THE HEALTH RIGHT OF REFUGEES IN TURKEY

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ABSTRACT

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The main objective of this thesis is to analyze the access of refugees to the right of health in Turkey. There are significant problems in the access of refugees to the available health services and there are no special health services designed to meet the needs of the refugees. Through field research in a city where refugees are settled, the problems related with the access to health services by refugees were examined. In a qualitative study design, this piece of research involved in depth interviews with health professionals, representatives of the NGOs working with refugees and refugees to understand the problems associated with the access of refugees to health services and the dynamics of the clinical encounter between the health professionals and refugees. The study has found that refugees cannot reach sufficient and appropriate health services in Turkey and their fundamental right of access to the right to health is not realized in practice. Moreover, it was found that the provision of health services is riddled with many difficulties, such as the lack of professional translators, the stereotypes common among health professionals about refugees. The legislation about health services and health insurance should be revised in a way to cover all asylum-seekers and to provide special health services for refugees such as comprehensive medical screenings on arrival and trauma and psychological counseling.

Keywords: Refugees, Asylum-Seekers, Health Services, the Right to Health, Medical Sociology

ÖZ

TÜRKİYE'DEKİ MÜLTECİLERİN SAĞLIK HAKKI

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Bu tez çalışmasının temel amacı Türkiye'de yerleşik mültecilerin sağlık hakkına erişimlerini incelemektir. Mültecilerin mevcut sağlık hizmetlerine erişimi konusunda ciddi sıkıntılar söz konusudur ve mültecilerin ihtiyaçlarını karşılaması için tasarlanan özel sağlık hizmetleri bulunmamaktadır. Mültecilerin yerleştirildiği bir şehirde alan araştırması yapılarak, mültecilerin sağlık hizmetlerine erişimi ile ilgilli sorunlar araştırılmıştır. Niteliksel araştırma tasarımı ile bu çalışma sağlık çalışanları, mülteciler ile çalışan sivil toplum örgütlerinin temsilcileri ve mülteciler ile derinlemesine görüşmeler yaparak mültecilerin sağlık hizmetlerine erişimi ile ilgili sorunları ve sağlık çalışanları ile mülteciler arasındaki klinik karşılaşmanın dinamiklerini anlamaya çalışmıştır. Çalışma sonucunda mültecilerin yeterli ve uygun sağlık hizmetlerine erişemedikleri ve sağlık hakkına erişim temel haklarının uygulamada hayata geçirilemediği bulunmuştur. Bunun yanı sıra, sağlık hizmetlerinin sunulmasında, profesyonel tercümanların bulunmayışı ve mülteciler hakkında sağlık çalışanları arasında yaygın önyargılar gibi bazı sorunlar olduğu belirlenmiştir. Sağlık hizmetleri ve sağlık sigortası hakkındaki mevzuat bütün sığınmacıları kapsayacak ve mültecilere ülkeye girişlerinde kapsamlı sağlık muayeneleri yapılması ve travma ve psikolojik danışmanlık hizmetleri verilmesi gibi özel sağlık hizmetlerinin sunulmasını sağlayacak şekilde düzenlenmesi gerekmektedir.

Anahtar Kelimeler: Mülteciler, Sığınmacılar, Sağlık Hizmetleri, Sağlık Hakkı, Sağlık Sosyolojisi

To My Parents

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LIST OF ABBREVIATIONS

EU	European Union
LGBTT	Lesbian, Gay, Bisexual, Transvestite, Transsexual
NGOs	Non-governmental organizations
PTSD	Post Traumatic Stress Disorder
RSD	Refugee Status Determination
SGK	Social Security Institution
UNHCR	United Nations High Commission for Refugees

CHAPTER I: INTRODUCTION

The basic objective of this thesis is to understand and analyze the experiences of refugees in Turkey in accessing health care services. As a country located at the crossroads of migration routes, Turkey has been receiving large number of migrants and refugees. Since the 1980s, it has been a transit route for many refugees trying to reach to European countries. Due to its geographical limitation to the 1951 Geneva Convention relating to the Status of Refugees, Turkey has been providing only a temporary asylum but not permanent refuge to asylum seekers that are not coming from European countries.

For non-European asylum seekers, a dual process is implemented, with the UNHCR running the Refugee Status Determination (RSD) procedure for international protection and assisting refugees for third country resettlement and the Ministry of Interior conducting the procedure for the granting of temporary asylum, and thus temporary protection in Turkey. Those that are found to be eligible for the temporary asylum seeker status are given a residence permit in Turkey until they are resettled in a third country.

In this process, refugees are settled in one of the 30 provinces, called satellite cities, and have the right to employment, education and health. However, as explained in the third chapter, the right to employment is subject to various limitations, which make it almost impossible for the refugees to find work. The biggest obstacle before the realization of such rights is the obligation to pay the residence fee every 6 months, which is a financial burden that many refugees cannot afford.

In this study, I have focused on the realization of the right to health for refugees settled in Turkey. As a fundamental right, the right to health is guaranteed by the Turkish Constitution, as well as international instruments signed by Turkey, regardless of race, color, language, sex, political opinion and other such considerations. The study has aimed to analyze whether asylum-seekers and

refugees in Turkey can have access to health services. Therefore, the main question of the research was whether the health to right, as a fundamental human right, is realized for asylum-seekers and refugees in Turkey.

There are significant problems in the access of refugees to the available health services and there are no special health services designed to meet the needs of the refugees. Through field research in a satellite city, the problems related with the access to health services by refugees were examined. Another question related with the broader question mentioned above is what the special needs of asylum seekers are related with health services.

Under this general question of whether refugees can have access to the right to health in Turkey, the obstacles in practice were analyzed, together with the attempts to overcome the obstacles and solve health problems. Therefore, the provisions of the legislation about health services for refugees, how such provisions are implemented in practice, the health problems that could and could not be solved and the role of NGOs in the resolution of the problems in accessing health services have been the focus of analysis. Following this analysis, the dynamics and the problem areas of the relations between refugees and health professionals were reviewed in line with the findings of the field research. In this respect, the questions for this review include how language problem is and should be solved in the clinical encounter, whether cultural differences act as an obstacle for the diagnosis and treatment processes and what the common complaints of refugees are related with the provision of health problems. Based on the interviews with health professionals, it will be asked whether health professionals have sufficient knowledge about refugees and their conditions in general and whether they are immune from the common stereotypes about refugees. Whether the refugees make different patients than locals was investigated in the study as well, alongside the common characteristic problems of refugees, such as psychological complaints and trauma.

My interest in this particular research topic was due to three reasons. The first was that the studies in the literature about refugees in Turkey are limited in number and

are usually concerned about the legal aspects of the experience of refugees, or, the ones reporting the findings of a field study usually relied on the perceptions and resources of the non-governmental organizations working with refugees. In this study, I attempted to study the various layers of the field about the access of refugees to health services. This has included, the legislation, the practice, the non-governmental organizations, the refugees, the health professionals and even the general public with the impact of their perceptions about refugees on the encounter between the health professionals and refugees. I believe that such an investigation on the multiple layers of the field assists the process of understanding the dynamics better and putting all the actors relevant to the field in context.

Secondly, in my brief employment at a major NGO working with refugees, I have witnessed that the health problems of refugees are usually the ones that are most urgent and hardest to solve. Later, while I was working for an EU project about the training of physicians on torture and ill-treatment, I was able to attend several trainings of physicians and saw in these trainings that, although the issue was not directly related with the topics covered in the trainings, many physicians had questions about refugees in general, since they did not know why they are in Turkey, what their legal situation is, what rights they had and under which legal document the physicians needed to examine and treat them. The physicians were also concerned that they did not have much intercultural experience with the patients and experience about the use of interpreters in clinical services. Therefore, I thought choosing the health sector for the examination of the public services provided for refugees from the perspectives of these two parties would be appropriate given the many areas of exploration and the problems to be analyzed.

Thirdly, the studies in the literature usually focused on the dynamics of health service provision stopping at the gate of the hospital or the door of the doctor's clinic. As a major part of the field, I wanted to take a closer look at the "clinical encounter" between health professionals and refugees. I believe the clinical encounter is a significant part of the research topic to be investigated and I have taken into account the perspectives of both parties to this relationship.

Therefore, with a qualitative research design, I have investigated both the problems of access of refugees to health services and related with this question, I have researched the health problems of refugees, the legislation about refugees in general, and the right to health for refugees, the practice and how the legislation is implemented, and the role of NGOs in the resolution of the problems with regards to the solution of the problems. All these layers form a complex relationship with regards to the research topic and the connections were sought and tried to be shown in the thesis.

Following this analysis, I will look closer into the dynamics of the relationship between the health professionals and refugees. In this relationship, problematic areas such as the language differences, the use of translators and its effect on the communication between the parties and confidentiality of physicians and refugees, and cultural differences will be investigated. Related with these aspects, the comments of the health professionals and refugees about the dynamics of the clinical encounter will be investigated and it will be discussed whether the health services for refugees are sufficient and appropriate.

To seek answers to these questions, a field study was conducted in a Central Anatolian province and two other cities for some interviews. For the study, 13 physicians, 13 other health professionals, the representatives of 6 NGOs working with refugees and 24 refugees were interviewed. All the personal information about the interviewees was kept confidential throughout the thesis.

The first chapter of the study is the introduction part, summarizing the questions of the study, the reasons for the interest in the research topic and the methodology of the study. The second chapter will present the findings of other studies in the literature about health services of refugees, the common health problems and the "pathologization" of refugees in general. In the second section of the chapter, the methodology of the study was discussed in detail and information about the interviewees was provided.

The third chapter will start with the provisions of legal documents about refugees in general and their right to health and employment, to familiarize the reader with

the subject and the rights of refugees. This is followed by an analysis of how these provisions are translated into practice will be analyzed, with the complex procedures implemented. Such complex procedures prevent many refugees from seeking or accessing medical care. Thus, the third section of the third chapter continues with a focus into the health problems of refugees and whether they can be solved or not. The role of NGOs in assisting refugees to solve their health problems will be narrated in the last section of this chapter.

In the fourth chapter, the dynamics of the clinical encounter will be analyzed. The chapter starts with the issue, which was argued to be the most important problem, of language differences and the use of translators to ensure communication. The downsides of the use of friends and relatives as translators will be discussed and the use of professional and trained translators, who may also act as cultural interpreters, will be recommended. In the next section of the fourth chapter, the effect of cultural differences on the examination, diagnosis and treatment processes were discussed. The complaints of the refugees about the examination being too short after a long period and the impact of the perceptions of the general public on refugees on the perceptions of health professionals on the same group constitute other sections of this chapter. Following these aspects, the answer to the question whether refugees are different patients from locals for health professionals will be sought, with the implication of whether have some special needs with regards to health services. Psychological problems and trauma were analyzed under a different section in this chapter because of the argument about the commonness of such problems among refugees and its direct impact on the clinical encounter. Finally, some remarks about the appropriateness and sufficiency of the health services for refugees will conclude this chapter.

The last chapter of the study is the conclusion part. Here, the main findings of the study will be presented once again and the shortcomings of the study will be discussed. Recommendations for the improvement of health services and the health-related conditions of refugees will be developed and questions will be raised about the areas for future research.

CHAPTER II: CONCEPTS, DEFINITIONS AND METHODS OF RESEARCH

One of the consequences of globalization process is often cited as increasing international migration, and particularly, an increasing number of refugees. Among the most frequently cited reasons for this trend is the new technologies of mass transportation, making it easier and cheaper to have access to the opportunities to move within and from one's own country, together with the new technologies of communications, informing the would-be migrants and refugees about the opportunities and possibilities in the would-be destinations and therefore facilitating the decision-making process for such agents. Another significant, though less mentioned feature of globalization process creating more refugees is the discourse of universal human rights. Marfleet argues that while, on the one hand, the global processes increase awareness all over the world regarding the rights owned for simply being a human, the human rights discourse, on the other hand, also serves as a legitimizing tool for Western intervention into the domestic affairs of nation-states, resulting in conflict and thus more asylum-seekers and refugees (Marfleet 2006, 219-20). Meanwhile, globalizing process, with its direct and indirect consequences of weakening the nation-state and increasing inequality both at local, national and international levels, is also a factor increasing the number of international migrants and refugees.

2. 1 The term refugee: definitions, labels, debates

There are a number of categories referring to the non-nationals living within the borders of a nation state, distinctions being drawn between them in line with the legal processes related to their acquisition or non-acquisition of a residence permit on that territory, and also in line with the reasons for their arrival to that territory. One major distinction refers to the difference between migrants and refugees, stemming from a rather arbitrary distinction between economy and politics as the

primary motivation for their leaving their country of origin. Another distinction in terminology is between asylum-seekers and refugees and while the former refers to the people who have filed their applications to be recognized as refugees and waiting for the finalization of these legal processes for their status determination, the latter are people whose refugee status are recognized by the host state and therefore are entitled to the rights pertaining to the refugee status, which are regulated in broad lines in the 1951 Geneva Convention but are subject to differences in line with differing regulations of states.

In line with this rather simple distinction made according to the obligations of states under the international law, the term "refugee" has rather recently attracted the attention of scholars of the field of international relations with its implications for the domestic policies and practices for individual states. In the current international states system, which is based on the notion of sovereignty of nation states, the category of refugee is situated between the states, "at the intersection between the international and the domestic." (Haddad 2008, 3) The category is based on the fundamental right of an individual to seek asylum, recognized under the Universal Declaration of Human Rights, when a sovereign nation-state rejects or fails to offer protection to its citizen, although it is assumed to be the body that is solely responsible to provide for the protection of all its citizens in the international system of states. Therefore, the emergence of refugee is seen as a purely domestic process, with its implications for other states and the international system, due to the flight of the concerned individual and its quest for international protection.

Understood in this manner, the refugee emerges out of an anomaly in the normal functioning of the international system of nation-states. According to Keely, "In the contemporary geopolitical system, everybody belongs somewhere... Flows of refugees unable to receive their state's protection are not only deviant, they also threaten geopolitical structures based on the sovereign state." (Keely 1996, 1051) Within this approach, when the individual who has fled his or her country of origin is recognized as a refugee, the anomaly is fixed with the assumption of the responsibility of protection by another country.

