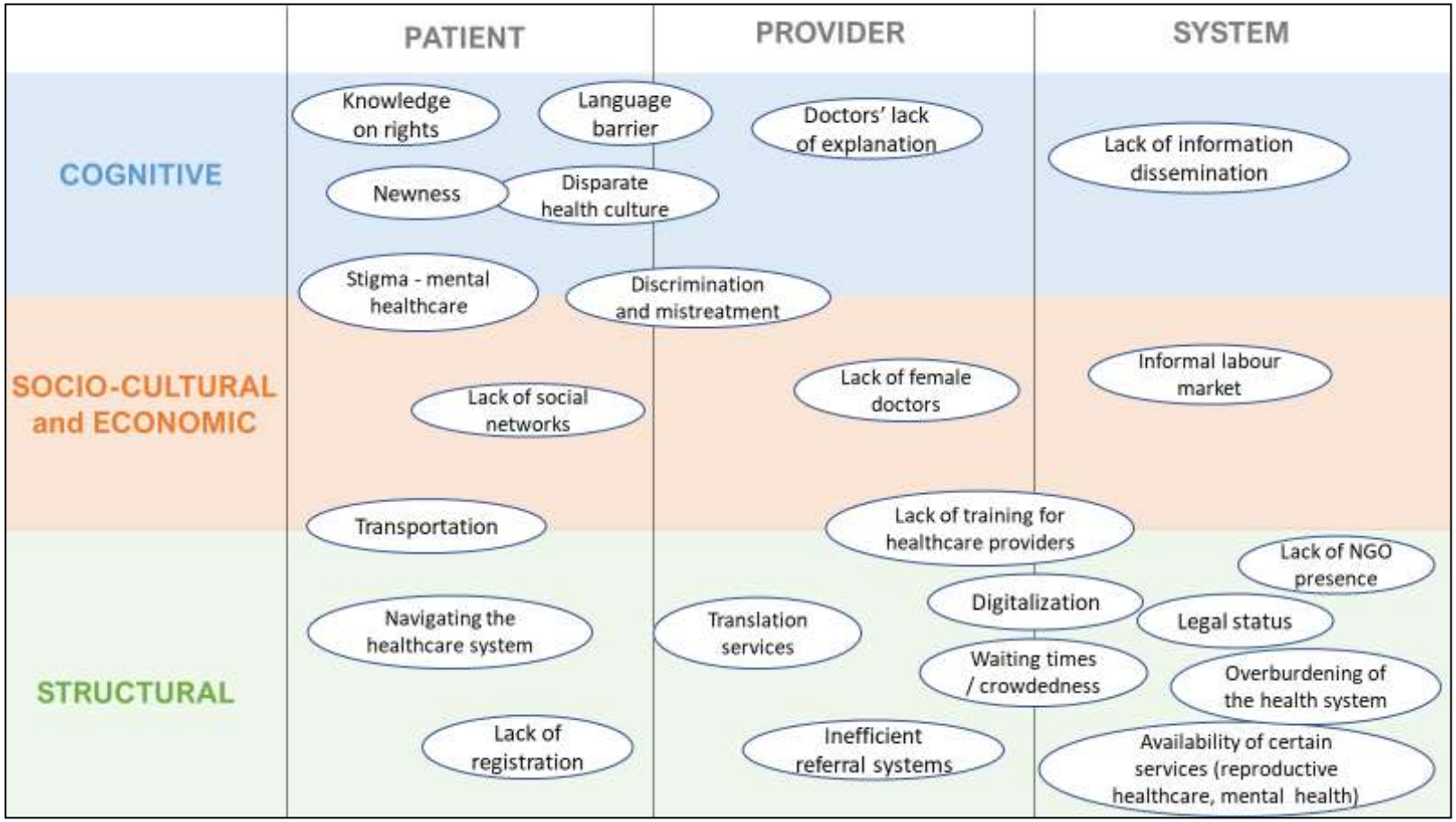

Figure 1: Classification of Healthcare Access Barriers

6.2. Suggestions from the Fieldwork and the Literature

Throughout the literature many suggestions have been made and during the fieldwork suggestions to ameliorate healthcare accessibility were also elicited as well. From the literature on refugee access to healthcare in Turkey recommendations include:

- Establish information centers to disseminate information about the services available that are accessible to refugees and migrants. Ensure that information on mental healthcare and reproductive healthcare is disseminated. (Cloeters & Osseiran, 2019)
- Offer more specialized services such as reproductive health services, and mental health services (Şimşek et al.,2018; Cloeters & Osseiran, 2019).
- Increase the number of national and international organizations that can operate in healthcare services and/or support, and bolstering their coordination with the government (Assi et al., 2019; Cloeters & Osseiran, 2019)
- Increase integration efforts of refugees' into the formal labour market to ensure full healthcare access especially in the case of work-related injuries (Cloeters & Osseiran, 2019)
- Increase the number of refugee healthcare professionals into the national health system at different levels. Especially female service providers (Cloeters & Osseiran, 2019)
- Extend the coverage of health insurance to all cities without limitation on registration (Mardin, 2017)
- Increase the number of translators and improve translation services. Incorporate multi-lingual staff at information desks of hospitals. (Mardin, 2017; Cloeters & Osseiran, 2019)

- Provide training to Turkish healthcare staff (people at the desks, nurses, doctors) on dealing with refugees, gender sensitivity, cultural healthcare practices, forced migration etc. (Cloeters & Osseiran, 2019)
- Regulate work in informal Syrian clinics to ensure medical standards (Cloeters & Osseiran, 2019)

During the field work when asked what they would like to change; nine people (including one key informant) stated more translators needed to be hired, five respondents said they wouldn't change anything, again five respondents said (including one key informant) more Arab or Syrian doctors should be employed; two key informants stated people should be informed on transportation, two interviewees stated that doctors should treat people better; two key informants stated hospital staff could be trained, five respondents including one key informant stated doctors needed to explain more to patients.

> *Doctors need to attend to patients more, the doctor sees patients as like a robot and just say what's wrong what's the problem and just type things into the computer. Illness is human. Words make people feel better more than medication. A nice word gives you more relief than any medication. (elderly man, 63)*

> *For me it's easy yes. But for Syrians it can be difficult if they don't know transportation. I think we need more translators at hospitals. There aren't enough translators. And uhm… actually the staff at the hospital should be informed about Syrians more maybe on like how to treat them or things to say. But other than that it's good. Some staff members don't know so much about the health rights of Syrians like free medication. I think that's it (W.,26)*

> *I think they need to inform people on what Syrians have been through. We have suffered enough, we don't want to suffer anymore when we come here, we can't take it anymore. (M.,21)*

6.3. Concluding Remarks

Upon the ninth year of the Syrian crisis, there are many challenges that still remain. The access to healthcare of Syrian refugees has been dealt with in this piece of research, the legal scope, the means of healthcare provision to Syrian refugees, the access barriers they face have been outlined. Although healthcare is one of the services that Syrian refugees are most content with in Turkey, there are still issues that need to be dealt with. As it was mentioned before just because healthcare services are provided for free and the accessible services are almost akin to those that are accessible to Turkish nationals does not translate into ease of access. The barriers underlined in the literature were the language barrier, lack of translation services, overcrowding of hospitals, lack of specialised services such as mental and reproductive healthcare, discrimination, crowdedness and waiting times, difficulties navigating the Turkish healthcare system. However, there was a lack of qualitative data on the experiences and challenges Syrian refugees are faced with when seeking healthcare such a study was conducted. The aim was to present a picture of the experiences of Syrian refugees regarding healthcare access in Ankara through 22 semi-structured interviews and five participant observations. The fieldwork revealed similar findings as the previous studies conducted in other provinces of Turkey; Syrian refugees were indeed content with healthcare services, the language barrier and other barriers mentioned were confirmed. Additionally, though, what this study drew out was how perhaps more latent issues such as digitalization, lack of social networks, the gaps filled by civil society, lack of information, limited agency, doctor-patient relations impacted access. Thus, this also underlines the importance of qualitative data in refugee studies.

The use of ethnographic methods provided a more wholistic understanding and strongly demonstrated how the mere concept of newness in a country in a setting limits the understanding of the health system, and in turn limits the potential for agency when it comes to managing one's own healthcare. All participant

observations also showed the importance of social networks and how perhaps "softer" components of access should not be neglected. Furthermore, the ethnographic work and semi structured interviews enabled a few stories of actual experiences of refugees to run through the paper and provide a more in-depth understanding to further comprehend their predicaments, as "listening to the stories people tell one another and observing the various ways in which they engage with their situation as refugees adds important context and depth of understanding to the stories elicited by the researcher" (Eastmond, 2007).

The study while of an exploratory nature, also attempted to ask Syrian refugees what they thought would help ease their access to healthcare. To which they responded that translators needed to be increased, more Arabic staff could be employed, the approach of doctors could be improved and training could be given to healthcare personnel, awareness raising, information dissemination could be conducted. Furthermore, the study grouped the identified barriers into groups to map out areas of possible interventions at varying levels. For instance, looking at the provider level and issues with discrimination, dealing with patients from a different culture with diverse health culture as well, it can be ascertained that trainings to medical staff would be a point of intervention. Or when the lack of NGO presence and the lack of specialised services is coupled another suggestion that has also been highlighted in the literature is allowing for more coordination among NGO's and the government to work together in filling in the necessary gaps especially with reproductive healthcare services and mental healthcare services.

Future study areas in the area of refugee access to healthcare could be; the role of NGOs and specifically civil society in ameliorating healthcare access for Syrian refugees, challenges other refugees who are not under temporary protection face, birth rates and family planning policies, the importance of social support networks in accessing services, the incorporation of Syrian healthcare professionals into the Turkish health care system. A finding from the study was that migrant health centres

are underused thus research specifically focusing on the migrant health centres would prove to be useful. Furthermore, the dearth of studies that focus on Syrian refugees who frequent hospitals, who are in need of continuous care, who have undergone operations or who have chronic diseases in Turkey warrants the need for focused studies to reveal more about the bottlenecks of the Turkish healthcare system for Syrian refugees.

REFERENCES

AFAD, (2018) Information not on Temporary Accommodation Centres. Feb. 2018. https://www.afad.gov.tr/upload/Node/2374/files/28_02_2018_Suriye_GBM_Bilgi_Notu.pdf

AFAD, (2017). Field Survey on Demographic View, Living Conditions and Future Expectations of Syrians in Turkey. Prime Ministry Disaster and Emergency Management Presidency. Ankara, 2017.

Ager, A. (2014) "Health and Forced Migration" . In The Oxford handbook of refugee and forced migration studies, Fiddian et al (Eds.), pp.433-446. Oxford, United Kingdom: Oxford University Press.

AIDA (2018). Asylum database information report, Turkey.

Akbulut,Y. et al. (2019). *Public Hospital Utilization among Syrian Refugees in Turkey, Health Scope*. 2019 February; 8(1):e13405. doi: 10.5812/jhealthscope.13405.

Akçapar, Ş.K. (2017). *International Migration and Diplomacy: Challenges and Opportunities in the 21st Century*. PERCEPTIONS, Winter 2017, Volume XXII, Number 4, pp. 1-34.

Akgül, A., Kaptı, A. & Demir, Ö.O. (2015). Göç ve Kamu Politikaları: Suriye Krizi Üzerine Bir Analiz, The GLOBAL A Journal of Policy and Strategy, 1/2, pp. 1-22.

Alawa, J., Zarei, P., & Khoshnood, K. (2019). Evaluating the Provision of Health Services and Barriers to Treatment for Chronic Diseases among Syrian Refugees in Turkey: A Review of Literature and Stakeholder Interviews. *International Journal of Environmental Research and Public Health*, *16*(15), 2660.

Al-Kateab, W., Al-Kateab,H. (2019, June 5). Interview by K. Guru-Murthy. Channel 4 News.

Arendt, H. (1976). *The origins of totalitarianism*. New York : Harcourt Brace Jovanovich.

Atun, R., Aydın,S., Chakraborty,S., Sümer,S., Aran,M., Gürol,İ., Nazlıoğlu,S., Özgülcü, Ş., Aydoğan,Ü., and Ayar,B. (2013). "Universal Health Coverage in Turkey: Enhancement of Equity." The Lancet 382 (9886): 65–99.

Assi, R., Özger-İlhan, S. and İlhan, M.N. (2019). *Health needs and access to health care: the case of Syrian refugees in Turkey*. Public Health, Volume 172, 2019, Pages 146-152.

Ay, M.; Gonzalez, P. A. & Castro Delgado, R. (2016) "The Perceived Barriers of Access to Health Care Among a Group of Non-camp Syrian Refugees in Jordan" International Journal of Health Services, 0(0), pp. 1-22.

Barghouti, M., & Soueif, A. (2003). *I saw Ramallah*. New York: Anchor Books.

Betts, A., Ali, A., Memişoğlu, F. (2017) "Local Politics and the Syrian Refugee Crisis: Exploring Responses in Turkey, Lebanon, and Jordan" Refugee Studies Centre, University of Oxford.

Bilecen, B., & Yurtseven, D. (2018). Temporarily protected Syrians' access to the healthcare system in Turkey: Changing policies and remaining challenges. Migration Letters, 15(1), 113-124.

Carrillo, J. E. & Carrillo, V. A. & Perez, H. R. & Salas-Lopez, D. & Natale-Pereira, A. & Byron, A. T. (2011). Defining and Targeting Health Care Access Barriers. *Journal of Health Care for the Poor and Underserved*22(2), pp. 562-575. The Johns Hopkins University Press.

Chong, C. (2018). *Temporary Protection: Its Impact on Healthcare for Syrian Refugees in Turkey,* Int Health 2018; 10: pp.217–218.

Cloeters, G. and Osseiran, S. (2019). *Healthcare Access for Syrian Refugees in İstanbul: A Gender-Sensitive Perspective*, Workshop Report, Istanbul Policy Centre. Sabanci University.

Cole, P. (2009). *Migration and the Human Right to Health*. Cambridge Quarterly of Healthcare Ethics 18, pp. 70–77.

Çallı, M . (2016). *Health Rights of Refugees And Asylum Seekers In Turkey*. İş ve Hayat, 2 (3), pp. 131-154.

Çolak, Ö. et al. (2018). *Yerinde Erişim Projesi Değerlendirme Raporu*. Istanbul: YUVA, March 2018.

Dağtaş, S. (2017). Whose *Misafirs?* Negotiating Difference Along the Turkish–Syrian Border. *Int. J. Middle East Stud.* 49 (2017), 661–679.

Dedeoğlu, N. (2016). In War, Migration and Health; Experiences of Turkey. Turkish Medical Association Publications, pp. 60-67.

Demir, E. et al. (2016). Present State, Problems and Obstacles Encountered In The Use Of Health Services By Refugees/People Under Temporary Protection, In War, Migration and Health; Experiences of Turkey. Turkish Medical Association Publications, pp. 60-67.

Demirel, D. (2017). E-HEALTH APPLICATIONS in TURKEY. PressAcademia Procedia, 4 (1), 422-432.

Dinç, G. (2017). *The Health Rights of Syrian Refugees in Turkey from a Legal and Ethical Perspective,* Turkiye Klinikleri J Med Ethics 2017;25(2), pp. 37-42.

Doocy et al. (2015), Prevalence and care-seeking for chronic diseases among Syrian refugees in Jordan, BMC Public Health Vol. 15, No. 1097, pp.1-10.

Eastmond, M. (2007). *Stories as Lived Experience: Narratives in Forced Migration Research. Journal of Refugee Studies Vol. 20, No. 2. Published by Oxford University Press.*

Egici, M.T. (2019). Migrant Health Care Services Provided by Public Sector in Turkey. Anatol J Family Med 2019;2(1):7–12.

Ekmekci, P.Elif. (2017). *Syrian refugees, health and migration legislation in Turkey*, Journal of Immigrant and Minority Health 19(6), Dec 2017, pp.1434–1441.

El-Jardali, F., Hammoud, R., Fouad, F. M., & Bou Karoum, L. (2014). K2P Briefing Note: Promoting Access to Essential Health Care Services for Syrian Refugees in Lebanon. Knowledge to Policy (K2P) Center. Beirut, Lebanon.

Erdoğan ,M. M. (2015). Türkiye'deki Suriyeliler, İstanbul Bilgi Üniversitesi Yayınları, İstanbul.