However, Haddad reminds that the concept refugee is not such an anomaly as being "outside" the international system, but an inevitable consequence of the international states system (Haddad 2008, 1). Haddad argues, "Refugees are not a sign of the international system going wrong. They are in fact an inherent if unanticipated part of the system. Refugees are victims of an international system that brings them into being, then fails to take responsibility for them." (Haddad 2008, 69) Therefore, if refugees are considered a threat to the nation-states and the sovereign-state-based international structure, this threat is created by the system itself (Keely 1996, 1058). Moreover, in the increasingly interdependent world of nation-states, the formation of the refugee flows is a process that cannot be limited strictly to domestic conditions, but are always consequences of transnational processes. (Zolberg *et. al*. 1986, 153)

The construction of the refugee as a threat for the international states system coincided with the end of the Second World War and the response generated for the threat was the formulation of the international refugee regime, in order to protect the states and the international system of states that are considered to be threatened when sovereign states fail to fulfill the roles they are supposed to take on. (Keely 1996, 1057) Since the 1980s, the perceived threat is voiced louder by the media and politicians, particularly in the Western states, although the major refugee burden are shared by the Third World countries, while around 10 percent of the refugee population, which constitutes relatively younger, wealthier and more educated refugees, are in Western countries (Ingleby 2005, 3).

As an administrative term, a clear definition of the term refugee is provided by the first international legal document regulating the status of refugees: the 1951 Geneva Convention, which was codified largely due to the need of the European states to respond to the massive displacement events following the Second World War. According to the oft-quoted definition of the 1951 Convention, a refugee is a person who,

> owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is

> unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

The 1951 Convention was originally formulated for the refugees that originate from European countries, but the Protocol signed in 1967 removed the Eurocentric geographic limitation and made the Convention a universal instrument of international refugee law. In many countries today, the refugee determination procedure is undertaken by the United Nations High Commissioner for Refugees (UNHCR), and in some by the state itself, using the criteria set by the 1951 Convention. However, the encounters with the officials of the UNHCR and the state, who conduct the refugee status determination procedure, are usually experiences that are considered hostile by the refugees. Regarding the UNHCR staff, Harrell-Bond contends that the staff follows procedures that are usually less favorable than what UNHCR recommends state officials to adhere to, and goes on to argue, "The majority of refugees go through this process, without enjoying their right to legal representation, in a social environment that is dominated by a culture of disbelief or cynicism." (Harrell-Bond 2002, 54) In a similar vein, Marfleet states, "The world of the refugee is one in which attempts to innovate – to cope – are inhibited by institutions which exhibit deep mistrust of the displaced." (Marfleet 2006, 214) It is in this environment of mistrust the decisions regarding the refugee status determination, "a matter of life or death" for many applicants (Selm-Thorburn 1998, 5), are made.

There are a number of criticisms against the 1951 Convention, particularly with regards to the narrowness of the category due to the signatory states' willingness to avoid assuming too much responsibility and the effect of the Cold War politics on the definition of the refugee in the Convention. According to Marx, the main concern of the 1951 Convention was to "narrow down the category refugee, in order to give governments a free hand whom to call a refugee" (Marx 1990, 190). The states that created the 1951 Convention formulated an individualistic definition of the refugee, requiring that the applicants for the refugee status prove that there was a threat of persecution directed particularly towards them individually. The

Convention was created due to the regret for the tragedies of 1930s, yet displayed a "continuing fear and rejection of others." (Marfleet 2006, 144) Hence, the definition excluded people who had to flee from their countries due to mass disturbances, civil strife, and other similar conditions that influence the society at large, situations that create the majority of mass displacements in today's world, setting out a rather narrow and political approach (Marfleet 2006, 146). As a typical example of the criticisms directed against the 1951 Convention, Kennedy and Murphy-Lawless contend that the refugee definition of the 1951 Convention does not capture the realities of today's world.

> The context that lies behind people's movements is very different now to when the UN Convention on Refugees was produced in 1951. The Convention reflected the politics of the Cold War, emphasizing those fleeing political and religious persecution then associated with the Soviet Union. Those forms of persecution are international and continuing, but in an era of free-flowing globalized capital, that definition does not cover all the reasons that now drive people from their own country, such as military and political upheavals, the collapse of the old borders, forced migration or eviction, famine, natural or environmental disasters, and environmental degradation and pollution and land scarcity. (Kennedy & Murphy-Lawless 2003, 42)

Apart from the criticisms raised against the refugee as a legal category, social scientists also challenge the usefulness of the term in capturing the social experiences of the people subsumed under the category, which are assumed to be dramatically different from people that have gone through other forms of displacement. "Within academic discourse," Griffiths argues, "the attempt to enforce a rigid distinction between refugees and other categories of migrants, other than in terms of legally encoded forms of protection, is becoming increasingly untenable." (Griffiths *et. al*. 2005, 85) Other authors contend that the term is ambiguous (Marx 1990, 189), to the point that it is actually easier to define who is not a refugee (Haddad 2008, 27) and some have sought alternative definitions for the term refugee for sociological analysis and research, such as "a person whose social world has been disturbed." (Marx 1990, 190)

A common point to be observed through all such arguments challenging the usefulness of the distinction between refugees and other migrants for social analysis is the relative arbitrariness of the rigid distinction between politics and

economy. As argued above, the category refugee is primarily a political one, whereas the people that have left their countries for economic purposes, without experiencing any kind of persecution or the threat of persecution, are categorized as migrants. Hence the terms "political refugees" and "economic migrants," a distinction that can be found abundantly in the discourse of the Western media and politicians targeting the asylum seekers for "abusing the system of asylum although their primary motives for leaving their countries are economic." However, in practice, the distinction between politics and economy in any given country is not so clear-cut. Therefore, in many cases, the primary motive for one's fleeing his or her country of origin is usually a mixture of both politics and economy and it is hard to differentiate whether the fear of persecution claimed by the applicant can be considered to be in line with the criteria set in the 1951 Convention.

Moreover, the severity of the perceived threat to one's survival is hard to measure in absolute terms and the conditions that drive people out of their homes may vary in severity. Zolberg *et. al.* argue that while dichotomous categories as in the distinction between refugees and non-refugees may be necessary for legal and administrative purposes, for social analysis, the refugee concept should be considered a variable that has varying degrees of danger. Using this approach that allows for different degrees of forcedness for one's flight would allow for analyzing different degrees of refugeness. (Zolberg *et. al.* 1986, 153)

While some authors contend that while the nature and impact of flight and refugee in situations of crisis are exceptional, it is untenable to argue for the inherently different nature of refuge from other migratory experiences (Essed *et. al.* 2004, 6), there are some others claiming that the refugee experience as a whole, with its legal and administrative consequences, is fundamentally different from the experience of immigrants.

> Refugees are in some ways different, at least initially, from other immigrants, and the nature of these differences appears to affect their adjustment strategies, processes and patterns. They are different from a legal standpoint because of the criteria by which they are selected for admission, and from a public policy standpoint because of the programs which have been authorized for them. But their differences fundamentally derive from factors surrounding their need or

> desire to flee their homeland, their route and ultimate destination, the disruption or destruction of their families and perhaps society, their choice and ability to return, and in some cases, the numbers and rate of their resettlement. (Howell 1982, 122)

Although such debates hold for the analysis of the dynamics of the experiences of refugees in settlement and resettlement countries, for the purposes of this thesis, a distinction will be made between refugees and other immigrants in Turkey, because of their temporary settlement and thus precarious presence in this country due to Turkey's geographical limitation for granting refugee status. Because of the limitation, the people seeking asylum are granted a temporary leave to remain in Turkey until they are granted the refugee status by the UNHCR and are settled in a third country, as will be discussed in detail in the next chapter of the thesis. The transitory nature of their settlement in Turkey fundamentally changes the experiences they have in this country.

With the increase in the interest towards refugees in literature, political speeches and media, the efforts to understand and explain the refugee experiences in the world created an assumed homogenous identity for refugees. Stein and Keller endeavored to explain a generalizable experience for all refugees and were criticized by Malkki for creating "an essential refugee" figure in the literature (Malkki 1995, 510). According to Stein, the stages of the refugee experience are as follows: perception of a threat, decision to flee, the period of extreme danger and flight, reaching safety, camp behavior, repatriation, settlement or resettlement, the early and late stages of settlement, adjustment and acculturation, residual states and changes in behavior caused by the experience. (Stein 1981, 321)

The media and politicians around the world, and particularly in Western countries, made use of this image of "essential refugee" as well, portraying refugees and asylum seekers as an "undifferentiated mass of people, erasing individual differences" (Harrell-Bond 1989, 48). This image was fed by an assumption of a homogenous identity for all refugees, which is increasingly characterized with a loss of identity following displacement (Malkki 1995, 508), pathologization, criminalization and even dehumanization. With the label of refugee, people with different backgrounds and histories are stereotyped according to the

institutionalization of a legal status for them, creating and imposing an institutionalized dependency. (Zetter 1988, 1)

For sociological analysis in general and for the purposes of this study, the term refugee should be taken not as a label for a homogenous and generalizable kind of person or experience, but as an administrative and legal term that incorporates a world of different histories, conditions of flight, socioeconomic statuses, and experiences of settlement as a refugee (Malkki 1995, 496). Such differences will be actively sought and included in the analysis throughout the thesis.

2.2 Health of refugees

The increasing interest in refugees since the 1980s was met with a growing number of articles in the literature on refugee health. Describing the health situations of refugees and asylum seekers in the countries of resettlement, many scholars have pointed to the problems encountered in the delivery of health services and developed recommendations for the improvement of health services for refugees and asylum seekers.

The literature survey on the health situation of refugees reveals that the majority of studies on the health situation are about Southeast Asian refugees living in the U.S.A. (Young *et. al*. 1987, 761-762). Such studies report the findings of medical assessment programs, indicating that the two most common problems among Southeast Asian refugees are parasitic infections and tuberculosis, followed by hepatitis B, anemia, dermatological problems and antigenemia. (Cantazaro and Moser 1982; Lindes 1979; Erickson and Hoang 1980; Powell *et. al*. 1983). Examining the health situations of 277 refugees from the Middle East, Eastern Europe and Southeast Asia settled in Detroit metropolitan area, Young *et. al*. found that the health situations of the refugee groups are quite good, comparable to the average health situation of U.S. citizens, except for the existence of measles and viral hepatitis. (Young *et. al*. 1987, 765) Similarly, Holtzman and Nezam compare the health situations of refugees and other displaced persons in Europe and Central

Asia based on reports of the states and international bodies, concluding that the health situations of displaced persons appear fairly comparable to those of the local populations. (Holtzman and Nezam 2004, xiii)

With regards to dental health, the situation seems to be worse based on self-reports of the refugees and asylum seekers and dental screening programmes. Young *et. al*. report in the study mentioned above that the most common health problems among refugees are dental problems (Young *et. al*. 1987, 763). Similarly, Tamil refugees in Australia report dental health problems and obstacles in accessing dental health services (Silove *et. al*. 1999, 954). As a result of a dental health screening programme in Italy, Angelillo *et. al.* report poor oral health among immigrants and refugees and argue, "those who need oral treatment rarely receive comprehensive dental care and when the treatment was provided it was likely to be in form of extractions." (Angelillo *et. al*. 1996, 363)

Some studies in the literature also focus on the special needs of refugee women with regards to health services. Looking into the maternity care needs of refugee and asylum seeking women in Ireland, Kennedy and Murphy-Lawless state that the majority of women experience health problems because of poor health services prior to departure and, some, due to rape and torture. (Kennedy & Murphy-Lawless 2003, 43) However, they experience problems in accessing antenatal care (Kennedy & Murphy-Lawless 2003, 46), as well as health problems after they are resettled because of bad settlement conditions (Kennedy & Murphy-Lawless 2003, 45). The refugees resettled in the United States are also reported to be having gynecological examinations significantly less frequently than U.S. citizens. (Weinstein *et. al*. 2000, 313) Reviewing the policies and practices in many different states, Lehmann argue that services for refugees wanting to have abortion are almost nonexistent throughout the world (Lehmann 2002, 152), usually because refugees may be unaware when abortion is permitted under the local law or health practitioners may not be fully informed about the broader indications for abortion (Lehmann 2002, 153). The focus on the health situation of refugee women is criticized for being misleading for two reasons: this focus usually defines women

only in terms of their reproductive capacity and it also overlooks the impact of gender as a variable influencing the life in asylum. (Muecke 1992, 518)

The traumatic nature of events experienced by refugees prior to their departure, the harsh conditions during flight and the settlement conditions, as well as the difficulties in adopting to a new environment and culture, in the resettlement areas have brought the mental health of refugees to the fore in the literature. The number of articles on the mental health of refugees has increased significantly since 1980s, with a focus on the impact of past sufferings prior to migration, rather than the experience of forced migration itself (Ingleby 2005, 7). Ingleby argues that the acceptance of Post Traumatic Stress Disorder (PTSD), which will be discussed in detail below, as a psychiatric category in 1980 contributed to the rise in the level of interest on the mental health of refugees (Ingleby 2005, 7) and that a review of the literature reveals that since 1980s, researchers of trauma, who got interested in refugees, are responsible for the rise in the number of articles on the issue, rather than researchers of refugees becoming interested in the mental health of the subjects they study. (Ingleby 2005, 9) The implications of the points raised in the literature will be discussed later in this chapter, while this section will refer to the studies that examine the frequency of mental health complaints among refugees and the issue of somatization, which is argued to be directly linked with mental health.

With regards to refugees settled in United States, both Young *et. al.* (Young *et. al.* 1987, 776) and Weinstein *et. al.* (Weinstein *et. al.* 2000, 321) report low prevalence of diagnosed and self-reported mental problems among refugees. However, there seems to be high frequency of ill-defined symptoms and conditions (Weinstein *et. al.* 2000, 313), which lead researchers in the field to argue for the high prevalence of somatization among refugees, both because of cultural interpretations of mental illness, the desire to avoid the stigma of mental illness and communication problems with providers of health care.

Somatization refers to the "expression of personal and social distress in an idiom of bodily complaints and medical care seeking" (Lin *et. al.* 1985, 1080), and leads to

failure of treatment for the complaints of the patients and an increase in the cost of health services. Various studies suggest that somatization is common among asylum seekers and refugees, and explanations for this trend include the emphasis of physicians on biomedical problems and their tendency to overlook psychosocial ones (Lin *et. al*. 1985, 1080), the possibility that refugees experiencing severe psychological problems may lack the direct communication skills to express them or interpreters may not be experienced (Gong-Guy *et. al*. 1991, 645) and the possibility that refugees experiencing mental health problems try to avoid stigmatization due to mental illness (Gronseth 2001, 494). Cultural factors may also influence interpretation of the complaints and, therefore, the help-seeking behavior of refugees experiencing psychological problems. A study conducted with Mariel Cuban and Haitian refugees in South Florida concludes that need for care is a major determinant of help-seeking behavior and while singles, women, young adults seek more help, education and knowledge of English play no role in the help-seeking behavior of refugees (Portes *et. al.* 1992, 295).

Apart from the traumas experienced before flight, scholars also suggest that the departure period, which is usually full of dangers and threats (Gong-Guy *et. al*. 1991, 642), and the resettlement processes, with the difficulties of adopting to the new environment, the problems in settlement conditions and the stigma of the refugee status (Gronseth 2001, 505), may lead to psychological complaints among refugees and asylum seekers. The liminality of refugee experiences are stressed by a number of authors (Malkki 1992, 34; Williams 2006, 876; Kibreab 2004, 25) with its impact on the psychological health of refugees (Holtzman and Nezam 2004, 93) because of the sense of loss, particularly with regards to social and religious relations (Gronseth 2001, 494) and the creation of a sense of dependency, as a result of the policies of states with regards to asylum seekers and refugees.

Examining the linkage between the social conditions for Tamil refugees in Northern Norway and ill health, Gronseth draws attention to the fact that the psychological health of Tamil refugees cannot be simply reduced to the traumas experienced prior to migration or the adjustment to the host society (Gronseth 2001, 495). She argues, “it might be possible to understand Tamils' complaints at

the health care centers as expressions of the aches and pains of being lost and in search of identity and well-being" (Gronseth 2001, 507), and concludes that such quests of identity should be recognized as Tamil refugees complain that they are treated as organs rather than as persons while they seek medical help.

One of the problems detected by several authors in the field with regards to the provision of health services is the problems of access to appropriate health services by refugees and asylum seekers. Prior to resettlement, in the refugee camps, the health services are usually considered to be fragmented and uncoordinated, because of the simultaneous provision of health services by different organizations and lack of leadership among them. Such problems are creating an obstacle for the service provision of mental services for refugees in camps. (Gong-Guy *et. al.* 1991, 643)

In countries of resettlement, access to health care can be problematic particularly for asylum seekers and because the personnel of health institutions may be lacking information about the rights of refugees and asylum seekers regarding health care. In Australia, refugees have a right to access health services but asylum seekers are excluded from the health system, except in cases of emergency and essential medical services. (Silove *et. al.* 1999, 952) Essed and Wesenbeek discuss the situation of illegal migrants, an issue that is directly linked with the strictness of refugee policies in many countries, and argue, "there are few areas where the contradiction between policies and moral principles is negotiated more critically than in healthcare for people without legal status." (Essed and Wesenbeek 2004, 54) Pointing out that illegal migrants have no rights regarding health services, except in the case of infectious diseases, they contend that extending health services to illegals becomes a matter of personal consciousness on the side of the health service providers (Essed and Wesenbeek 2004, 64). Meanwhile, in South Africa, African asylum seekers and refugees continue to be refused emergency health care in public hospitals (Belvedere *et. al*. 2008, 250) because of lack of information and clear guidelines for the personnel of public hospitals about the health rights of such groups, which leads to health care providers making their own decisions (Belvedere *et. al*. 2008, 253). Difficulties in accessing health services is

listed among the reasons for the underuse of health services in the U.S. by Southeast Asian refugees (Uba 1992, 546)

In general, host countries guarantee the rights of refugees to health services as provided to citizens but the reasons for the problems of access are due to the lack of coordinated government policy that recognizes and incorporates the special needs of asylum seekers and refugees, such as trauma counseling and comprehensive medical screenings. Belvedere *et. al*. argue, "Refugees often fall through the cracks in national health and welfare systems, and access to appropriate services is not always guaranteed, often for bureaucratic reasons" (Belvedere *et. al*. 2008, 248). Some authors call for more comprehensive health programmes for refugees and asylum seekers, to overcome problems of access, such as logistical difficulties, lack of cultural competence and availability of interpreters, since "detecting and treating all medical conditions is important from both humanitarian and economic perspectives." (Kennedy *et. al*. 1999, 471)

Language problems are one of the most cited problems in the health service delivery for refugees and asylum seekers (Gong-Guy *et. al*. 1991, 643-644; Kennedy *et. al*. 1999, 471; Uba 1992, 544; Belvedere *et. al*. 2008, 251; Betancourt *et. al*. 2003, 296). In the study conducted by Young *et. al*., mentioned above, the findings indicated that getting the doctor to understand the refugee and understanding what the physician was saying were the two highest ranking problems among refugees. (Young *et. al*. 1987, 776) On the importance of interpretation services, Weinstein states that the risk of compromising proper health care, including informed consent, is high where there are language barriers between the providers of health service and patients that prevent proper communication. (Weinstein 2000, 322) Communication between the physician and the patient, without an interpreter or an adequately trained and culturally competent interpreter, can completely block the provision of health care services, since "effective communication is crucial for the health care professional to explain preventative measures, make a diagnosis, or treat the conditions that threaten and compromise an individual's state of physical, mental or social well-being." (c.f. Pillar, Belvedere *et. al*. 2008, 272)

The problem of the unavailability of interpreters for health care is usually tried to be overcome through the use of family members, friends or community members as interpreters in the delivery of health care services. Refugee networks are usually used by health service providers through making use of usually unpaid interpretation services of them when refugees bring them to their appointments (Williams 2006, 878), and, in this context, are crucial resources to fill the gaps in service provision (Griffiths *et. al*. 2005, 133). Although the use of refugee networks may be crucial in establishing dialogue with refugees in general, "informal networks should never be expected to replace state welfare provision" (Williams 2006, 878). In the case of interpretation services, there is a risk of misunderstanding in the use of refugee networks, because of the lack of adequate training, the attitudes of the translator used to the patient or the complaints and the problems of disclosing some confidential information to a member of the refugee's community.

Related with communication problems between refugees and health care providers is the problem of cultural differences that may lead to a loss of confidence in the treatment suggested by the physician and the refugee's failure to follow the treatment. According to Uba, many Southeast Asian refugees settled in the U.S. experience severe health problems but underuse the health care system mainly due to their cultural interpretations of their illnesses and distrust in the Western medicine, contributed by the provision of culturally irrelevant services. (Uba 1992, 544-547) Analyzing the health care decision making processes among Cambodian women, Frye concludes that there are significant perceptual differences between refugees and health care providers regarding areas such as the definition of kind and causes of diseases, illness behaviors and treatment modalities (Frye 1991, 33).

Medical care is usually considered the application of universally accepted scientific based truths on the persons of the refugees and culturally-specific dimensions of the illness and treatment are rarely acknowledged. However, there is a growing awareness in the literature about the need to understand the culture of health and the sociocultural context that surrounds the patient and how these circumstances affect his or her interpretations of the disease, particularly its origins and meanings,

and decisions to follow the medical treatment (Ito 1999, 339). Based on this approach, a number of authors investigated how diseases and treatments prescribed by the physicians are interpreted by Southeast Asian refugees settled in the U.S. (Ito 1999, 353; Frye & D'Avanzo 1994, 90) The authors particularly stress that being treated as sick is an insulting experience for Southeast Asians, particularly in the case of psychological problems and that the diagnoses of the physicians are treated with suspicion in line with the mistrust to the Western medicine practices.

As a result of the increasing awareness on the significance of cultural interpretations, it is emphasized that "the clinical encounter between the patient and the health care provider is critical to the patient's confidence in the doctor's understanding of his or her illness and to the patient's eventual medical compliance." (Ito 1999, 338) Therefore, scholars in the field suggest cultural competent health care, which is defined as one that "acknowledges and incorporates – at all levels – the importance of culture, assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs," (Betancourt *et. al*. 2003, 294), which can be incorporated into the existing systems of health care through cross-cultural trainings to be delivered to health care providers.

Apart from these difficulties, refugees and asylum seekers may also encounter xenophobic attitudes and treatments when seeking medical care (Belvedere *et. al*. 2008, 251; Gong-Guy *et. al*. 1991, 646). The providers of health care are not immune to the stereotypes about refugees and asylum seekers widespread in the larger society, and racial, gender and other stereotypes may contribute to discriminatory practices in health institutions (Essed and Wesenbeek 2004, 61). Racism in particular is argued to be affecting health care in three ways: "direct racism, where a person is treated badly because of her ethnic background; indirect or institutional racism, where services that should be equal, favor the needs of some groups while not answering the needs of others; and ethnocentrism, where inappropriate ideas or lack of awareness dominate the response of a majority group over a minority." (Smaje (1995) c.f. Kennedy & Murphy-Lawless 2003, 49)

Racism can be also riddled with the general policies of states with regards to asylum seekers and refugees, having an impact on the health of these groups. The increasingly restrictive policies of the western states lead to "social marginalization of asylum seekers and refugees, both in terms of their socioeconomic position and in relation to their diminishing rights and entitlements. (Griffiths *et. al*. 2005, 2) In the U.S., the health policy regarding refugees indicates that all applicants will be subject to a comprehensive health screening prior to their arrival on the U.S. territories, and when a serious disease is detected, the person is not allowed to enter the U.S. (Kennedy *et. al*. 1999, 470). Another medical screening is conducted right after the arrival of a refugee or asylum seeker to the United States and people with infectious diseases are quarantined. Historically, Weinstein *et. al.* argue, the policy of the U.S. "on refugee health has been shaped by quarantine practices historically, since refugees and immigrants are considered "potentially dangerous people, capable of compromising the health of "real" Americans." (Weinstein *et. al*. 2000, 304)

In general, the health care policies of states towards refugees and asylum seekers are partly motivated by the principles of human rights, in line with the obligations assumed under international documents on human rights and rights of asylum seekers, and partly by pragmatic considerations since health problems lead to unemployment and failure to integrate into the larger society, making refugees more dependent on the state (Ingleby 2005, 5). However, in most western countries, the policy of refugee health is primarily aiming to protect the health of the host population (Weinstein *et. al*. 2000, 305). With little consideration of the special needs of asylum seekers and refugees with regards to health care, these groups have also been excluded from the decision making processes about health care systems (Muecke 1992, 518).

One particular example for the impact of refugee policy on the health of refugees is the dispersal policy implemented in Britain, which is similar to the policy of the Turkish state with regards to asylum seekers and refugees as will be discussed in the next chapter. Under the policy, the refugees with granted refugee status are sent to different areas of the country, which have little experience with different

cultures. Griffiths *et. al*. argue that the primary motive behind dispersal is firmly assimilationist, "reducing the social visibility of asylum seekers and their potential pollution of social space" (Griffiths *et. al*. 2005, 42). Sending refugees to previously monocultural areas increases social friction and hostility and the refugees frequently complain about the lack of facilities in the dispersal areas and the hostility of local populations (Griffiths *et. al*. 2005, 100). Moreover, refugees sent to dispersal areas remain far from their established ethnic communities living in larger metropolitan areas and cannot have access to the resources these ethnic networks provide for them, such as interpretation services while seeking health care and valuable information about the available services. Marfleet argues that far from their ethnic communities, refugees have higher levels of depression because of the dispersal policy and, "more recent proposals include plans for comprehensive health checks on all applicants for asylum, with the implication – echoing many earlier episodes of state hostility to refugees – that as bearers of disease they require isolation and remedial treatment. Refugees in Britain are to be quarantined – identified as alien and undesirable and set aside from society at large." (Marfleet 2006, 276)

2.3 Pathologizing the refugee

In the first section of this chapter, it was mentioned that the discourse of the media and politicians about refugees and asylum seekers creates an essential refugee identity, pathologizing and dehumanizing the refugees (Marfleet 2006, 193) in particular countries and in the world. The process of pathologization is closely related with the interventions, practices and discourses about the health of refugees, which have accompanying analyses in the literature as well. In this section, the pathologization and medicalization processes with regards to refugees will be traced and the responses to these processes in the literature will be referred to.

The pathologization process is closely related with the discourses about the mental health of refugees. The experiences of the refugees prior to their flight, which are assumed to be so severe and heavy, are considered to be traumatizing all refugees

and asylum seekers without any exception and because of the assumption that all people experiencing a trauma are automatically traumatized (Ingleby 2005, 9), there is an equation of refugeeness with psychological disorder (Malkki 1995, 510).

Summerfield argues that there are seven common assumptions that lie behind the medical interventions in times of war and crisis, which are that the experiences of war and atrocity are so extreme and distinctive that they do not just cause suffering, they cause traumatisation; that there is basically a universal human response to highly stressful events, captured by Western psychological frameworks; that large numbers of victims traumatised by war need professional help; that western psychological approaches are relevant to violent conflict worldwide and victims do better if they emotionally ventilate and work through their experiences; that there are vulnerable groups and individuals who need to be specifically targeted for psychological help; that wars represent a mental health emergency; and that rapid intervention can prevent the development of serious mental problems, as well as subsequent violence and wars. He argues that such assumptions are pathologizing the people experiencing wars and such crises because they transfer the events in the social realm to the biopsycho-medical realm. He goes on to argue, "this is the objectification of suffering as an entity apart, relabelling it as a technical problem – trauma – to which technical solutions (like counselling or other psychological approaches) are supposedly applicable. However, misery or distress per se is surely not psychological disturbance in any meaningful sense and for the vast majority of survivors, traumatisation is a pseudocondition." (Summerfield 1999, 1452)

Since all refugees are assumed to be traumatized, a common concept mentioned with regards to the mental health of refugees is the Post Traumatic Stress Disorder (PTSD). As argued above, the PTSD was accepted as a psychiatric category in 1980 and has been used frequently in reference to asylum seekers and refugees since then. However, there are a number of criticisms directed against the almost general use of PTSD to explain the mental health status of the refugees and their experiences. Summerfield argues that the PTSD category emerged as a socio-political, as well as medical, response for particular people at a particular point of time, but the field of mental health ascribed a status of scientific truth to it, which

made it a universal category to explain different experiences alike independent of the context. (Summerfield 1999, 1450) However, "the causes of the psychological problems of refugees cannot be reduced to a single catastrophic, life-threatening event, or even to a sequence of such events... The concept of PTSD focuses on only a part of the stressful experiences which most refugees have undergone. Likewise, the PTSD concept focuses on a small selection of the effects of these experiences." (Ingleby 2005, 11) Muecke also criticizes the widespread utilization of the PTSD diagnosis as perpetuating the reductionism of psychiatric categories and sanctioning the constant neglect of refugee suffering due to the stigma of the refugee status and the isolation and discrimination from the host society. (Muecke 1992, 520)

Alongside the trauma experiences prior to the flight of refugee, the experiences in the host country are also considered to have pathological consequences for the mental health of refugees. The dependency syndrome is one of the most frequently cited pathological consequences, with the sense of helplessness, loss of identity because of displacement, and manic and aggressive disorders (Stein 1981, 324). Overall, refugees are labeled as helpless and vulnerable (Harrell-Bond 2002, 57) because of the pathologization of uprootedness, which has political, medical and moral forms (Malkki 1992, 32). As a result of such experiences, "... the "real refugee" was imagined as a particular kind of person: a victim whose judgment and reason had been compromised by his or her experiences. This was a tragic, and sometimes repulsive, figure who could be deciphered and healed only by professionals, and who was opaque even (or perhaps especially) to himself or herself." (Malkki 1996, 384)

Whereas Western officials and journalists treat refugees as villains and describe them as difficult people (Conquergood 1988, 195), the personnel of the agencies that work with refugees and asylum seekers in refugee camps and in the countries of resettlement are not immune to the trend of pathologization of refugees. (Harrell-Bond 2002; Malkki 1992; Conquergood 1988) With regards to the personnel of the state and organizations dealing with refugees, Marfleet argues that

they regard refugees as separate people that should be isolated and provided specific services directed to a narrow range of outcomes. (Marfleet 2006, 211)

The analyses on the views regarding the health of refugees reveal that medicine cannot remain outside the racist or sexist views that are widespread in the society as a whole. Moreover, since medicine, both physical and psychological, focuses on problems and pathologies, talking about the medical services of refugees seems to be portraying solely pathologies of refugees, rather than the endurance and strength they have displayed in creating themselves new lives in new countries. Muecke argues, "medicine and agency-serving assumptions in health care reduced the persona of refugees to physical bodies in need of repair...Refugees were so objectified by this perspective that their suffering and emotional distress were fundamentally overlooked." (Muecke 1992, 520) What is needed is an analysis of the health problems of refugees and their access to health services, recognizing that access to health is a fundamental right to be accorded to all individuals, rather than being a matter of charity or personal conscience, through contextualizing such aspects with the relevant histories and cultures of refugees, host societies and states.