Essed, P.; Frerks, G. & Schrijvers, J. (2004) "Introduction: Refugees, Agency and Social Transformation" In Refugees and the Transformation of Societies, Philomena Essed, Georg Frerks and Joke Schrijvers (eds.) New York, Oxford: Berghahn Books.

Evans, J. (1987) "Migration and Health" The International Migration Review, Vol. 21, No. 3, pp. v-xi

Fındıkoğlu, M. (2019). *The Metamorphosis of the Turkish Health System under the AKP*, Turkeyscope Vol. 3, No. 5, February 2019.

Gülay, M. (2016). *Legislative Arrangements in the Field of Right to Health.* In War, Migration and Health; Experiences of Turkey. Turkish Medical Association Publications, pp. 54-56.

Haddad S, Mohindra K. (2002) "Access, Opportunities and Communities: Ingredients for Health Equity in the South". Paper presented at the *Public Health and International Justice Workshop*. New York: Carnegie Council on Ethics and International Affairs.

Hunt, P. (2016). *Interpreting the International Right to Health in a Human Rights-Based Approach to Health,* Health and Human Rights Journal, 18 (2), Dec 2016, pp. 109-130.

İçduygu, A. Ustubici, A., Aral, I., Ayar, B. (2017): *Legitimising settlement of refugees: unpacking humanitarianism from a comparative perspective*. Geografie, 122, 4, 449–475.

İçduygu, A., and Şimşek, D. (2016). "Syrian Refugees in Turkey: Towards Integration Policies." Turkish Policy Quarterly 5, no. 3 (2016): 59–69.

Ineli-Ciger, M. (2017). *Protecting Syrians in Turkey: A Legal Analysis,* International Journal of Refugee Law, 29(4), Dec 2017, pp. 555 – 579.

Ingleby,D. (2011) "Good practice in health service provision for migrants" In Migration and health in the European Union, Rechel, B. et al. (Eds.), Maidenhead : Open University Press, pp.227-244.

IOM. (2018) World Migration Report 2018.

Jadoo, A. et al. (2014). *Turkish Health System Reform from the People's Perspective: a Cross Sectional Study*, BMC Health Services Research 2014, 14:30, pp. 1-9.

Kaya, A. and Kıraç, A. (2016). *Vulnerability Assessment of Syrian Refugees in Istanbul.* Istanbul: Diakonie Katastrophenhilfe and Swiss Agency for Development and Cooperation.

Kibreab, G. (1999) “Revisiting the Debate on People, Place, Identity and Displacement” Journal of Refugee Studies, Vol.12, No.4, pp.385-407.

Kirişçi, K. (2014) “Syrian Refugees and Turkey's Challenges: Going Beyond Hospitality” Brookings-Bern Project on Internal Displacement.

Kirişci, K. & E. Ferris (2015). Not Likely to Go Home: Syrian Refugees and the Challenges to Turkey and the International Community, Turkey Project Policy Paper 7, Brookings Institution, Washington DC.

Kutlu, Z. (2015). *From the Waiting Room to the Living Room. A brief assessment on NGOs working for Syrian Refugees*. Istanbul, Anadolu Kultur.

Levesque JF, Harris MF, Russell G. (2013) “Patient-Centred Access to Health Care: Conceptualising Access at the interface of Health Systems and Populations*”. International Journal for Equity in Health* 12(18).

Lloyd, A. (2014) Building Information Resilience: How do Resettling Refugees Connect with Health Information in Regional Landscapes – Implications for Health Literacy, Australian Academic & Research Libraries, 45:1, 48-66.

Malkki, L. (1995b) `Refugees and Exile: From “Refugee Studies” to the National Order of Things', Annual Review of Anthropology 24: 495-523.

Malkki, L. (1995) Purity and Exile. Violence, Memory and National Cosmology among Hutu Refugees in Tanzania. Chicago and London: University of Chicago Press.

Marcus, G.E. (1995). *Ethnography in/of the World System: The Emergence of Multi-Sited Ethnography*. Annual Review of Anthropology, Vol. 24. pp. 95-117.

Mardin, F.D. (2017). *Right to Health and Access to Healthcare Services for Syrian Refugees in Turkey*, MireKoç Policy Brief Series, March 2017, pp. 1-6.

Memişoğlu, F. (2018). The Syrian Community in Turkey: Perspectives, Prospects, and Policies. Public Policy and Democracy Studies.

Memisoglu, F., & Ilgit, A. (2017*). Syrian refugees in Turkey: multifaceted challenges, diverse players and ambiguous policies*, Mediterranean Politics, 22:3, 317-338.

MoNE, Closing TEC's. Accessed on July 2019. https://www.meb.gov.tr/demirci-gemler-uc-yil-icinde-misyonunu-tamamlayacak/haber/11850/tr

Moore, S.F. (1987). *Theoretical Dilemmas in Processual Ethnograpgy*. American Ethnologist, Vol. 14, No. 4. pp. 727-736.

Nielsen, S. Y. (2016). Perceptions between Syrian refugees and their host community. *Turkish Policy Quarterly, 15*(3), 99–106.

Nørredam, M. & Krasnik A. (2011). "Migrants' access to health services" In Migration and health in the European Union, Rechel, B. et al. (Eds.), Maidenhead : Open University Press, pp. 67-80.

Nussbaum, M. (2000). *Women and Human Development: The Capabilities Approach*, Cambridge University Press: Cambridge, MA.

The Ombudsman Institution of Turkey, (2018). Syrians in Turkey, Special Report. OMBUDSMAN INSTITUTION OF THE REPUBLIC OF TURKEY, Ankara.

Özçürümez S, Yıldırım D. (2017). *Syrians under Temporary Protection, health services and NGOs in Turkey: the Association for Solidarity with Asylum Seekers and Migrants and the Turkish Medical Association*. In: Greer SL, Wismar M, Pastorino G, et al., editors. Civil society and health: Contributions and potential Copenhagen (Denmark): European Observatory on Health Systems and Policies; 2017. (Observatory Studies Series, No. 48.) Chapter 7.

Özgülnar, N. (2016). "Problems of Women". , In War, Migration and Health; Experiences of Turkey. Turkish Medical Association Publications, pp. 68-72

Paillard, S.D. (2011) "Differences in language, religious beliefs and culture: the need for culturally responsive health services" In Migration and health in the European Union, Rechel, B. et al. (Eds.), Maidenhead : Open University Press, pp.203-226.

Parkinson, S. E. & Behrouzan, O. (2015) "Negotiating health and life: Syrian refugees and the politics of access in Lebanon" Social Science & Medicine, Vol. 146, issue C, pp. 324-331.

Penchansky R, Thomas WJ. (1981) "The Concept of Access: Definition and Relationship to Consumer Satisfaction". *Med Care*. Vol:19, pp. 127–140.

Republic of Turkey Ministry of Health. 2015. Fundamentals of health services to be delivered to Syrians under Temporary Protection https://dosyasb.saglik.gov.tr/Eklenti/1376,saglik-bakanligi-gecici-koruma-yonergesi-25032015pdf.pdf?0

Republic of Turkey Ministry of Interior. (2013). Law No. 6458 on Foreigners and International Protection http://www.goc.gov.tr/files/files/eng_minikanun_5_son.pdf

Republic of Turkey Ministry of Interior. (2014). Regulation No. 29153 on Temporary Protection. http://www.goc.gov.tr/files/_dokuman28.pdf

Republic of Turkey Prime Ministry Directorate General of Migration Management. (2018). http://www.goc.gov.tr/icerik3/gecici-koruma_363_378_4713

Republic of Turkey Prime Ministry Disaster and Emergency Management Presidency. (2018). https://www.afad.gov.tr/upload/Node/2374/files/13_08_2018_Suriye_GBM_Bilgi_Notu.pdf

Republic of Turkey Prime Ministry Disaster and Emergency Management Presidency. (2018). protocol between AFAD and Ministry of Health on the procurement of health services based on a lump sum price. https://dosyamerkez.saglik.gov.tr/Eklenti/19264,afet-ve-acil-durum-yonetimi-baskanligi-goc-idaresi-genel-mudurlugu-ve-saglik-bakanligi-arasinda-goturu-bedel-uzerinden-saglik-hizmeti-alim-protokolu-03072018pdf.pdf?0

Saleh, A., Aydın, S. & Koçak, O. (2018). *A comparative study of Syrian refugees in Turkey, Lebanon, and Jordan: Healthcare access and delivery*. OPUS – International Journal of Society Researches, 8(14), 448-464.