2.4 Research method

The overall question of the research is whether refugees and asylum-seekers in Turkey can have access to health services, which is a basic right for all people. In this respect, this study aims to analyze the problems related with the health care service provision to refugees and the dynamics of the clinical encounter between refugees and health professionals in Turkey. The reports on the situation of refugees in Turkey argue that there are significant problems in the access of refugees and asylum seekers to health care. Thus, the study aims to detect the common health problems among refugees and the problems in accessing health care services provided by the state, regarding physical, mental and dental health needs. The special health care needs of women refugees will also be addressed. Related to these questions, the study will seek to determine the differences, if there

are any, between the recognized refugees by the UNHCR and the asylum-seekers in their access to health care and whether such services provided by the state are appropriate for their needs. The Turkish government currently does not have a health policy designed particularly for refugees and asylum seekers. Through research in the field, I aimed to ascertain whether there are special health care needs of the refugees settled in Turkey and the problems associated with the lack of a clear policy for these needs.

In a qualitative study design, in-depth interviews including semi-structured questions with refugees and the health professionals in the field helped to understand the problems encountered in the provision of health care services to refugees and asylum-seekers, from the perspective of both parties of this interaction. Such problems may be related with logistical difficulties, such as the lack of proper documents for the provision of such services or language-related communication problems, or cultural differences or any other barriers blocking the provision of effective health care services. Particularly with regards to long-term treatment plans requiring follow-up visits, the success of the treatment plan depends on the resolution of such problems, thus it is even more important to detect the problems that may lead to the failure of the refugees in following the treatment plan.

I am particularly interested in the dynamics of the clinical encounter of health professionals and the refugees in Turkey. As stated above, the clinical encounter is crucial for the patient's compliance with the medical treatment. However, there are many intervening factors that influence such encounters, such as the problems in health care provision as stated above and the approaches of each party to the other. As also indicated above, there is a growing tendency in the discourse about refugees by the media, state officials and the organizations dealing with refugees throughout the world equating refugeeness with loss of identity, severe trauma and thus resulting psychological disorders and pathology. Health professionals are not immune to the widespread stereotypes about refugees and asylum seekers. The discourse leads to a general disbelief for refugees in recounting their own stories and in the case of medical service provision, their medical complaints in any form.

In this sense, all kinds of symptoms that can be seen and observed by medical professionals tell more truth than the words of refugees about their medical problems of any kind.

The lack of confidence by health professionals in refugees, in turn, may lead to the complaints of refugees and asylum seekers of being treated just as organs, rather than complete human beings. I am interested in finding out the dynamics of such clinical encounters between the health professionals and refugees and the intervening stereotypes and prejudices of the parties of this relationship towards each other.

Due to the problems in the access of health care services by refugees, there are a number of organizations in Turkey trying to fill the gap in the provision of such services. In the case of the city, where I conducted the field study for the research, civil organizations dealing with refugees and asylum seekers settled in the province also take on responsibility in the delivery of health services. Such organizations were also interviewed to understand how they help refugees in having access to health care, alongside their motivations in such assistance and the aspects of their selection of the refugees they choose to help. Overall, the study aimed to answer the question whether and how the fundamental right to health for refugees is fulfilled in Turkey and what should be improved to realize the right for them.

To seek answers to these questions, I have interviewed 13 physicians, 13 other health professionals, the representatives of 6 NGOs working with refugees, and 24 refugees between November 2009 and January 2010 in three different cities. The majority of the interviews were made in the city that formed the focus of the study. The name of this city was anonymized for this report, as well as the names and personal information of all the interviewees, to make sure that the unique information about the identities of the informants will not lead to their identification, combined with the information about the city. Therefore, the city will be referred to as the Midtown throughout the thesis, both because it is a Central Anatolian city and for the refugees in particular, it is a middle station between their countries of origin and the third country they will be resettled.

The other two cities where interviews were conducted was two large cities where organizations dealing with refugees and their health problems were based. To be able to include their perspectives and experience to the study, I have travelled to these cities and conducted interviews with the organizations' representatives in their offices.

Midtown is a relatively developed industrial city close to several centers of tourism. Regarding its population, the city can be regarded as one of the biggest provinces among the "satellite cities" determined by the Ministry of Interior. With its relatively more high-quality education and employment opportunities, the Midtown has been attracting internal migration from other provinces in the region for a long time and has been home to a significant number of refugees for the last decade. The city usually votes for more conservative parties in the general and local elections. During my stay in the Midtown for the field research, I witnessed a very lively city in day time, although it was not common to see women in the streets after it got dark. Overall, the Midtown is known as a conservative city.

The Midtown is one of the 30 provinces where the refugees and asylum seekers are settled by the Ministry of Interior, while awaiting the result of the Refugee Status Determination procedure at the UNHCR and the result of the third country resettlement procedures. In this process, the refugees and asylum seekers have to report to the local police foreigners department twice a week in this city and can leave the city with the approval of the police, for their transactions at the UNHCR, the embassies of the third countries, and for health or family visit purposes. The Midtown has been one of the cities with the greatest number of refugees in Turkey for several years. While the field study was conducted, there were around 1200 to 1300 refugees in the Midtown. As indicated by the refugee organizations, the more vulnerable cases such as the members of the LGBTT group and single women are sent to this city by the Ministry of Interior because of the presence of an established working relationship between refugee organizations and the state institutions in the city. The NGOs that I interviewed argued that the problems of the refugees in the Midtown can be solved more easily and quickly because of this established working relationship.

There are a number of large health institutions in the Midtown, which attract large number of patients, both citizens and refugees, from the other provinces in the region. The city has also started the pilot implementation of the family physicians system, and, as a result, the health clinics were turned into family physicians' and public health centers. Under the family physicians system, all people are assigned to a particular family physician based on their area of residence and should apply to their own doctor for health problems. The family physicians centers are located at neighborhoods close to the areas where the people they are assigned to are settled in and serve as health clinics as a first-step health institution. For the study, 13 physicians with various specialties working at the state hospital, the university hospital, the gynecology hospital, a family physicians center and a public health center were interviewed. Almost all of the interviews with the physicians were conducted at the doctor's offices during the working hours and some physicians had to continue examining the patients waiting in the meantime. Two physicians were interviewed at the lunch break in a restaurant. The specialties of the physicians interviewed were family physicians, gynecology, otolaryngology (ear, nose and throat medicine), brain surgery, general practitioner, emergency medicine, general surgery, internal medicine and psychiatry. To identify the physicians to be interviewed, previous contacts with an official at the Provincial Health Directorate, the state hospital and the gynecology hospital were used and the other physicians at the state hospital and the family physicians center were recommended by these contacts. For the physicians working at the university hospital, I sent an e-mail to all physicians working in all departments at the university hospital, as they were available at the hospital's website and asked if they would accept to make an interview about their experiences with refugee patients. Many physicians replied that they did not have any or enough refugee patients and some agreed to make an interview.

The interviews with physicians lasted between 20 minutes to 90 minutes, depending on the experiences of the interviewee with refugee patients and the availability of time for the physician. The interviews were semi-structured and included questions about the common health problems of refugees, demographic information about their refugee patients, the problems regarding the examination

and treatment processes, the language problem, the cultural differences and their effect on the examination and treatment, the definition of the refugee and ideas about the solutions for the problems.

The 13 other health professionals included the officers of the hospitals' registration desks, the social workers at the hospitals' social services, the officers of the information departments of hospitals, nurses in emergency, orthopedics, chest surgery departments, pharmacists, and the administrators of the state, university and dental hospital. All of the interviews were conducted at the informants' officers and the people to be interviewed were chosen purposefully or through referrals from other health professionals. The interviews with these health professionals tended to be shorter than the interviews with physicians and refugees and focused more on the problems about the registration of refugees, the problems about legislation, if there are any, the language problem and their ideas for the resolution of the problems encountered in practice.

The interviews with the representatives of the non-governmental organizations related with the issue included 7 interviews with 6 different NGOs in three different cities. Three of the NGOs included in the study have activities throughout Turkey and did not have a branch office in the Midtown but had information about the situation of the refugees with regards to access to health care both in the Midtown and other provinces. One of these NGOs was working on human rights in general, with a particular programme targeting the refugees, while one was focused on a particular health problem and the other was working with members of the LGBTT group, including refugees. One NGO included in the sample was targeting the refugee population with several branch offices in Turkey and one in the Midtown. This association is working in close cooperation with the UNHCR and had projects to provide psychological and social assistance to refugees. The remaining two organizations were local in character, one of them being a charity organization that has activities about refugees, alongside other target populations and one was a health foundation, providing medical assistance to people in need, including refugees. The interviews with the representatives of the NGOs were conducted at the representative's office and lasted between 40 minutes and 3 hours.

The interviews included semi-structured questions about the organization's activities in general, the problems of refugees, the problems related with refugees' access to health services and their ideas about how these problems can be resolved.

The refugees interviewed for the study were all officially resettled in the Midtown by the Ministry of Interior. According to information provided by the refugee NGOs, there are around 1200 refugees in the Midtown, 90 percent of them being Iranians, 4 percent Afghans, 4 percent Iraqis and 2 percent other nationalists, such as Somali and people from East Turkestan. For this study, a total of 24 refugees were interviewed. While 5 of these interviewees have come alone to Turkey, 19 interviewees were in Turkey with their families. When the interviewee was in Turkey with his/her family and living with family members, the interview was about the experiences and problems of the whole family. The sole exception to that were four Somali women and a Somali child who were settled in the same house but were not related to each other. In this case, all four Somali women responded to the questions together. Overall, the information gathered through interviews with the refugees was related with a total of 106 refugees.

To ensure confidentiality of the refugees interviewed, I asked the refugees to pick a nickname for themselves and used those nicknames throughout the thesis. For the refugees who left it to me to pick a name, I used online lists of name common in their countries of origin. Other unique information that may facilitate the identification of the informants were also omitted.

The refugees included in the sample of the study were selected to represent the groups of refugees settled in the Midtown, when possible. In this regard, 7 interviewees were Iranian Muslim refugees, while 5 were Iranian Christians, 4 Iranian Bahais, 1 Iraqi, 2 Somali, and 5 Afghan refugees. Despite the attempts, no member of the LGBTT group refugees could be contacted but their problems were discussed with the representatives of the non-governmental organizations dealing with refugees. Information about the profile of interviewed refugees, as well as about the situation of their cases at the UNHCR and social insurance coverage, for interviewed refugees is provided in Appendix A. The common questions posed to

refugees included when they have come to Turkey, their status of case files at the UNHCR, whether they are alone or with their family in Turkey, whether they are covered by the general health insurance and their experience with health professionals in the Midtown. A list of common questions posed to refugees is provided in Appendix B. It should be noted that the list is not an exhaustive list of the questions asked to refugees in the interviews, since the interview was semi-structured and the questions were formulated in line with the experiences of refugees in general. The list covers the common questions posed to all refugees in the initial stages of the interviews.

The snowball technique was used for sampling the refugees to be interviewed for the study. For this qualitative study, rapport and intimacy with the interviewees were considered to be the most important aspect of the research. Thus, snowball technique was preferred despite its lower reliability, more appropriate for the study because of its higher validity. The first contact points were the organizations working with refugees in the city and then through these refugees, other informants were found. Almost all of the interviews were conducted at the houses of the refugees with their families, except three refugees who wanted to meet outside for the interview, and three refugees who came to the house of one of their friend, who was another refugee that arranged the interviews with them. When the refugees were feeling comfortable speaking English or Turkish, the interview was conducted in one of these languages. Six interviews were conducted in Turkish and five interviews were held in English without translation. An Iranian refugee who has been in Turkey for 12 years and was able to speak Turkish fluently translated the interviews for me with seven refugees. Two Afghan refugees introduced me to the other refugees and helped me with translation into Turkish for three refugees. Another two Iranian refugees helped me with translation into English for three refugees. The interviews with refugees lasted between 40 minutes and two hours and were semi-structured including questions about the demographics of the family, the case status at the UNHCR, the status with regards to social insurance coverage, the financial situation and the assistance received from governmental and non-governmental organizations or the UNHCR, the health problems, the

experiences with the health professionals and their ideas about the resolution of problems in accessing the health care services.

All informants for the study were informed first about the identity of the researcher, the research topic, where the findings of the research will be used and that their identities will be anonymized for the study. It was particularly important to underline this latter point in the interviews with refugees, as they feared that the police or the UNHCR may disapprove their decision to give an interview to a researcher. When communication with the informant could be established in Turkish and English without translation, his/her permission to make voice recording was sought and a voice recorder was used. However, this was possible only in rare cases, as the health professionals usually did not want a recorder because they are public officials and most refugees did not allow me to record the interview. In these cases, I took notes during the interview and filled in the gaps in these notes at the end of every day to avoid confusion afterwards.

The findings of the field research will be reported in the following two chapters. While the third chapter will focus on how refugees can access the health services in Turkey and, in particular, in the Midtown, the fourth chapter will aim to analyze the dynamics of the clinical encounter between refugees and health professionals.

CHAPTER III. ACCESS OF REFUGEES IN TURKEY TO HEALTH CARE SERVICES

The access of refugees to health care services is riddled with many difficulties in Turkey. In this chapter, the various layers of such impediments will be examined. In the first section of this chapter, the legislation related with the status of asylum seekers in Turkey, their rights to work and health will be explained and the problematic areas of the legislation leading to obstacles for access to health care services will be pointed out. In the second section of the chapter, the practice will be narrated, how the various procedures for accessing health care services for refugees work in practice and how the problematic and, at times, clear-cut provisions in the legislation about refugees' health care is translated into practice. The particularly difficult point in the practice is the lack of health insurance coverage for most refugees, even if they have been granted asylum seeker status by the Ministry of Interior, which is the condition set for general health insurance for asylum seekers under the law. Thus, many refugees have to cover their own health expenses and because of the lack of resources cannot reach the health services available. In the third section, I will look into the common and uncommon health problems among refugees, as described by health professionals, NGO staff and refugees themselves, with a closer look into how and if they can resolved and what are the obstacles before the resolution of the health problems. In practice, non-governmental organizations and charity foundations working with refugees are major actors intervening to remove such obstacles when possible and/or resolve the problems usually on a case-by-case basis for the access of refugees to health care services in some way. Therefore, the role of NGOs in trying to overcome such difficulties was discussed in the last section of this chapter, with a consideration of their views about the problem and their motivations in assisting the refugees they choose to assist.

3.1 Related Legislation

Under the Turkish legislation, an artificial differentiation between the terms "refugee" an "asylum-seeker" was made with the 1994 Asylum Regulation and the implementation directives of the Ministry of Interior, and these terms were defined. Under the 1994 Asylum Regulation, the definition of the refugee was made in line with the 1951 Geneva Convention and the foreigners who come under the same conditions from non-European countries were defined as asylum-seekers.

The reason behind such differentiation in the legislation is the geographic limitation of Turkey to the 1951 Geneva Convention, based on Article 42 of the Convention. According to the limitation, the foreigners who are eligible to become refugees under the Geneva Convention but come from non-European countries will be accepted as asylum-seekers rather than refugees in Turkey.

As a result, while it is possible for an asylum-seeker to be granted the refugee status upon the determination of the eligibility of the person for this status under the international refugee law, the people that are referred to as asylum seekers under the Turkish law cannot be granted the refugee status. (Çiçekli 2009, 49)

Under the 1994 Regulation, there is a dual process for the granting of the refugee/asylum-seeker status in Turkey. The asylum applications of the non-European foreigners are processed both by the General Directorate of Security and the UNHCR. As a result of the examination of their files, the asylum seekers who are granted the temporary asylum seeker status under national legislation by the security officials and refugee status under international refugee law by the UNHCR are resettled to a third country. While the procedures for the determination of the asylum seeker and refugee status are ongoing, non-European foreigners seeking asylum are settled in a guest house determined by the Ministry of Interior or in a city determined by the Ministry, under the 1994 Regulation.

The non-European asylum seekers that are awaiting for the result of their application for the asylum-seeker/refugee status or awaiting to be resettled in a

third country are issued a temporary residence permit under the same regulation. The implementation directive number 57 stipulates that the applicants of asylum in Turkey will be directly given six months residence permit and a residence certificate. The residence certificate is issued only by the 30 provinces designated by the Ministry of Interior as "satellite cities," where refugees are allowed to be settled. In the provinces other than the satellite cities, the residence permit will be issued upon the order of the Ministry of Interior, if the applicant's residence in that city is considered appropriate in line with humanitarian considerations.

The refugees are charged for the residence certificate booklet and six monthly residence permit. In a joint statement by the NGOs working in the field of refugees about residence permit charges, which, according to Council of Europe Human Rights Commissioner Hammarberg, only exists in Turkey and Monaco in Europe, the NGOs argue that for asylum seekers and refugees who do not receive any social support to meet their basic needs such as food, shelter, health, clothing and heating and who do not have the chance to legally work in practice, it is impossible to pay these fees. Since they are unable to these fees, they face serious difficulties in accessing basic services such as education and health, the NGO argue. They also state that although the article 88/d of the Law of Fees no. 492 allows the administration to keep people who are unable to pay the fee exempt from it, this authority is implemented in a very limited manner, that varies from province to province, by the officials. (http://www.hyd.org.tr/?pid=770)

The work permits of foreigners, as well as asylum-seekers are regulated with the Law on the Work Permits of Foreigners number 4817, which came into force in 2003. Under the law, the asylum-seekers can get a work permit but there are strict conditions for the work permit to be issued. Article 14 of the Law stipulates that the applications for work permits by foreigners will be rejected if, a)The situation in labor market and developments in work life and the sectoral and economic conjunctural changes regarding employment are not appropriate for the issuance of the work permit, b) A person who has the same qualifications to do the job that is applied to is found in four weeks within the country, c) The foreigners does not have a valid residence permit, d) In case an application is made for work permit

before a year passes after the date a request for permit by the foreigner, the enterprise, the work place or profession is rejected for the same enterprise, work place or same profession, e) The working of the foreigner constitutes a threat for national security, public order, general security, public interest, public morals and public health." One recent amendment in the regulation related to the law led to a slight change in the procedure and indicated that the asylum seekers applying for work permit should have a residence permit but the residence permit does not have to be valid for 6 months, while other foreigners have to have a residence permit valid for 6 months. Under these conditions and with the increased tax burden on employers employing foreigners, the work permit for asylum seekers is almost impossible to get.

With regards to health rights of asylum seekers, under article 10 of the Constitution, as stipulated in the basic human rights instruments, all people are equal before the law irrespective of language, race, color, sex, political opinion, philosophical belief, religion and sect or any such considerations. The articles 12 and 17 of the Constitution stipulate that everyone possesses inherent, fundamental rights and freedoms which are inviolable and inalienable and that everyone has the right to life and right to protect and develop his material and spiritual entity. There is no difference between citizens and foreigners regarding the use of basic rights and freedoms in the Constitution but article 16 has stipulated that the fundamental rights and freedoms for foreigners may be restricted by law in a manner consistent with international law.

Under articles 56 and 60 of the Constitution regulate how the state should provide health and social security rights to people in its country, irrespective of whether they are citizens or foreigners. Under these articles, the state will ensure that everyone will benefit from health and social assistance institutions to protect and develop their physical and mental health, to make plans for the realization of such rights, and take the necessary measures and establish the organization for the provision of social security for everyone. (Şahbaz 2009, 417)

The provisions with regards to the health and social security rights of refugees, asylum seekers and stateless people in the Turkish legislation were not gathered together in one instrument but were dispersed in several laws, regulations, Council of Ministers decrees and implementation directives.

The article 60(c)(2) of the Social Insurance and General Health Insurance Law number 5510 includes stateless people and asylum seekers as people with general health insurance. In the article 3 of the Law, entitled definitions, asylum seekers and stateless people are defined as people that are considered asylum seekers and stateless people by the Ministry of Interior. This means that for an asylum seeker or a stateless person to be covered by the general health insurance, he/she has to be recognized as such by the Ministry of Interior. Under article 61(b) of the law, stateless people and asylum seekers will be considered to be covered by the general health insurance as of the date they are accepted as stateless and asylum seekers and the related institutions inform the Social Security Institution in a month following the date they are accepted as included. The children of stateless people and asylum seekers will benefit from the health services and other rights under the article 61(f) of the Law as the people that are covered by the general health insurance, irrespective of whether the parents of such children are registered and without the need for any other transaction, until they are 18 years old.

However, the law number 5510 is obviously not covering all refugees and asylum seekers in Turkey. The refugees, asylum seekers who are awaiting their status as such to be recognized and people who are allowed to stay in Turkey under secondary protection are not listed as covered by the general health insurance and cannot benefit from the rights regulated by the Law.

The article 1 of the Law of the Encouragement of Social Assistance and Solidarity number 3294 defines the aim of the Law as assisting citizens that are in need and people who are accepted by or come to Turkey regardless of conditions, when necessary. The article 2 of the Law stipulates that the people, other than the Turkish citizens, shall benefit from the assistance of the Fund if they can be useful for the society and can be productive with a small amount of assistance temporarily

or if education opportunities are provided. The Social Assistance and Solidarity Encouragement Fund Health Support Assistances Programme Implementation Principles issued on January 31, 2005, regulates how and under what conditions the health assistances will be made. According to these principles, foreigners that were accepted or come to Turkey regardless of the circumstances shall be able to apply to the Fund for their health expenses beyond their ability to cover. Such applications can be made before applying to a health institution and following the treatment, for the coverage of the debts they have incurred for the hospital, medication and medical materials. The principles have made a distinction between people with residence permit and people without residence permit for stateless people and asylum seekers for the place of application. In this regard, the asylum seekers with residence permit will apply to the Province/District Social Assistance and Solidarity Foundation at the place of their residence and asylum seekers without residence permit will apply to the Foundation at the place where they are. However, the Implementation Principles regulate the health assistance principles until the people in question are covered by the general health insurance or another programme except the green card system. Since Law number 5510 accepts asylum seekers and stateless people as covered by the general health insurance if their status as such is accepted by the Ministry of Interior, such people cannot benefit from the health assistance funds of the Social Assistance and Solidarity Foundations. However, asylum seekers whose status are not determined by the Ministry of Interior or foreigners that benefit from secondary protection can benefit from these assistance funds, without any legal obstacle.

Under articles 3(14) and 133 and following of the Public Health Law number 1593, the task of dealing with the health affairs of people who have migrated to Turkey was given to the Ministry of Health and the Ministry of Interior.

The Implementation Directive of the Ministry of Interior General Directorate of Security, dated June 22, 2006, with number 57, includes provisions regarding the health situation of foreigners who have applied for asylum. According to the directive, the tests of the applicants who carry the risk of infectious diseases will be done in coordination with the Provincial Health Directorates. Meanwhile, the

directive also stipulates that asylum seekers whose health problems cannot be solved in the province of residence will be transferred to another province upon a report from the state hospital and a view by the Provincial Health Directorate about in which cities the treatment can be made. In the chapter of the directive related with health assistance, the directive stipulates that all health costs of applicants and recognized refugees and asylum seekers shall be covered by themselves, but indicates that the health related costs of people who cannot meet their health related costs on their own accounts or through the UNHCR and who has no social insurance can be met by the state in line with the legislation and the opportunities, referring to the Law of Encouragement of Social Assistance and Solidarity number 3924. However, after the Social Insurance and General Health Insurance Law number 5510 has come into force, the stateless people and asylum seekers whose status as such is recognized by the Ministry of Interior have become subject to this law as indicated.

3.2 Implementation of legislation and the obstacles in accessing health care services

The legislation about health service provision to refugees is regulated based on the legal situation of the person in Turkey and in practice, the General Health Insurance of refugees is considered valid based on whether the person has acquired and holds a valid residence permit or not, by the Social Security Institution (SGK). As in the case of parallel procedures for the status determination of non-European asylum seekers in Turkey (Hammarberg 2009, 12-3), the dualism about the procedures for access to health care services seems to be overly complex and leading to confusion both among health professionals and refugees.

A person seeking asylum in Turkey has to apply both the UNHCR for international refugee status determination process and to the Turkish authorities under the provisions of the 1994 Asylum Regulation, which was amended in 1999, for the determination of whether the person is eligible for temporary asylum seeker status, and can reside in Turkey while waiting to be resettled in a third country by the

UNHCR. The procedure for the determination of whether the applicant is a "temporary asylum seeker" is undertaken by the Ministry of Interior and lasts for a minimum of one year and when the temporary asylum seeker status is granted to the person in question, the Ministry of Interior issues a residence permit, ikamet, for the person. Each asylum seeker granted the residence permit is required to pay 135 TL for the residence permit booklet. The asylum seekers are also charged 306.30 TL as six-monthly residence fee, and 288.15 TL for minors between 15 and 18 years old, according to the charges set for 2009. In some cases, if the person is found to be unable to afford the residence fee, the administration can hold the asylum seeker exempt from the fee and can extend the validity of the residence permit without any charge.

If the asylum seeker holds a valid residence permit either through the payment of the residence fee or exemption, registration to the Social Security Institution (SGK) is possible and generates a Foreigner's ID number. The registration has to be renewed every 6 months, after the validity of the residence permit is extended. Through the Foreigner's ID number, the person can apply to health institutions to get examined free of charge and purchase medication with a certain amount of the cost to be paid as contribution share.

Registration to the SGK was not found to be common among refugees in the Midtown. The NGO working with refugees settled in the Midtown indicated that among around 1300 refugees, a maximum of 20 refugees are registered with the SGK and thus have social insurance coverage. The researcher has also applied to the institution, requesting information on the number of refugees registered to the SGK in the Midtown, under the provisions of the Law on Acquiring Information number 4982, but received no response. Thus, the actual number of refugees having social insurance coverage in the Midtown is unknown, but the majority of the refugees interviewed for this study were not registered with the SGK. Of the 24 refugees interviewed, only one was registered with the SGK, while 10 refugees were not granted residence status yet because all of them had been in Turkey for less than a year, 6 refugees were waiting for a response from the police about their requests to be exempt from the residence fee, 3 refugees were unable to pay the

residence fee and were not found eligible for exemption, 2 refugees were held exempt from the residence fee but did not register for the SGK since they did not know about it and 2 refugees have paid their residence fees but did not know about the SGK. (See Table 1 for information about the refugees' legal status and status about SGK registration.) Since the majority of the refugees interviewed were settled in Turkey with their family and responded to the questions for the whole family, it can be said that out of the 106 people contacted through interviews with one of their family members, only one family of 9 people were registered with the SGK. The researcher also asked those who were not registered with the SGK if they knew any refugees who were able to get examination from the state hospital free of charge and the respondents said they did not know such refugees around them.

Thus, it can be argued that the majority of refugees in the Midtown are not covered by the Law on Social Insurance and General Health Insurance number 5510, either because they are waiting to be granted the residence permit by the government, they cannot pay the residence fee or waiting to be held exempt from the residence fee, or they do not know about the social insurance and that they have the right to benefit from the social insurance coverage in Turkey. Although the law on general health insurance stipulates that the asylum seekers are registered to SGK after their status as asylum seekers is recognized by the Ministry of Interior, in Midtown the institution accepts registration of the asylum seekers only if he/she presents a valid residence permit. Thus, it is worthy to note that those who were eligible for registration with SGK at the time of the interview but were not because of lack of information, were found to be the ones that did speak Turkish only a little or did not speak Turkish at all, despite the length of their stay in Turkey. During the interviews, they found about their right to benefit from social insurance coverage and complained that little information is provided to them about their rights in Turkey by the police, the local refugee organizations and the UNHCR, in their own language. In addition, the refugees who were not eligible for registration with SGK, either because they could not acquire a residence permit yet or did not pay the residence fee, usually did not know about the SGK and their right to social insurance. Therefore, lack of information about the available services, as in the

case of the availability of free health care services in the health clinics, as well as the right to social insurance coverage, seems to be one of the most important obstacles before refugees in accessing the health services, as will be argued in the ensuing sections of this chapter.