Samari, G. (2017). *Syrian Refugee Women's Health in Lebanon, Turkey, and Jordan and Recommendations for Improved Practice.* World Medical & Health Policy, 9:2.

Savas, Nazan et al. (2016). "*Syrian Refugees in Hatay/Turkey and Their Influence on Health Care at the University Hospital.*" International Journal of Clinical and Experimental Medicine 9(9): 18281-18290.

Scheppers E, Van Dongen E, Dekker J, Geertzen J, Dekker J. (2006) "Potential Barriers to the Use of Health Services Among Ethnic Minorities: A Review", *Family Practice,* Volume 23, Issue 3 , pp. 325–348.

Sen, A. (2002). "Why Health Equity?" Health Economics 11(8): 659–66.

Shengelia B, Murray CJL, Adams OB. (2003) "Beyond Access and Utilization: Defining and Measuring Health System Coverage". *Health Systems Performance Assessment. Debates, Methods and Empiricism.* Murray CJL, Evans DB, editor. Geneva: World Health Organization; pp. 221–234.

Şimşek,Z. et al. (2018) "A community-based survey on Syrian refugee women's health and its predictors in Şanliurfa, Turkey", Women & Health, 58:6,617-631.

Stein B. N. (1981) "The Refugee Experience: Defining the Parameters of a Field of Study" International Migration Review, Vol. 15, No. 1/2, pp. 320-330.

Tayfur I, et al. Healthcare Service Access and Utilization among Syrian Refugees in Turkey. Annals of Global Health. 2019; 85(1): 42, 1–6.

Toebes, B. (1999). *Toward an Improved Understanding of the International Human Right to Health.* Human Rights Quarterly 21(3):661–679.

Torun, P., Mücaz Karaaslan, M., Sandıklı, B. et al. (2018). *Health and health care access for Syrian refugees living in Istanbul.* International Journal of Public Health (2018) 63: 601.

Türkay, M. (2016). Problems of Children. In War, Migration and Health; Experiences of Turkey. Turkish Medical Association Publications, pp. 53-55.

United Nations. (1998). *The Universal Declaration of Human Rights, 1948-1998*. New York: United Nations Dept. of Public Information.

UN General Assembly, UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3.

United Nations High Commissioner for Refugees. (2011). Global Trends Report 2011.

United Nations High Commissioner for Refugees. (2012). Global Trends Report 2012.

United Nations High Commissioner for Refugees. (2018). Operational Portal Refugee Situations: Syria Regional Refugee Response, Turkey. Retrieved from https://data2.unhcr.org/en/situations/syria/location/113

Uzun, A. (2015) "Günümüzün Sosyal ve Ekonomik Sorunu Olan Suriyelilerin Mülteci ve Ekonomi Hukuku Bakımından Değerlendirilmesi" Ankara Barosu Dergisi, 2015/1,pp.107-120.

Venkatapuram, S. (2011). *Health Justice: An Argument from the Capabilities Approach.* Cambridge, England: Polity Press.

Wacquant, L. (2004) *Following Pierre Bourdieu into the Field.* Ethnography 5, pp. 387-414.

Wacquant, L. (2006) *Chapter 16: Pierre Bourdieu*. Forthcoming in Rob Stones (ed.), Key Contemporary Thinkers (London and New York: Macmillan, new edition).

Willen, S. (2011). *Do "Illegal" Im/migrants Have a Right to Health? Engaging Ethical Theory as Social Practice at a Tel Aviv Open Clinic.* MEDICAL ANTHROPOLOGY QUARTERLY, Vol. 25, Issue 3, pp. 303–330.

Willman, S. (2013) "Do migrants have an enforceable right to healthcare in international human rights law?". In Migration, health and inequality, Thomas, F. & Gideons, J. (Eds.) pp. 44-61. London Zed Books

Yardım, M.S., Uner,S. (2018). *Equity In Access To Care In The Era Of Health System Reforms In Turkey*. Health Policy 122 (2018) 645–651.

Yasin, Y. (2016). Non-government Organizations Delivering Health Services and Refugees, In War, Migration and Health; Experiences of Turkey. Turkish Medical Association Publications, pp. 68-72.

Yavuz, Ö. (2015). *The Legal and Ethical Foundations of Health Assistances to Syrian Refugees in Turkey*, Mustafa Kemal Üniversitesi Sosyal Bilimler Enstitüsü Dergisi Yıl 2015, 12(30), pp. 265-280.

Yıldız, Ö. (2013). Syrian *Refugees in Turkey's Camps*: Problems, Expectations, Turkey and Future Perception. *Journal of Sociological Research, 16*(1), 141-169.

Young, R.F.; Bukoff, A.; Waller, J.B.; Blount, S.B. (1987) "Health Status, Health Problems and Practices among Refugees from the Middle East, Eastern Europe and Southeast Asia" International Migration Review, Vol. 21, No. 3, pp. 760-782.

16.03.2018 tarih 2018/11208 YÖNETMELİK DEĞİŞİKLİĞİ: Resmi gazete http://mvc.aeo.org.tr//UserFiles/files/20180316%20Resmi%20Gazete%20Yo%CC%88netmelik.pdf

APPENDICES

A. MIDDLE EAST TECHNICAL UNIVERSITY HUMAN SUBJECTS ETHICS COMMITTEE APPROVAL LETTER

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

ORTA DOĞU TEKNİK ÜNİVERSİTESİ
MIDDLE EAST TECHNICAL UNIVERSITY

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27 ŞUBAT 2018

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Doç .Dr. İpek EREN VURAL ;

Danışmanlığını yaptığınız yüksek lisans öğrencisi Alexandra Zehra AKSU'nun ***"Ankara'da yaşayan geçici koruma altındaki Suriyelilerin sağlık hizmetlerine erişimi"*** başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülerek gerekli onay **2018-SOS-020** protokol numarası ile **20.03.2018 - 30.09.2018** tarihleri arasında geçerli olmak üzere verilmiştir.

Bilgilerinize saygılarımla sunarım.

Prof. Dr. Ş. Halil TURAN
Başkan V

Prof. Dr. Ayhan SOL
Üye

Prof. Dr. Ayhan Gürbüz DEMİR
Üye

Doç. Dr. Yaşar KONDAKÇI
Üye

Doç. Dr. Zana ÇITAK
Üye

Yrd. Doç. Dr. Pınar KAYGAN
Üye

Yrd. Doç. Dr. Emre SELÇUK
Üye

B. TURKISH SUMMARY / TÜRKÇE ÖZET

ANKARA'DA YAŞAYAN SURİYELİ SIĞINMACILARIN SAĞLIK HİZMETLERİNE ERİŞİM DENEYİMLERİ

Sağlık hizmetleri herhangi bir kişi için hayati öneme sahip bir hizmettir. Amartya Sen'in de ileri sürdüğü üzere "sağlık insan yaşamının en önemli koşulları arasındadır ve değer vermemiz gereken insan yapabilirliklerinin kritik öneme sahip bir bileşenidir" (2002, s.660). Bunun yanı sıra evrensel niteliğe sahip olan yapabilirlik listesinde Martha Nussbaum "bedensel sağlığı", iyi bir yaşam sürmek için gerekli olan en önemli insan kabiliyetlerinden biri olarak listeliyor (2000, s.78). Bu nedenle sağlık hizmetlerinin erişilebilirliği, iyi bir yaşam sürdürebilmek için büyük önem taşımaktadır. Ancak, yerinden edilme durumlarında, insan sağlığını tehdit eden ve sağlık hizmetlerine erişimi engelleyen zorluklar meydana gelebilir. Ülkelerini terk etmek zorunda kalan mültecilerin sağlık durumu, sağlıksız yaşam koşulları, maddi ve manevi kayıplar, güvensizlik ve travmaya maruz kalma ile birlikte bozulma eğilimindedir (Torun ve ark., 2016, Bilecen ve Yurtseven, 2017, Alawa, J., Zarei , P. ve Khoshnood, K., 2019). Bu nedenle, sağlık hizmetlerinin ele alınması ve mültecilerin sağlık hizmetlerine erişiminin sağlanması her ev sahibi ülke için hayati öneme sahiptir. 2011'de başlayan Suriye iç savaşı nedeniyle sekiz yıldır Suriye'den göç alan Türkiye'de, şu an 3,6 milyondan fazla Suriyeli sığınmacı (UNHCR, 2019) kayıtlı ve tahminlere göre bu rakamın da üzerinde çok sayıda kayıt dışı Suriyeli sığınmacı bulunmakta. Bu yüksek rakamın sadece yüzde 3,02'si beş ilde bulunan yedi Geçici Barınma Merkezinde (Göç İdaresi, Kasım 2019) ikamet etmekte. Geçici koruma kapsamındaki Suriyelilerin çoğu şehirlerde yaşamaktadır ve her gün yerel nüfus arasındadır, dolayısı ile birçok hizmet ve özellikle herkesin yaralanması gereken sağlık hizmetleri ciddi bir yük altındadır. Tüm Suriyeli mülteciler resmi olarak kayıtlı oldukları sürece birinci ve ikinci basamak sağlık