Hence the majority of refugees in the Midtown remains outside the social security schema and have to pay for the health care services provided by the state and university hospital and the medication either themselves or through funds they can find.

The Midtown is one of the pilot provinces to implement the family physician system in the provision of the first-step health services. Thus, all buildings and the citizens legally residing in the buildings are assigned to one family physician, who works in family physician centers that replaced the health clinics, for their health problems that can be resolved in a first step health care institution. All health care services provided by the family physicians and the family physician centers are free of charge and the family physicians are paid by the state based on the number of patients they examined, to be monitored through entries into the online database system.

However, refugees are not assigned to a family physician unless they have the Foreigner's ID number referred to above. Nevertheless, some of the family physicians based in the Midtown indicated that they examine the refugees that are settled in the buildings assigned to them without any entries into the online health care database and thus, without any payment to the physician for the examination of refugees. Two family physicians interviewed stated that the majority of the family physicians are not willing to examine and treat the refugees since they cannot register such patients to the system and do not get paid by the state. The doctors also said that they examine the refugee patients, because they consider it "a moral obligation, resulting from the Hippocratic oath" they have taken. One of the family physicians especially indicated that she examines as much as 90 refugees a month, almost exclusively Iranians, and said, jokingly that she became a "refugee doctor." The family physicians center and the female family physician were known

among the interviewed refugees, who preferred to apply to this institution mainly for the minor health problems, for simple blood tests and for vaccinations. However, it was observed that the Somali, Afghan and Iraqi refugees interviewed did not know about the health clinic and the free services available there, while some Iranian refugees did not choose to apply to the health clinic as it was relatively far to the neighborhoods where most of the refugees were settled.

For more serious health problems, the refugees preferred to apply to the state hospital, but since they are not registered with the SGK, they are required to pay for the health services they are provided with. According to information given by the local refugee NGO and the hospital administrators, the fee for examination is 15.50 TL, while this figure goes up to 26 TL if tests are requested and to around 50 TL if more advanced tests are requested by the physician. In cases of emergency, the emergency service of the state hospital, as well as the university hospital, provides the treatment without asking for how the costs of the treatment would be paid. Following the treatment, the hospital administration charges the costs or, if the person that was treated is unable to pay, make the patient sign a bill of debt. If the debt is not paid in due time, a letter is sent to the given address of the refugee by the hospital administration, indicating that the debt should be paid in a certain time period or the hospital administration will resort to legal means to collect the claim. The local refugee NGO stated that they usually apply to the Social Assistance and Solidarity Foundation (SYDV) to get aid for the payment of the debt in such cases and there have been 223 applications to the SYDV but only 3 or 4 requests were accepted in 2009. To solve the problem, the refugees usually wait for their residence permit to be issued and apply to the SGK to get their previous debts to the hospital to be paid by the institution, but since the social insurance coverage becomes valid on the date the person is registered with the SGK, such requests for the payment of previous debts are turned down. Therefore, in general, such debts accumulate over time with the legal interest and are paid only when the refugee in question gets permission from the police for leaving Turkey to be resettled in a third country.

When there is no emergency in the treatment, the refugees have to apply to the police to get a letter to the Social Assistance and Solidarity Foundation to pay for the hospital expenses of the person in question. It usually takes one day for the police to write such letter and the interviewed refugees said that the police may not give such letter for people that do not seem to have serious health problems or those who want to go to the hospital very frequently. If the letter can be acquired from the police, the patient then needs to apply to the Social Assistance and Solidarity Foundation to get their hospital expenses to be incurred paid by the foundation. Such requests are told to be usually rejected and the refugees are obliged to pay for their own hospital expenses. The whole process of applying to the police, the Social Assistance and Solidarity Foundation and to the hospital usually takes a few days and is exhausting particularly for people with health problems. If the health problem is more serious, in some rare cases, the refugee is referred to the Social Services Unit of the state hospital and the social workers try to provide health services to the refugee, "on their own initiative" and solve the issue of money following the treatment, in the way the emergency cases are solved, like applying to the Social Assistance and Solidarity Foundation to get the hospital expenses covered from their funds.

The patients with more severe conditions and those that need operations, which may have more complications, are referred to the university hospital by the state hospital. If the patient is not registered with the SGK and it is not an emergency case, the refugee cannot get examined by a doctor in the university hospital unless there is an official letter by the UNHCR or the Social Assistance and Solidarity Foundation, as a commitment to cover the expenses of the health service to be provided to the patient. The administrators of the university hospital interviewed indicated that it was easier in the past to get approvals to such requests from the UNHCR and the Social Assistance and Solidarity Foundation, but currently less people get financial aid from these institutions, thus the number of refugee patients obtaining health services from the university hospital dropped significantly in the last few years.

Similarly, for taking medication, the refugees usually apply to the Social Assistance and Solidarity Foundation but such request are rarely accepted. Instead, the refugees and the local refugee NGO apply to the foundation of a private hospital in the Midtown, which has a medicine collection company from the public and can provide certain medications free of charge to the people in need. But not all medicines can be found at this hospital, particularly not the more expensive ones to treat the more rare conditions. The local refugee NGO tries to find the necessary medications from local foundations first and if they cannot be secured, applies to the UNHCR with a doctor report about the condition of the person and the prescription. Through interviews with refugees, local organizations and pharmacy personnel, it was found that the UNHCR agrees to pay the costs of the medicine for more serious, life-threatening and chronic diseases, such as diabetes, heart conditions, epilepsy and severe psychiatric conditions. If the UNHCR approves the payment, the medicines can be taken from a certain drug store that has an agreement with the UNHCR.

The medicine problem is solved by some refugees through the medicine brought from their own country while migrating to Turkey or through requesting some relatives or friends that come to visit them or migrate to bring the needed medicine from Iran. Most Iranian refugees said that medicine in Iran costs a lot less than in Turkey, so they try to procure medicine from Iran. Among the Bahai group, there is a well-known doctor, the father of two refugees that are settled in the city of field research, who visits his children often and conducts examinations of the refugees with health problems when he is in Turkey. He is also available to Bahais over the phone when he is in Iran, so Bahais told that when they get sick, they usually call him first and when he advises, they go to the hospital. He also brings medication from Iran based on the needs of the refugees.

All in all, although the legislation seems to be more clear-cut about the health service provision to refugees, the procedures in practice for access to health services is complicated and riddled with difficulties. With extensive efforts, serious health conditions can be resolved by the refugees themselves or through the local organizations dealing with refugees. But the seemingly less serious ones usually

remain unresolved. In the field study, many refugees were observed to be not applying to the doctors at all, if their complaints are not severely impeding their lives. In the words of one refugee, Fatma, who have seen a doctor in the only once in the ten years she has been in Turkey:

> The people responsible for us tend to ignore us, they refer to us to another place, and then, they refer us to another. I wonder how people don't lose their lives while going from one place to another seeking health care. It is usually better to stay home and try some herbal medicine instead of going to the hospital.

3.3 The health problems of refugees

The refugee quoted above has been in Turkey with her family of 7 people for 10 years and without the right to employment, has been living in very precarious conditions. The housing they could find has been very bad in this time period and the amount of stress very high, since they did not hear from UNHCR for more than 5 years, between 2003 and 2008, when the case files of the Iraqi refugees in Turkey were frozen. She is 18 and has 3 sisters aged between 12 and 19 and a brother aged 22. As indicated above, she was the only person among her siblings taken to a doctor once in 2008, because of an eye infection, and for that, her parents took her to a private clinic and paid for the expenses on their own account. Her mother had facial paralysis twice and the UNHCR paid for the treatments in these two cases. Apart from the teeth problems of her mother and complaints of pain in the back by her father, she said they have no health problems, despite all the adverse conditions that may affect their health.

As a researcher on the health problems of refugees and their access to health services, I was usually referred to the refugees with health problems by the local organizations and refugees, during my field research. Yet, some of the refugees I interviewed had been in Turkey for several years with no source of aid or income, in quite adverse conditions, but had not experienced any health problems and had no experiences of seeing a doctor in the Midtown. While this section of the chapter is on the health problems experienced by refugees, it should be noted that the

majority of refugees were quite healthy, a fact that amazed me seeing the conditions they lived in.

The same observation was made by several physicians I met. One emergency medicine specialist interviewed said that refugees tend to have less life-threatening conditions than the locals because they are relatively younger. Meanwhile, an otolaryngologist (ear, nose and throat specialist) said that the refugee patients he had seen usually do not have serious problems, so much so that "if a Turkish person had the same complaint, she/he would not bother to come all the way to the hospital."

However, as indicated above, the researcher encountered some health problems as well in the field research. One of the most common problems among the interviewed refugees was dental problems. The dental care hospital, working under the state hospital but in a separate building outside the city center, is usually very crowded and as the manager indicated, the appointments for dentists are given usually between 90 days and 180 days later than the registration. Added to that, the high cost of dental care for people without social insurance coverage, makes it very hard for refugees to seek dental care in the state hospital. The official of a local NGO providing assistance and aid to particularly Somali and Afghan people in the Midtown also complained about the lack of proper dental services for refugees. He said that the dentists he contacted to get aid in providing dental services usually prefer extractions rather than dental filling and he tried very hard in vain to get dental filling for refugees. The private hospital helping refugees in obtaining their medicine, mentioned above, used to employ a dentist speaking Persian three months ago but does not have a dentist now. Therefore, the majority of dental problems seem to be unresolved and refugees usually hope that their dental problems will be solved in the third country they will be resettled in.

One other common problem among refugees is depression, which is connected with the long waiting periods and the stress of setting up their lives in a country of transit, by the refugees. According to the local refugee NGO, a refugee has to stay for 2 to 3 years on average in Turkey before being resettled in a third country. With

the increase in the number of refugees in recent years, the average number of years a refugee has to wait for resettlement is increasing as well. “Just waiting and not knowing what will happen next and when is like torture,” said one refugee, Massoud, who has survived torture in his country of origin and is still experiencing psychological problems but is unwilling to receive psychological support since he thinks it would be no use without his current problem of waiting is solved. Some refugees also complain that there is nothing to do in their daily lives and thus they only think, which, they claim, worsens their psychological conditions. To avoid being without anything to do, Farhad said that he is willing to work as a translator without any payment, “just to keep busy.” Many refugees complained about sleep problems, loss of appetite and being depressed. A psychiatrist interviewed also said that Post Traumatic Stress Disorder (PTSD) is common among refugees.

A specialist in internal medicine stated that the refugees he examines usually have complaints of abdominal pain and diarrhea and explained that such health problems are called functional diseases, which are usually caused by stress and anxiety, without any organic problem. Meanwhile, a family physician said that due to environmental changes and the adverse conditions in their houses, most refugees apply to him with complaints of sciatic nerve pain, throat infections and upper respiratory tract infections. Another family physician said that the most frequent test refugees request is pregnancy test, since they are concerned about being pregnant in a country of transit, with many things unclear about their lives. Similarly, the doctors working in the gynecology hospital said that the most common cause of application by refugees to their hospital is menstrual delay and abortion.

For Somalis, the official of the NGO providing aid to Somali and Afghan refugees in the Midtown said that kidney problems are quite common, since they usually have one kidney and/or have trouble with their kidneys. Somalis also have complaints with their eyes, such as dry eyes, and explain that with not being used to cold weather.

Among the refugees interviewed for the study, some had relatively rarer conditions. One refugee, Farah, had been particularly worthy of note in this regard, with her 5 year old son having a rare genetic skin disease, called epidermolysis bullosa dystrophica. As a result of the disease, her son lost function in his hands and tongue. The doctors in the state and university hospital in the Midtown told her that there is no known course of treatment for his son's condition in Turkey but through her relatives in the U.S.A., she could get a report from an American hospital indicating that her son can be operated and can be healed with the available treatment plans in the U.S.A. She is now expecting her case to be decided soon and settled in a third country, as the doctors told her that the disease can be life-threatening.

Cancer, although not common, is seen among refugees in the Midtown. A doctor specialized in gastric, colorectal and esophageal cancer said that he operated on more than 10 refugees in the 10 years he has been working at the hospital. In many cases, cancer patients either get covered by the SGK or by the UNHCR for their long and costly treatment. Heart conditions are also usually considered to be eligible for financial aid by the state institutions or the UNHCR. Among the interviewed refugees, one 8-months old baby had atrial septal defect and needed operation immediately, with the costs of medical tests and examinations paid by the UNHCR and the costs of the operation to be covered by the SGK. One 57-year old refugee, Mahyar, had a chronic heart disease and the high costs of his medicine were in general covered by the UNHCR, as well as the costs of his son's medicine for schizophrenia. However, he stated that the UNHCR has stopped paying for his and his son's medicines for the last three months and had to borrow money from his relatives to buy these costly medications. Such serious conditions like cancer, chronic heart diseases and schizophrenia, when reported by the doctor, usually cause the refugee status determination procedures to be speeded up by the UNHCR.

In the interviews I conducted, I also encountered one advanced diabetes patient, one epilepsy and bipolar disorder patient and two asthma patients, which have worsened in the Midtown because of the high levels of air pollution and the use of

coal in the houses of many refugees for heating. Many refugee parents also indicated that because of malnutrition, their children tend to get sick more easily than they had been in their country of origin. Apart from conditions caused by malnutrition, the official working in an NGO based in İstanbul mentioned tuberculosis as a common health problem about refugees in general in Turkey.

Although there is no known case of AIDS among refugees in the Midtown, I have also interviewed an NGO working with people with HIV positive status and was informed that they have found out about three advanced AIDS cases among refugees, indicating that there may be more cases with HIV positive status since refugees from sub-Saharan Africa and LGBTT refugees are particularly in the risk group but confidentiality is particularly important for this condition. He also pointed out to the need of getting access to regular medication and health care is crucial for people with HIV positive status and explained the related difficulties among refugees because of the lack of social insurance coverage. In the case of HIV positive status refugees, the NGOs usually intervene to generate a solution for the medication problem.

3.4 The role of NGOs

The number of NGOs working in the field of refugee assistance has proliferated in recent years, particularly with the establishment of cooperation between the larger NGOs working in big cities and the local organizations in various provinces and the establishment of new field offices of the already existing organizations. With little or no assistance by the government and the UNHCR, the non-governmental refugee organizations have a huge gap to fill regarding social assistance and counseling to refugees, a gap that can be rarely filled given the limitations on the resources of such organizations. In this section, I will refer to the works of the NGOs in reaching and helping refugees in Turkey, particularly with regards to access to health services.

Under the legislation on asylum seekers in Turkey, the Turkish state provides aid to asylum seekers through Social Assistance and Solidarity Foundations established in every province, the municipalities and the Turkish Red Crescent, in the form of food, medicine, accommodation, coal, health services and financial support. According to the statement by the Ministry of Interior in 2009, "the assistance given to 17537 asylum seekers in 2008 amounts to 1.547.909,69 TL (approximately 700.000 Euros)." (Hammarberg 2009, 31) In the Midtown, most of the refugees interviewed were rejected by the municipalities and Social Assistance and Solidarity Foundations for their requests of financial aid and coal. The Social Assistance and Solidarity Foundation works in close cooperation with the police foreigners department in determining the refugees that are eligible for financial aid. After a refugee makes an application to the foundation, the officials contact the police foreigners department and ask them to conduct a social examination visit to their houses. Following the visit, the police issues a report about the situation of the applicant and makes recommendations about eligibility to financial aid but the final decision belongs to the board of the foundation. The whole process, interviewees told, usually takes a few weeks, and the number of refugees found eligible for financial aid has dropped significantly compared to the previous years. Some of the refugees interviewed in the Midtown said that their application for financial aid was rejected because they had natural gas in their apartment. The amount of the financial aid received by refugees from the Social Assistance and Solidarity Foundation ranged from 100 TL once a year to 300 TL in three months. The NGO working with refugees in the Midtown stated that the majority of applications for coal aid to the foundation were rejected this year, although in previous years the foundation used to accept such applications to a large extent.

Meanwhile, the municipalities in the Midtown provide food and bread aid to some refugees through a cook house. In the interviews I conducted, I have encountered a few refugee families, who have been settled in the Midtown for some years and benefit from the cookhouse but they complained that the cookhouse recently moved to a far place and they have to walk to get there since they have no resources to cover the costs of transportation. The refugee NGO also said that the municipality started to reject new applications for food aid by refugees in the last

two years, stating that the capacity of the cookhouse is sufficient only for Turkish citizens. Nevertheless, in some very urgent cases, the municipality has agreed to provide food aid to a few refugees in the last two years.

Meanwhile, the UNHCR is providing very limited financial aid to refugees in general. Until the applicant's Refugee Status Determination Procedure (RSD) is completed and the asylum seeker is granted the refugee status under the international law, the asylum seekers can apply for financial aid to the UNHCR only once. Considering the length of the procedure, such financial aid is far from being any contribution to the life conditions of asylum seekers. Following the granting of the refugee status, the refugees can apply to the UNHCR for financial aid and a financial interview is conducted with the refugee. Because of the financial limitations, the UNHCR cannot provide financial aid to all the applicants, and usually prioritizes vulnerable cases such as single women with children, refugees with chronic diseases and members of the LGBTT group. According to information gathered from NGOs and refugees, UNHCR pays a single person 100 TL a month, 190 TL to a single mom with two children and 205 TL to a family of four people. In order to encourage refugee parents to send their children to school, UNHCR also provides financial aid to students as 135 TL per semester to cover the school expenses of students, regardless of whether the student is an asylum-seeker or a refugee.

Given the extremely limited nature of the financial aid by the UNHCR and the Turkish state, most refugees attempt to find employment in Turkey. In theory, refugees have the right to work in Turkey. But as mentioned in the section on legislation, the right is subject to various conditions, which make it almost impossible to obtain a work permit for refugees. Added the language problems particularly in the early stages of their stay in Turkey, refugees have many troubles in finding employment and when they can, they usually work in menial jobs such as dishwasher, construction worker and cleaner in workshops and factories. Many refugees reported that they are paid very little or not at all for their work and are fired easily without any payment for the days they have worked. The local refugee NGO said that they have many applications from refugees who were not paid for

their work but they cannot do anything since they are illegally working and cannot report such abusive behavior to the police.

Therefore, refugees usually apply to various NGOs for financial, food or medicine aid. One NGO particularly active working with refugees in the Midtown has Islamic orientations and is providing aid to refugees from Somalia and Afghanistan and in some rare cases, to Iranian single women. The official of the association explained that their primary focus is on people who have fled from war and the vulnerable cases such as single women and that they do not help refugees who came to Turkey "in search of a better life." The official also explained that he considers it a duty to help people in need, under the teachings of Islam. According to the information given by the official, the association has 14 houses with 14 refugee families settled, and in addition they help 4 Somali and 2 Iranian single women. For the families and single women, they pay the apartment rents, bills of electricity and water, the heating material, food and in cases of health problems, the treatment expenses. They also hold cooking courses, send some refugees to Koran courses, sewing courses, picnics and meetings, where refugees and donators come together. He said, "We try to provide all that they need, because we regard them as fish in a bowl. A fish in a river can go and look for food, but if you don't feed a fish in a bowl, it dies."

The official of the association helping Somali and Afghan refugees is quite critical about the refugee policy of the Turkish state and the attitude of the government officials, including the state hospital personnel, towards refugees in general, stating that there is nothing humanitarian about the policy and attitudes of state personnel. "There is no government policy about refugees in Turkey, but only arbitrariness of the public personnel," he said. Therefore, he usually does not take the refugees that need medical attention to the state hospital but to private hospitals. He explained that the managers of private hospitals rarely charge them for the examination and tests, because they want to contribute to the charity activities of the association. For medicine, he said the association works in close cooperation with the foundation of a private hospital, which has an unused medicine collection campaign, to find the

medicine needed but if the medicine cannot be found there, the association can get a significant discount from pharmacies they work with regularly.

However, he is concerned about the image created by some Iranian refugees among the local people in the Midtown and the effect of this image on local people, who are reluctant to help refugees in general. He said that some Iranian women wear much makeup and engage in activities that the local people in the Midtown usually disapproves, such as grown-up women using the swing in children's park. He warned a 15-year old refugee girl wearing nail polish that the donators to the association he works for would not approve such behavior. Regarding the nature of aid, he told that he usually makes the shopping himself and takes them to refugee families but sometimes takes refugee families to supermarkets to enable them to make their own shopping.

> At the supermarket, they usually buy things that I would never consider necessary. For example, one Afghan woman bought tahini. I would have never thought that they would need tahini. We usually think that we would have better ideas about what they need but maybe we are wrong, maybe people should be able to decide for themselves.

Another charity foundation in the city has a private hospital, where they provide free examination and testing opportunity for people in need and who have no social insurance coverage. Although they do not particularly target refugees, they also provide the same services to refugees referred to by one of the other NGOs working more closely with refugees. Until a few years ago, the foundation has also given to the main refugee organization in the city a quota of 20 refugees to be examined and treated free of charge in their hospital, but this practice ended when the chief physician of the hospital changed. However, the main motivation for application by refugees to the foundation is for finding the medicines they were prescribed by a doctor and were unable to purchase. Because of the foundation's widely known unused medicine collection campaign in the city, the more common medications for more commonly encountered health problems can be easily found in the foundation. The official of the foundation explained that they also send some medicine, particularly when their expiration date is close, to the physicians working in health clinics so that they can give the medicine to the patients they prescribe

them for. The foundation also operates a guest house for especially oncology patients and their relatives referred to them by the state or university hospital, since many oncology patients come from other cities in the region. Asked how many refugees have stayed in the guest house they are operating, the official said she is unable to give a number because she does not ask people if they are refugees or not, but a few must have stayed there.

The main organization working with refugees in the Midtown is the branch office of an organization established in several cities of Turkey. The activities of the NGO are funded by the UNHCR and aim to provide social and psychological assistance to refugees. In general, the organization aims to provide assistance to refugees about accommodation, employment, social assistance by refugees, transactions with the state and the UNHCR, education and health. However, they do not have any resources to provide financial aid or fund the health and similar expenses of the refugees. All refugees directed to be settled in the Midtown by the UNHCR are informed about the NGO working with refugees in the city and they apply to the association for various reasons. The personnel of the association interviewed indicated that the most important problem for refugees in the province is the problems of health service, as they are usually more urgent and harder to solve.

Regarding health services, the personnel of the association usually tries to find funding for the treatment and medicine costs, makes the necessary correspondence for financial aid with the municipalities, Social Assistance and Solidarity Foundation and the UNHCR. The personnel explained that their primary aim is to use the available resources in the city and then apply to the UNHCR. They also try to get medical reports for people with serious health problems and report such health problems to the UNHCR. If the health problem cannot be solved in the province, they contact the related institutions for the transportation or transfer of the related refugee to another province. In critical cases, the personnel of the association accompany the refugee with the health problem to the health institution and follow the transactions for the required treatment of the patient. A part-time translator in Persian language is available at the association’s office and helps

refugees that do not speak Turkish for all of their transactions with the state personnel, including doctor visits, either personally or via the phone.

The personnel indicated that the problems in the access of refugees to health services generally stem from the loopholes in the legislation about refugees and can only be solved through a law that has more definite terms and conditions about the responsibilities of all institutions. Because of the loopholes, they argued, different interpretations of the roles of different actors are possible and the provision of services is left to personal choices. Stating that there are widespread prejudices among local people in the Midtown considering Iranian refugees and members of the LGBTT group, which have quite heavy problems with the local people, and such prejudices should and can be overcome through introducing refugees to citizens through press.

The organization working with refugees is currently not providing psychological counseling but there is another one in a big city which has legal and psychological aid services for refugees and has clients from refugees all around Turkey, including the Midtown. Asked how they started to provide psychological counseling, the official of the organization said that while providing other services to refugees, they encountered many refugees suffering from psychological problems and particularly PTSD. One other organization providing social support for refugees of LGBTT group is based in another big city and tries to reach members of LGBTT group in various provinces. The volunteer of the organization that I interviewed said that in case of health problems that cannot be solved, they refer the refugee to the city that I conducted my field research in, because it is usually easier to solve the health problems there. This organization focusing on LGBTT refugees also distributes materials related to the sexual health of refugees, free of charge, through their own offices and the offices of other NGOs they cooperate with.

In general, the non-governmental organizations seem to be the most important actors that have the highest level of access and communication with refugees and have the highest level of knowledge about the problems in the field and are usually the only place the refugees can resort to for the resolution of their problems.

However, because of the limitations of their financial and human resources, they can only partially solve the problems of refugees, including the ones related with access to health services. Due to the failure to resolve such problems, in the field research, I have observed a significant level of mistrust among the NGO staff and refugees towards each other. The effect of this mistrust on the provision of the services presented by the NGOs deserves another detailed research focusing on the question.

Overall, it can be argued that there are significant problems about the access of refugees to health care services. In this chapter, the legislation about refugees and their access to health rights, as well as how it is translated into practice, were analyzed. Under the Turkish legislation, asylum seekers who are accepted as such by the Ministry of Interior at the end of a process that takes at least a year, are registered with the SGK and covered by the general health insurance. The applicants for asylum are left outside the scope of the general health insurance coverage. However, in practice, asylum seekers with recognized status have to present a valid residence permit, with the residence fee paid, in order to register with the SGK in the Midtown. This requirement leaves a lot of asylum seekers uncovered by the health insurance. It was found in the field study that the majority of refugees are not registered with the SGK. Therefore, for the health problems they have, such as dental problems, psychological problems and other internal problems, they have to cover their own expenses and usually at this point the NGOs intervene to cover the costs of health services and particularly the medicine. One of the charity organizations working with refugees in the Midtown is assisting particular groups of refugees and has certain standards expecting the assisted refugees to comply with them. In general, a lack of confidence between NGOs and refugees was observed, but this point needs further elaboration through another study.

CHAPTER IV. THE CLINICAL ENCOUNTER FOR REFUGEES

In the previous chapter, the problems with the access of refugees to health services were examined, along with common health problems among refugees and the role of non-governmental organizations working with refugees in the resolution of these problems. This chapter will focus on the dynamics of the encounter between health professionals and refugees, when refugees can have access to the health services in some way. The first section will elaborate on the language problem, which is argued to be the most important problem in this relationship, and the use of translators, who are usually friends or relatives of the refugees. The effect of the use of the relatives and friends as translators on the communication difficulty and the doctor-patient confidentiality will be discussed. Related with this discussion, the use of trained and professional translators will be suggested, who can also act as cultural interpreters to avoid miscommunications due to cultural differences. The complaints of refugees about the shortness of the examination period will be mentioned and perceptions of the attitudes of health professionals will be examined, with a particular attention to the recurrent theme in the interviews about the lack of knowledge among health professionals about refugees will be mentioned. This observation about the health professionals was confirmed through interviews, and the ideas of health professionals about refugees were found to be based on the hearsay in the Midtown in general. Thus, the common perceptions of the local people in the Midtown will be narrated in the next section and it will be argued that health professionals are not immune to such stereotypes. The response of physicians to the complaint of the refugees that they do not ask about the living conditions of refugees was that they treated all of their patients equally. Therefore, the next section of this chapter will seek answers to the question whether refugees are different patients from local people. In line with the statements of the physicians in this respect, the high frequency of psychological problems, particularly depression, will be analyzed in a different section, as well as the refugees' need for psychological counseling. In the concluding section of the

chapter, the discussion will focus on whether health services for refugees are sufficient and appropriate.

4.1 Language problems and the use of translators

Most of the physicians and health professionals interviewed for the research argued that language problems are the most important issue that arises in the clinical encounter with refugees. Usually, refugees speak some Turkish themselves or bring a friend or a relative who speaks some Turkish to the hospital or health clinic. Sometimes, the translation is done through phone calls to the NGO working with refugees or to someone the refugees know. If the refugee did not bring a translator and the physician cannot find any way to communicate with the patient, the physicians required the patient to call an interpreter or leave and come back later with a translator. At times, such requests lead to a delay in the examination of the refugee by the doctor, as some refugees complained.

Most of the communication between refugees and health professionals is in the Turkish language, but some doctors said that if the refugee speaks English, they can also speak in English. Some physicians said that the level of competence in the English language may not be sufficient in one of the parties to the relationship, which makes communication even harder. Some refugees also told that they are trying to learn the English language while they are in Turkey, because they hope or wait to be resettled in the United States, Canada or Australia. One refugee, with excellent command of English, however, complained that many physicians do not speak English so he has to try hard to communicate in the little Azeri Turkish he speaks.

Because of the language problems, in the interviews I conducted, I learned that many patients mistakenly apply to the wrong policlinics or wrong departments at the hospital. An otolaryngologist (ear, nose and throat specialist) said that he has seen some refugees coming to his office for complaints of abdominal pain and an internist said that one refugee mistakenly applied to him for orthopedic problems.