hizmetlerine ücretsiz erişim hakkına sahip olmalarına rağmen (Ekmekçi, 2016), kamp dışı ortamlarda yaşayanların durumu kamplarda yaşayanlardan çok daha vahimdir (Kirişçi, 2014, Yavuz, 2015, Uzun, 2015, Akgül, 2015). Suriyeli sığınmacıların sağlık hizmetlerine erişimi noktasında Türkiye'de birçok çalışma gerçekleştirilmiştir ve literatürde en sıkça rastlanılan zorluklar şunlardır: bilgi eksikliği, dil engelleri, hastane kapasite yetersizlikleri, Türkiye'deki sağlık sisteminin karışık gelmesi, ayrımcılık, kayıt problemleri, ruh sağlığı ve üreme sağlığı hizmetlerinin eksikliği. Bununla birlikte, Suriyeli mültecilerin Türkiye'deki sağlık hizmetlerine erişimini nicel yöntemlerle ele alan akademik çalışma sayısı azdır. Sağlık temel bir hak olduğundan ve eksikliğinin vahim sonuçlara yol açabileceğinden, sağlık alanına odaklanmak ve Suriyeli sığınmacılar için sağlık hizmetlerinin erişilebilirliğinin ve karşılaşabilecekleri engellerin bir resmini sunmak istiyorum.

Bu çalışmanın temel amacı, Ankara'da yaşayan Suriyeli sığınmacıların sağlık hizmetlerine erişimde karşılaştıkları zorlukları incelemek ve Türkiye'deki sağlık hizmetlerine erişim durumlarını sunmaktır. Aynı zamanda sağlık hizmetlerinden faydalanan mültecilerin Türk sağlık sistemi hakkındaki görüşlerini anlamak ve sığınmacıların sağlık hizmetlerine olan erişimlerini kolaylaştırmak için neler yapılabileceğine dair görüşlerini almak da çalışmanın amaçları arasındadır. Bu amaçlar doğrultusunda Ankara'da yaşayan yirmi üç Suriyeli sığınmacı ile mülakatlar gerçekleştirilmiş ve beş tane hastane ziyareti gerçekleştirilmiştir. Tezde etnografik yöntemlerin mülteci çalışmalarında kullanılmasının getirdiği derinlik ve zenginlik de vurgulanmıştır. Yazın taraması ve saha çalışmaları sonucu tespit edilen sağlık hizmetlerine erişimi engelleyen etmenler ayrıca yapısal, bilişsel, sosyo-kültürel ve ekonomik olmak üzere sınıflandırılmıştır; ve kişi seviyesi, sağlık hizmeti sunan seviyesi ve sistem seviyesinde incelenmiştir. Çalışmada yazın taraması ve saha çalışması sonucunda sağlık sistemine erişimi kolaylaştırmak için getirilen öneriler de sunulmuştur.

Sağlık hizmetlerine erişim ve erişime engel teşkil eden etmelerin kavramsal çerçevesi için literatürden dört farklı modelden Yardım alınmıştır. Levesque ve ark. tarafından geliştirilen oldukça kapsamlı ve çok yönlü olan, hasta merkezli bir kavramsal çerçeve sağlık hizmetlerine erişimi tanımlamak için kullanılmıştır. Erişim "algılanan bakım ihtiyacı durumlarında uygun sağlık hizmetlerine ulaşma ve bunlara ulaşma fırsatı" olarak tanımlanmakta (Levesque ve ark. 2013). Çerçeve arz ve talebi de göz önünde bulundurmakta, talep tarafında kişilerin, hane halklarının erişimini etkileyen faktörler, arz tarafında ise sağlık hizmetlerinin erişilebilirliğini etkileyen faktörler belirtilmiştir. Etki eden faktörler arasında ulaşım, ücret, bilgilendirme gibi konuların yanı sıra algı, kabul edilebilirlik, kültürel uygunluk, din, cinsiyet gibi etkenlere de yer verildiği için Suriyeli sığınmacıların kendi deneyimlerini ve algılarını yansıtmayı amaçlayan bu çalışma için elverişli bir çerçevedir. Erişim engellerine gelince Carillo ve ark. tarafından geliştirilen Sağlık Hizmetlerine Erişim Engelleri Modeli (2011), Norredam ve Krasnik'in kullandığı formal ve informal erişim engelleri (2011) ve Scheppers ve ark. tarafından geliştirilen hasta ve sağlık hizmeti sunanlar arası seviyelere göre ayırdığı erişim engelleri (2006) kullanıldı. Sonuç olarak bilişsel, yapısal, sosyo-kültürel ve ekonomik olmak üzere sağlık hizmetlerine erişim bariyerleri üç kategoriye ayrıldı; ve hasta/kişi, sağlık hizmeti sunucuları ve sistem olmak üzere üç seviyede incelendi.

Anayasada Türkiye'de sağlık hakkı vatandaşlığa dayalı değildir, ancak ülkede yaşayan herkes için bir hak olarak kabul edilmektedir (Mardin, 2017). Mülteciler ve vatansız kişiler söz konusu olduğunda, 5510 sayılı Sosyal Güvenlik ve Genel Sağlık Sigortası Kanununun (2006) 60. Maddesi, herkesi evrensel sağlık sigortası sahibi olarak kabul etmekte ve bu nedenle mültecileri Türkiye'nin genel sağlık sigortası programına dahil etmektedir (Çallı, 2016). Bununla birlikte, Suriyeliler Türk hukukuna göre mülteci statüsüne sahip olmadıklarından, sağlık hizmetlerine ücretsiz erişim hakkı ve Suriyeli mültecilere bu erişimin sağlandığı çerçeve, yakın zamanda yürürlüğe giren ulusal mevzuatın çeşitli yasal belgelerinde yer almaktadır. Suriyeli krizinin ilk yıllarında, sadece kamplarda yaşayan Suriyeliler kamplarda ücretsiz

tıbbi bakım alma hakkına sahipti, daha sonra 2013'te sayıların artmasıyla AFAD 2013/1 ve 2013/8 numaralı iki bildiriyi yayınladı. Bu yönergeler, kamp dışında yaşayan Suriyelilerin AFAD'a kayıtlı olduklarını belirterek sağlık kliniklerine veya hastanelere ücretsiz başvurabileceklerini öngördü (Çallı, 2016; Dinç, 2017). Şuan kullanılmakta olan başlıca hukuki mevzuatlar, 2013'te yürürlüğe giren Yabancılar ve Uluslararası Koruma Kanunu, 2014'te yayınlanan Geçici Koruma Yönetmeliği , 2015 yılında Sağlık Bakanlığı tarafından Geçici Koruma Kapsamında Yabancılar İçin Sağlık Hizmetlerinin Yürütülmesine İlişkin Genelge ve 2014 yılından beri her yıl yenilenen götürü bedel üzerinden sağlık hizmetlerinin alımı hususunda Göç İdaresi (2018 yılına kadar AFAD) ve Sağlık Bakanlığı arasındaki protokoldür. Bu mevzuatlar çerçevesinde geçici koruma altında bulunan Suriyeliler, Türkiye vatandaşlarına sunulan birincil ve ikincil sağlık hizmetlerinden ücretsiz faydalanma hakkına sahiptir. Ancak sadece kayıtlı bulundukları şehirlerde ve kayıtlı oldukları takdirde faydalanabilirler, Göç İdaresi ile kayıtlı olmayan Suriyeli sığınmacılar sadece acil hizmetlerinden yararlanabilmektedirler. Sağlık hizmetlerinin ödenmesi hususunda ise AFAD ve Sağlık Bakanlığı arasında 2014 yılında imzalanan ve her yıl yenilenen bir götürü bedele dayalı sağlık hizmetlerinin alımına ilişkin Protokol uyarınca hizmetlerin maliyeti AFAD tarafından karşılandı, ancak Mart 2018 yılı itibari ile Göç İdaresi tarafından karşılanıyor.

Türkiye örneğinde, geçici koruma kapsamındaki çok sayıda Suriyeli bulunması nedeniyle sağlık ve eğitim de dahil olmak üzere birçok hizmet devlet tarafından yönetilmektedir (Saleh ve ark., 2018; Kirişçi, 2015; Samari, 2017). Kamp dışında yaşayan mülteciler 2014 yılından itibaren düzenli olarak halk sağlığı hizmetlerinden faydalanabildiler ve tüm halk sağlığı tesislerinde Türk vatandaşlarının faydalanabildiği tüm sağlık hizmetlerine ücretsiz erişim hakkı tanındı (Bilecen ve Yurtseven, 2017). Türkiye'de sağlık kurumlarının üç hiyerarşik aşaması olduğunu belirtmek gerekir: Aile hekimliği klinikleri, göçmen sağlığı merkezleri, tüberküloz kontrol dispanserleri, toplum sağlığı merkezleri vb. birincil sağlık kurumları; özel ve devlet hastaneleri ikincil sağlık kurumları, üçüncü düzey kurumlar ise kamu veya

özel üniversitelere veya sağlık bakanlığına bağlı eğitim ve araştırma hastaneleridir (Mardin, 2017 ; Bilecen ve Yurtseven, 2017).

Suriyeli mülteciler birçok zorlukla karşı karşıyadır ve sağlık hizmetlerine erişimi engelleyen faktörler üzerine yapılan çalışma sayısı çok yüksek olmasa da, Türkiye'de halen önemli akademik çalışmalar yapılmıştır. Literatürde yapısal engeller, kültürel engeller, sosyo-ekonomik engeller, sistemik engeller gibi çok sayıda sorunun altı çizilmiştir. En yaygın zorluklar şunlardır; bilgi eksikliği, dil engelleri, ayrımcılık, kayıt bulunmaması, ruh sağlığı ve üreme sağlığı hizmetlerinin eksikliği, sağlık sisteminin karmaşık gelmesi ve kapasite problemleri. Gabriele Cloeters ve Souad Osseiran "İstanbul'da Suriyeli Mültecilere Sağlık Hizmetlerine Erişim: Cinsiyete Duyarlı Bir Bakış Açısı" başlıklı bir çalıştay raporu hazırladılar. Kapsamlı çalıştayda, önde gelen akademisyenler, Suriyeli ve Türk STK üyeleri, tıp uzmanları ve İstanbul'da çalışan halk sağlığı uzmanları yer aldı. Katılımcılar çeşitli zorluklar belirlediler: dil engelleri, yetersiz ruh sağlığı hizmetleri, geçici koruma kapsamında kayıt, Türk sağlık sistemi hakkında bilgi eksikliği, sağlık okuryazarlığı, STK'lar arasında koordinasyon eksikliği, projelerin finansmanı ve sürdürülebilirliği, cinsiyete dayalı şiddet, ayrımcılık, yanlış bilgilendirme, üreme sağlığı hizmetlerinin yetersizliği (Cloeters ve Osseiran, 2019, s.33). Perihan Torun ve ark. ayrıca Suriyeli kadınlarla İstanbul'da yapılan nitel araştırmaları üzerine kapsamlı bir erişim engelleri listesi sunmaktadır. Bunların arasında dil engelleri, uzun bekleme süreleri, randevu sisteminin karmaşıklığı, belirli hizmetler için nereye gidileceği konusunda bilgi eksikliği, Türk doktorlarına duyulan güvensizlik, kapasite sorunları ve sağlık sistemine aşırı yüklenmesi, haklar ve haklar konusunda farkındalık eksikliği, kadın doktor seçebilme, kayıt problemleri, sağlık hizmetlerine nasıl erişilebileceğinin anlaşılmaması, sevklerin ve genel olarak sağlık sisteminin karmaşıklığı ve akıl sağlığı hizmetlerine erişimde zorluklar sunuldu (Torun ve ark., 2017). Saleh ve ark. mali engellerin, kültürler arası iletişimin ve iltica ülkesinde sınırlı kültürel farkındalığın, mültecilerin sağlık hizmetlerine erişimini etkilediğini belirtmiştir (2018); Demir ve ark. erişimi engelleyen önemli zorluklar arasında mesafe, sağlık

çalışanlarının bir kısmına yönelik ayrımcı tutumlar, mevcut kapasite üzerinde baskı uygulamak, çevirmenlerin ve psikologların eksikliği bulunmaktadır (2016). Kirişçi, hükümetin tüm devlet hastanelerinde ücretsiz sağlık hizmeti erişimi sağlamasına rağmen, kamp dışında yaşayan mülteciler için sağlık hizmetlerine erişilebilirliğin daha da sorunlu olduğunu belirtiyor. Zorluklar aşırı yüklenmiş hastaneler, sağlık personeli adına farkındalık eksikliği, dil engeli ve kronik hastalığı olan hastaların takibi olarak tanımlanmaktadır (2015). Yurtseven ve Bilecen, "yasal düzenlemeler yoluyla sağlık hizmetlerine erişimin vaad edilmesinin, Türkiye'deki pratik zorluklar nedeniyle erişimde eşitliğe tekabül etmediğini" vurgulamaktadır (2018, s. 119) ve mülteci erişimini engelleyen üç ana engeli tanımlamaktadır: kayıt sıkıntıları, sağlık sistemini anlamada zorluklar ve dil engelleri.

Ancak tüm bu zorluklara rağmen yine de memnuniyet düzeyleri açısından sağlık, mültecilerin en çok memnun kaldığı hizmet olarak görünmektedir. 2017 yılında 9 ilde 10.838 kişi (kamplardan 1.221 kişi ve kamp dışı ortamlardan 9.617 kişi) ile yapılan bir AFAD Saha araştırmasına göre, "Katılımcıların yüzde altmış altısı Türkiye'nin sunduğu sağlık hizmetlerinden yararlandığını belirtti. Sağlık hizmetlerinden memnuniyet oranı yüzde 83'tür" (AFAD, 2017) . Murat Erdoğan'ın 1.235 Suriyeli hane halkını araştıran 2017 Suriye Barometresi'ne göre, "Suriyeliler için en olumlu hizmet alanı % 68,2 ile sağlık hizmeti. Türkiye'deki Suriyeliler Türkiye'deki sağlık hizmetlerinden çok memnunlar ". Ayrıca Suriyeliler Türkiye'nin sağlık hizmetlerine verdiği desteği 100 üzerinden 72,8 olarak değerlendirdi, bu hizmetler - eğitim, konaklama, finansal destek arasında en yüksek puanlamayı alan hizmet oldu (Erdoğan, 2017).

Bu tezde yürütülen çalışma da bu bulguları desteklemektedir, ancak istatistiki verilerin ötesine geçmek amacıyla saha araştırmalarında hem yarı – yapılandırılmış görüşmeler hem de etnografik metodoloji kullanılmıştır. Göç bir "insan süreci" olduğundan, göç çalışmaları insan deneyimi, yorumu, algısı ve katılımı ile derinden zenginleştirilebilir. Burada "eylemlilik" kavramı göç çalışmalarında çok önemli bir

unsurdur. Essed ve ark. insanları "kendi deneyimlerini ve diğerlerinin deneyimlerini işlerken bu deneyimlere göre hareket eden sosyal aktörler" olarak tanımlamaktadır (Essed ve ark., 2004). İnsan odaklı bu çalışmada yapılan mülakatların merkezi Ankara'da yaşayan Suriyeli mültecilerin deneyimlerini, mücadelelerini ve önerilerini toplamaktı. Yarı yapılandırılmış görüşmelerle bir başka amaç, anketlerde belki de belirtilmeyen ek engelleri ortaya çıkarmak, daha kültürel ve bilişsel engellere ulaşmak, Suriyeli sığınmacıların deneyimlerinin, zorluklarının ve algılarının ifade edilmesi için ortam sağlamaktı. Böylece, Mayıs 2018'den Eylül 2018'e kadar 13 kadın ve 9 erkekten oluşan 22 katılımcı ile, kendi ifadeleriyle sağlık hizmetlerine erişme deneyimlerini paylaşmak için yarı yapılandırılmış görüşmeler yapılmıştır. 14 tanesi tercüman eşliğinde yapılmıştır ve görüşme yapılanlardan dördü hastanelerde tercümanlık yapmış kişiler olarak önemli bilgiler sundu. Sorulan sorular, deneyimleri hakkında konuşurken gelişti ve konu rehberi ve sorular tartışmaları demirlerken, birçok katılımcı için, özellikle kilit katılımcılarda, görüşme sırasında birçok farklı soru ortaya çıktı. Tartışmaları birleştiren başlıca sorular sağlık hizmetlerinden memnuniyetleri ve yaşadıkları zorluklar üzerineydi.

Çoğu kişi Ankara'da sağlık hizmetlerine erişimi kolay bulduğunu belirtti. Hastanelerde sıkça tercümanlık yapmış olan bir Suriyeli ayrıca, mültecilere sunulan hizmetler açısından sağlığın açık ara en üst sırada yer aldığını belirtmiştir. Katılımcılar aslında sağlık hizmetlerine erişmenin kolay olduğunu ve dil dışında zorluk çekmediklerini söylediler. Türk hastaneleri ile ilgili olarak, görüşülen 22 kişiden 22'si, özellikle Suriye ile karşılaştırıldığında, olanakların ve hastanelerin "iyi" olduğunu ifade etmiştir. Gelişmiş ve modern hastane olanaklarını, tıbbi gelişmişliği ve sistemin düzenli oluşunu vurguladılar. 10'dan fazla görüşmeci hizmetlerden memnun olduklarını belirtmiştir. Hiç kimse hastanelerden duyulan bir memnuniyetsizlik ifade etmedi. Mülakatlar boyunca belirtilen zorlukları özetlemek gerekirse; 18 kişi Dili konuşmamayı, 8 kişi doktorların yeterli açıklama vermemesini, 12 kişi uzun prosedürler / sıralar / testleri, 6 kişi ulaşımı, 4 kişi kötü muameleyi zorluk olarak belirtti. 20 (4 kilit katılımcı dahil) kişi Ankara'da sağlık

hizmetlerine erişmenin kolay olduğunu ve geri kalan 2 görüşmeci kolay olduğunu belirtmedi. Bazı görüşülen kişiler çok kolay olduğunu, bazıları rahat olduğunu söyledi, bazıları zorluk olmadığını, bazıları Suriye'de daha kolay olduğunu, bazıları kolay olduğunu ancak ulaşım veya dilin bir sorun olduğunu söyledi. Görüşmeler sonucu sorun olarak on üç tane madde belirlendi, hastane sisteminin zorlukları, dil engelleri ve tercüman yetersizlikleri, bekleme süreleri ve uzun sıralar, prosedür ve testler, ayrımcılık, doktorların yaklaşımları, kadın doktor seçememe, kayıt dışı çalışma, bilgi eksikliği, devlet hastaneleri dışında hastane kullanmama, ulaşım, psikolojik destek olmaması.

Bu görüşmelere ek olarak Suriyeli mülteciler ile beş hastane ziyareti gerçekleştirildi. Daha önce gönüllü olarak çalıştığım Ankara'daki mültecilere ve dezavantajlı ailelere Yardım eden bir Facebook platformunda hastanelere gittiklerinde tercümanlık ve destek isteyen Suriyeli mülteciler ile hastaneye gittim. Görüşmeler sadece Suriyeli sığınmacılar ile gerçekleştirildiği için, hastaneye kendim gitmek doktorlar, hemşireler, hastane personelinin, yerel halkın da davranışlarını gözlemleme fırsatı verdi. İlk ziyaret göz doktoruna giden üç kadın ile gerçekleştirildi, diğer dört ziyaret ise yaşı daha ileri olan ve kimsesi olmayan Suriyeli bir kadın ile gerçekleştirildi. Bu ziyaretler bazı personelin dijital kayıt sistemi veya randevu sistemine halen daha hakim olmadığı, birisinin randevusu olsa bile hastaneler arası sevklerin bazen işlemediği, kalabalıklık ve uzun bekleme sıralarının, yerel halkın da hastanelere geldiklerinde de karşılaştıkları zorluklar olduğunu ortaya çıkardı. Ancak nereye gittiğini hiç bilmeyen birisi için ulaşımda yaşadığı zorluklar, mültecilerin bir çevirmen için hastaneye güvenmek yerine nasıl kendi çevirmenlerini getirmeyi tercih ettiklerini, hastanelerin uzun prosedürleri, bir hastayı muayene eden doktorların yaklaşımı gibi sıkıntıları öne çıkardı. Etnografik çalışma mülakatlarda de belirtilen kalabalıklık, dil engeli, uzun bekleme süreleri, sevk ve ulaşım, doktorlar-hasta ilişkilerini, sistemin test temelli olması, ulaşım gibi sıkıntıları göz önüne sermenin yanı sıra; sosyal ağların önemi, sağlık sistemine hakim olmamanın hastayı daha pasif hale getirmesi, dijital sistemlerle mücadeleler,

sivil toplumun sağladığı yarar, ve kayıt ve istihdamın sağlık hizmeti arama davranışını nasıl etkilediğini ortaya çıkardı. Etnografik çalışma sayesinde benim için en belirgin olan unsur, Lloyd'un belirttiği üzere "mültecilerin karmaşık ve zorlu bir sağlık ortamıyla bağlantı kurma ve bu ortama aşina olmayışı, mültecilerin sağlık sisteminin yapısal ve operasyonel yönlerini anlama yeteneğini sınırlayarak, karar verme ve kendi sağlığını yönetme potansiyelini sınırlandırmaktadır" (2014, s.48). Kimsesi olmayan Suriyeli kadınla hastaneye gittiğimizde çoğu durumda ben daha aktif roldeydim, çünkü onun için hastane ortamı karmaşıktı ve kendisi hasta olduğu için de yorucu oluyordu. Dolayısıyla, onun yerine ben hareket ediyor ve durumları ona izah ediyordu. Dahası, etnografik çalışma, uzun bekleme sıraları, kalabalıklık, dijitalleşme gibi zorlukların yalnızca mültecilere özgü olmadığını, yerel halk için de zorluklar yarattığını ortaya koydu. Ancak bu sorunları Suriyeli sığınmacılar için daha da zorlaştıran etmen onların sağlık sistemine olan "yeniliğiydi" (Norredam & Krasnik, 2011). Etnografik çalışma aynı zamanda sadece hastane ortamında değil ama yolculuk esnasında farklı durumlarda ve kontrol dışı durumlarda geçtiği için farklı gözlemlerin ortaya çıkmasını sağladı. Örneğin tercümanlık yapan arkadaşlardan biriyle yemeğe gidildiğinde orada kayıt dışı çalışan Suriyeli bir garsonun kolunun çıktığını ancak kaydı bulunmadığı için hastaneye gitmediği ve kolu çıkık bir şekilde çalışmaya devam ettiği gibi bulgular da ortaya çıktı.

Sağlık hizmetlerine erişim bariyerlerinin sınıflandırılmasına gelince Scheppers, Carillo ve Norredam ve Krasnik tarafından sunulan üç modeli kapsayan model, engelleri bilişsel engeller, sosyo-kültürel ve ekonomik engeller ve son olarak yapısal engeller olarak derleyerek tasarlanmıştır. Ayrıca, zorlukların hangi düzeyde yaşandığını belirlemek, erişimi iyileştirmek için müdahale alanlarının belirlenmesine yardımcı olur. Norredam ve Krasnik de iddia ettiği gibi "göçmenlerin erişimi sağlık sisteminin farklı düzeylerinde farklı şekilde etkilenmektedir. Bunu iyileştirmek için çeşitli konular ele alınmalıdır: haklar, sağlık politikaları, hizmetlerin yapısı ve sağlık profesyonelleri ile göçmenler arasındaki klinik karşılaşmanın özellikleri" (2011, s.72). Daha önce de belirtildiği gibi, bilişsel

engeller dil, doktor-hasta iletişimi, ayrımcılık farklı sağlık kültürleri gibi daha algısal, dilsel ve somut olmayan engellere işaret eden engellerdir; sosyo-kültürel ve ekonomik engeller kültürel uygulamalardan, sosyal ağlardan veya bunların eksikliğinden kaynaklanan engelleri ve kadın doktorların eksikliği, ulaşım maliyeti, sosyal ağların eksikliği gibi mali veya istihdamla ilgili konuları kapsar; son olarak yapısal engeller arasında sağlık sistemi, hastane ortamı ve bekleme süreleri, sağlık sisteminde gezinme, çeviri hizmetlerinin eksikliği, kayıtla ilgili konular yer almaktadır.

Çalışma sonucu derlenen öneriler ise literatür boyunca birçok öneride bulunulmuş ve saha çalışması sırasında sağlık hizmetlerine erişimin iyileştirilmesine yönelik öneriler de ortaya konmuştur. Türkiye'deki mültecilere sağlık hizmetlerine erişim ile ilgili literatür şunları içermektedir: Mülteci ve göçmenlerin erişebileceği hizmetler hakkında bilgi yaymak için bilgi merkezleri kurmak. Akıl sağlığı ve üreme sağlığı hizmetleri hakkındaki bilgilerin yayılmasını sağlamak (Cloeters ve Osseiran, 2019). Üreme sağlığı hizmetleri ve zihinsel sağlık hizmetleri gibi daha uzmanlaşmış hizmetler sunmak (Şimşek ve ark., 2018; Cloeters ve Osseiran, 2019). Sağlık hizmetleri ve / veya destek alanında faaliyet gösterebilecek ulusal ve uluslararası kuruluşların sayısını artırmak ve devlet ile işbirliklerini güçlendirmek (Assi ve ark., 2019; Cloeters ve Osseiran, 2019). Özellikle işle ilgili yaralanmalarda tam sağlık hizmetine erişim sağlamak için mültecilerin resmi işgücü piyasasına entegrasyon çabalarını artırmak (Cloeters ve Osseiran, 2019). Mülteci sağlık uzmanlarının sayısını ulusal sağlık sisteminin farklı düzeylerinde artırmak, özellikle kadın hizmet sağlayıcıların (Cloeters ve Osseiran, 2019). Kayıtla ilgili herhangi bir sınırlama olmaksızın sağlık sigortasının kapsamını tüm şehirlere yaymak (Mardin, 2017). Çevirmen sayısını arttırmak ve çeviri hizmetlerini geliştirmek. Arapça bilen personeli hastanelerin bilgi masalarına yerleştirmek (Mardin, 2017; Cloeters ve Osseiran, 2019). Türk sağlık personeline (masadaki kişiler, hemşireler, doktorlar) mülteciler, toplumsal cinsiyet duyarlılığı, kültürel sağlık uygulamaları, zorunlu göç gibi konularla alakalı çeşitli eğitimler vermek (Cloeters ve Osseiran, 2019). Tıbbi

standartları sağlamak için resmi olmayan Suriye kliniklerinde çalışmayı düzenlemek (Cloeters ve Osseiran, 2019). Saha çalışması sırasında Suriyeli sığınmacılara sağlık hizmetlerine erişimin iyileştirilmesi için neleri değiştirmek istedikleri sorulduğunda; dokuz kişi (1 kilit muhbir dahil) daha fazla çevirmenin işe alınması gerektiğini belirtti, beş katılımcı hiçbir şeyi değiştirmeyeceklerini söyledi, yine beş katılımcı (1 kilit muhbir dahil) daha fazla Arap veya Suriyeli doktorun istihdam edilmesi gerektiğini söyledi; iki kilit katılımcı, insanların ulaşım konusunda bilgilendirilmesi gerektiğini, iki görüşmeci doktorların insanlara daha iyi davranması gerektiğini belirtti; iki kilit katılımcı hastane personelinin eğitilebileceğini, 1 kilit katılımcı da dahil olmak üzere beş katılımcı doktorların hastalara daha fazla açıklama yapması gerektiğini belirtti.

Suriyeli mültecilerin sağlık hizmetlerine erişimi bu araştırmada ele alınmış, yasal kapsam, Suriyeli mültecilere sağlık hizmeti sağlama araçları, karşılaştıkları erişim engelleri ana hatlarıyla belirtilmiştir. Her ne kadar sağlık hizmeti Suriyeli mültecilerin Türkiye'de en fazla yararlandıkları en iyi hizmetlerden biri olsa da, hala ele alınması gereken konular var. Daha önce de belirtildiği gibi, sağlık hizmetleri ücretsiz olarak sunuluyor ve erişilebilir hizmetler Türk vatandaşlarına sunulan ile aynı alsa da bu erişimin kolaylığı anlamına gelmiyor. Literatürde vurgulanan engeller dil engeli, kayıt meseleleri, çeviri hizmetlerinin eksikliği, hastanelerin aşırı kalabalıklaşması, psikolojik destek hizmetlerinin ve üreme sağlığı hizmetlerinin eksikliği, ayrımcılık, kalabalıklık ve bekleme süreleri, Türk sağlık sisteminde çekilen güçlükler gibi zorluklardı. Bununla birlikte, Suriyeli mültecilerin sağlık hizmeti ararken karşılaştıkları deneyimler ve zorluklarla ilgili nitel verilerin eksikliği söz konusudur. Amaç, 22 yarı yapılandırılmış görüşme ve 5 katılımcı gözlem yoluyla Suriyeli mültecilerin Ankara'daki sağlık hizmetlerine erişim konusundaki deneyimlerinin bir resmini sunmaktı. Saha çalışması Türkiye'nin diğer illerinde yapılan önceki çalışmalarla benzer bulgular ortaya koymuştur; Suriyeli mülteciler gerçekten sağlık hizmetlerinden memnunlar, ancak dil engeli ve belirtilen diğer engeller de mevcuttur. Bununla birlikte, bu çalışma, dijitalleşme, sosyal

ağların eksikliği, sivil toplumun doldurduğu boşluklar, bilgi eksikliği, sınırlı ajans, doktor-hasta ilişkileri gibi konuların da erişimi nasıl etkilediğini ortaya koydu. Böylece, bu aynı zamanda mülteci çalışmalarında nitel verilerin önemini vurgulamaktadır. Ayrıca, çalışma, çeşitli düzeylerde olası müdahalelerin alanlarını haritalamak için belirlenen engelleri gruplara ayırmıştır.

Etnografik yöntemlerin kullanılması daha bütünsel bir anlayış sağladı ve bir ülkedeki "yenilik" kavramının sağlık sisteminin anlayışını nasıl sınırladığını ve bunun sonucunda kişinin kendi sağlık bakımını yönetmesi durumunda eylemlilik potansiyelini nasıl sınırladığını güçlü bir şekilde gösterdi. Tüm katılımcı gözlemler ayrıca sosyal ağların önemini ve erişimin belki de "daha soyut" bileşenlerinin nasıl ihmal edilmemesi gerektiğini gösterdi. Ayrıca, etnografik çalışma ve yarı yapılandırılmış görüşmeler, mültecilerin gerçek deneyimlerinin anlatıları ile daha bütüncül bir yaklaşım sağladı, ve mültecilerin görüşlerini sundu. Eastmond'ın da ortaya koyduğu üzere "İnsanların birbirlerini anlattıkları öyküleri dinlemek ve mülteciler olarak durumlarıyla çeşitli şekillerde ilişki kurmalarını gözlemlemek, araştırmacının ortaya koyduğu öykülere önemli bir bağlam ve derinlik katıyor" (2007, p.251).

Araştırma, Suriyeli mültecilere sağlık hizmetlerine erişimlerini kolaylaştıracaklarını düşündüklerini sormaya çalıştı. Çevirmenlerin artırılması gerektiği, daha fazla Arap personelin istihdam edilebileceği, doktorların yaklaşımı geliştirilebileceği ve sağlık personeline eğitim verilebileceği, bilinçlendirme faaliyetlerinin yaygınlaştırılması, gibi öneriler sunuldu.

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