Similarly, the specialist of emergency medicine stated that the personnel at the registration desk usually refer refugees to the emergency service when they do not understand what kind of complaints the patient has. Thus, he said, many refugees applying to the emergency service do not have conditions that require emergency care.

In the interviews with physicians and administrators of the hospitals, I asked them whether the use of relatives and friends, who cannot speak Turkish fluently, pose any problem with regards to communication of the complaints and to doctor patient privilege. Many of them said that there is no other way of communication and they have to use the people brought by refugees as translator, because, as a hospital administrator said, "communication is of primary importance in the practice of medicine, because if you cannot take the history of the patient, you cannot make the right diagnosis."

About the same question, the otolaryngologist said that communication can be hard with people that do not have full competence in the Turkish language, because when the patient applies to him with the complaint of dizziness, he wants the patient to describe the feeling, since there are four different kinds dizziness, all pointing to another health problem. He said, "If the patient can speak Turkish fluently, he can describe that feeling but it is very hard to realize the same level of communication with people speaking Turkish for only a few months."

But the use of tests and physical examination can compensate for the possibility of miscommunication, some physicians argue. Although the translators that are brought to the hospital by refugees may not have full competence in the language, one physician argued, they do not need to depend on what refugees and their translators say about their complaints and, doing tests and a detailed physical examination can give more clues about the health problem the refugee is experiencing.

For other physicians, the main concern was not the communication of the complaints by the refugee to the doctor but the communication of the treatment by the doctors to the refugee. One family physician working at the gynecology

hospital said that she is concerned that when she is telling what needs to be done following a procedure, some of her words may be lost in translation or be mistranslated and that would lead to complications for the patient. “Even when one word is changed in the translation, this may lead to serious complications,” she said.

Regarding confidentiality of the information to be given by the refugee, the physicians interviewed were not concerned, saying that if the patient brings a friend or relative as a translator to the doctor’s office, then she/he must have confidence in the translator and made the translator a secret-keeper of what she/he tells the doctor. One physician said that the violation of confidentiality is not an issue for his specialty because he works in an area related with the parts of the body above the neck. He added, “But that may be a problem in internal medicine. If I was an internist I would keep the translator behind a curtain, I am sure the internists do pay attention to that.”

The use of translators was considered a sensitive issue especially by psychologists and psychiatrists. One psychiatrist said that the interview with the patient must be done through a professional or at least a competent translator to ease communication and definitely with a professional translator to avoid any violation of the doctor patient privilege. The fact that the psychiatrist working in a health clinic working in close cooperation with the UNHCR in a big city is a Persian-speaking Turkish citizen result in many refugees with psychiatric problems to apply to this health clinic, despite the transportation costs and the time spent on the way to this city. The refugees interviewed also argued that the psychologist to be hired by the main refugee agency in the city where I conducted the field study should speak Persian, since translation may cause some difficulties in therapy.

The refugees interviewed did not report serious problems with regards to the lack of a professional translator while they were examined by the doctor. Some refugees with tolerable health problems do not apply to the hospital because they cannot speak the Turkish language and they choose to call a friend speaking Turkish only when the problems gets more serious and disturbing. In families, since many

children go to school in Turkey, the children usually act as the translator for their parents or their parents' friends. The violation of the doctor patient privilege has rarely been an issue indicated by the refugees.

In one case though, the lack of a translator could have had some serious consequences. A Somali woman, who gave birth in a private hospital two months after she arrived to Turkey, was accompanied to the hospital by a Somali friend, who spoke some Turkish, and the wife of the official working in the association providing aid to Somali refugees. During the preparations for the birth, the Turkish woman asked the nurses if she can be present in the delivery so that she can help if the Somali refugee needs anything.

> The doctor did not accept and the nurses said it should be fine. But, now I wish I have insisted more. Because during the delivery, the doctor wanted her to push and she did not understand. It was her first delivery, you know. She did not understand what she should do. The doctor then decided to do a vacuum extractor delivery. I know that the baby could get seriously damaged in a vacuum extractor delivery. After the delivery, they checked if the vacuum caused damage in the baby's head and brain and they said he is fine. But he can also have a hip bone broken, the doctor said that this should be checked when the baby is three months old. We will take him to the hospital again to check for the hip. I regret that I did not insist more, if I would be there during the delivery, I could talk to the mother and the vacuum extraction would not be necessary.

Under the article 202 of the Criminal Proceedings Law, in case a person, either a suspect or a victim, cannot speak and understand Turkish language with full competence in a court or before the public prosecutor during an investigation, the court or the public prosecutors shall appoint a translator to communicate the hearing or the investigation and the person's statement to the court or public prosecutor. Like the justice service, the health service is one of the fundamental public services provided by the state and similar conditions should be ensured in the provision of the health service as well. Asked whether a professional translator would avoid problems of miscommunication and ensure doctor patient privilege, many physicians and hospital administrators said that it would be ideal but the hospital or the clinic does not have the resources to employ a professional translator or use the services of an independent professional translator. However,

the use of professional and trained translators in the hospitals seems to be crucial for the provision of the health services and can be coordinated by the provincial health directorates in line with the resources and needs of different health institutions. Such professional translators may also improve communication between health professionals and refugees, as cultural interpreters, acting as patient advocates providing information about the procedures and legal rights of refugees, following the examination and treatment procedures and assist refugees in accessing appropriate and sufficient medical care.

4.2 Cultural interpretation of health problems

Both the communication between the health professionals and the patient, and the possibility of the patient's compliance with the recommended treatment may be affected by the different interpretations of health problems and treatment processes by both parties to the relationship. Culture may act as a mediating factor in this process. Therefore, during the field study I also investigated whether the cultural differences between refugees and health professionals are a factor affecting the clinical encounter of the two parties.

As indicated in the first chapter of the thesis, the majority of the refugees settled in the Midtown are Iranians, while around 10 percent is Afghan, Iraqi, Somali and refugees from East Turkestan. Asked about the profile of their patients, the majority of the physicians said that the refugees they examined were Iranian, young and well-educated. Meanwhile, however, the majority of the physicians also said that they do not usually see the same refugee more than once, because there are different policlinics at the hospital and several doctor's offices in the same family physicians' center. Therefore, the physicians interviewed usually could not comment about the patient's compliance with the recommended treatment.

The family physicians said that since the education level of refugees is usually quite high, they are more informed about health-related issues than the locals applying to the same family physicians center.

> They care about health issues, many of them got vaccinated for swine flu, so much so that the health directorate said we should stop vaccinating refugees because there will be no vaccines left for citizens. Then we saw that citizens do not get vaccinated and we will have plenty of vaccines left and we started to vaccinate refugees again. Many refugees came here to get vaccinated for swine flu, they are very careful about their health, even more than the citizens.

I asked the physicians interviewed if there is any cultural difference that may affect the examination and treatment procedure. "Naturally, there are cultural differences but the same applies to the citizens who come from rural areas, and even more so," said one physician. Similarly, most physicians argued that cultural differences do not play a role in the clinical encounter between refugees and health professionals. For one thing, they said, the cultural differences are not quite significant, since the Iranian refugees have a very similar culture. They also indicated that the high level of education among their refugee patients usually brings along much respect for the knowledge level of the physician and his/her job. One family physician said, "They are very respectful and kind, much more than the usual patients we have."

Another family physician working at the gynecology hospital stated that her job requires a very culturally sensitive procedure, abortion, and she always encounters very emotional reactions from her patients and their families. "But refugees come with the problems solved in their head. They are quite educated and thus civilized. I do not face any emotional reaction from the refugee patients and their families."

In a similar vein, the refugees also did not see any problem in clinical encounter due to any cultural differences. The refugees did not see much difference between the health system in Iran and Turkey and the culture of health in general. They said they use the similar or same herbal medicines when the health problem is minor such as a simple cold. But they also indicated that they are used to being ordered more tests in Iran when they apply to the hospital and considered the short period of examination a sign of the fact that health professionals "don't care about them." This point will be elaborated further in the next section of this chapter.

Although the physicians and the refugees did not report any cultural difference affecting the relationship, some of the health professionals interviewed mentioned a significant inclination towards shyness and uneasiness, partly explained by the

nurses with the "uncertain legal situation" of refugees. An internal medicine specialist argued that this may be because of the uneasy feeling of being in a foreign land.

> I lived abroad for some years and I can relate to that. One never feels as comfortable as one's own country. It is hard not to sense the uneasiness of refugees when they come to me. However, they are very cooperative and respect the doctor. If you explain the treatment well, they also follow the treatment. But I think this is a general problem in Turkey. Doctors don't communicate the problem and the treatment to the patient very well. In the U.S. for example, there is the informed consent concept, doctors explain the course of treatment to the patient, present the options and the patient decides on the treatment. But in Turkey, partly because of the social structure, doctors don't communicate with the patient about the options of treatment. I try to do that in my practice, explain the options to the patient and let the patient decide. But they usually say it is my call, this is both good and bad; it puts responsibility on the shoulder of the doctor. Nevertheless, I pay attention to making the patient understand the reasons of the disease, the treatment and why that treatment is better than the others.

In general, both parties to the relationship did not consider culture as an intervening factor in the dynamics of the clinical encounter. However, as will be argued below in detail, the refugees at times felt that the health professionals they encounter do not know about their situation, their problems and simply do not care and try to learn. The short examination periods and the lack of thorough physical examination and tests they complain about may be a result of the "institutional culture" of health professionals, which have to deal with many patients throughout the day and try to understand the health problem as quickly as possible without delving into the details, the health professionals consider irrelevant. Asked about a comparison of the Turkish and Iranian health systems, some refugees indicated that the hospitals in Iran are less crowded and the physicians tend to allocate more time for their patients, usually requesting more tests and taking more time to explain the diagnosis and the treatment. The complaints of health professionals not caring about who they are and what needs they have as refugees may be a result of the encounter with a different institutional culture of health care from what they are used to, but this explanation is in need of further research on the topic.

4.3 Examination – Too late, too short

A common complaint among refugees about the health services is the long waiting periods because of long lines at the health institutions and the short examination time allocated by the physicians. The university and state hospitals tend to be very crowded and the patients get in line a few hours before the actual time the physicians start to work, to get a number to be examined that day. As a result, the refugees wait a long time like other patients but they are not used to wait for such a long time in Iran. One refugee indicated however, that she waited more than the other people at the doctor's office and the citizens were taken to the examination room although it was her turn, but no other incidents were reported.

Because of the work load, the time allocated for the examination of one patient is usually very low compared to the standards determined by the World Medical Association. This is a common problem in Turkey regarding the health system and some refugees interpret it as the doctors not caring enough about their problems. One refugee told that he applied to the hospital with complaints of dizziness and sleep problems and was prescribed sleep pills, without any tests or even a check on his blood pressure. Another refugee named Sultan said that the interview with a psychiatrist she went only lasted five minutes.

> He asked me what my problem was and I said that I have sleep problems, I feel sad all the time and I have nightmares. He wrote me a pill and that was the end of the interview. I asked if I can talk to him about my problems for some time. He told me to take the pill and come back in a month. The other month I went to him again and he asked whether the pills were good for me, I said I used the pills but I need to talk to someone about my problems. He said it is not necessary, I should just take the pill. I have been using the pills for 1.5 years now, but I feel they are not enough, I should talk to a doctor about what happened to me. When I go to that doctor, he just writes the prescription and doesn't do anything else.

As in the case of the above-mentioned refugee, lack of psychological counseling is an important concern for many refugees. Most of the refugees who were using antidepressant pills said that they need psychological counseling but they cannot apply to any institution for that. This point will be elaborated further in the related section of this chapter.

One other refugee claimed that health professionals, in particular the nurses, do not care about their patients, and it is worse for refugees. As some other refugees underlined, Mahyar said that doctors and nurses do not ask about their conditions and they do not try to understand. “Some doctors, registration desk officers and nurses even do not know what a refugee is, they ask why we came to the country,” he said. He recalled an event when he was waiting in the line for the doctor examination, he said to a nurse that his leg hurts and the nurse replied that she has problems, too, and left. As the refugee organization in the city also stated, he claimed that most doctors are reluctant to issue a report about the patients they examined and considered that a sign of doctors not trying to understand their conditions.

In general, refugees complain about not being thoroughly examined and the tendency of the doctors to wanting to understand the problem fast and prescribe a medicine that will treat the disease they diagnosed. Refugees want to be examined in a more comprehensive manner, their blood values checked, a detailed physical examination made, their life conditions asked and taken into consideration about the diagnosis and treatment, and in the case of psychiatrists and psychologists, their problems listened to and psychological counseling given. However, given the long lines at the state hospitals, the doctors and nurses have very limited time to allocate for the examination of one patient. Most of the interviews with physicians were made in the working hours and at the offices of the doctors. During the interview, many patients came to the office and I asked whether I should step out during the examination to the doctors, and the doctors said it is O.K. for me to be there. Most examinations lasted around 3 to 5 minutes, since there were a lot of other patients waiting to be examined.

The idea that the examinations lasted short without asking questions about the patient’s life conditions was partially agreed by the health professionals interviewed, who said that the physicians usually do not have the time to ask about whether the patient is a refugee or not or what kind of conditions they live in. Physicians also added that it does not matter for them whether a patient is a refugee or a citizen, since they should and do treat all patients equally. This statement was

made by many physicians at the very beginning of the interviews, probably to avoid any questions that may imply some kind of discrimination against refugees in the services they provide. The fact that health professionals do not ask and mind if the patient is a refugee or a citizen may have led to communication deficiencies and lack of information. Towards the end of the interviews with health professionals, I asked what the term refugee means and some answers indicated lack of information about the term and the group in Midtown. The answers also indicated that the information health professionals had about refugees in general and the group in Midtown was, to a large extent, based on the hearsays common among local people in Kayseri, a point that will be elaborated further in the next section of this chapter.

4.4 Perceptions of refugees by general public – are health professionals immune?

As indicated in the methodology section of the dissertation, the study did not focus on the public's perception about refugees and did not include interviews with the members of the general public to find about their views on refugees in Turkey. However, the issue was considered worth elaboration in the dissertation for two reasons. First, the stereotypes of the public on refugees was a recurrent theme that arose in the interviews with refugees, NGOs dealing with refugees and even with some health professionals, although the topic was not included in the list of questions prepared for these groups. Secondly, it was observed that many health professionals interviewed did not know what a refugee is and when I explained the research topic to them, they usually asked, "About who?" The right answer to that question was "Iranians" as many local people used the term Iranians to refer to the refugees, even for Afghan and Iraqi people. Talking about the "Iranians," the same health professionals usually referred to "what people say" about the group.

The most striking aspect was the commonness of the idea among public that refugees get paid a few thousand dollars every month from an unknown source in the United States. The source of this rumor is unknown but I heard the same from

many health professionals, refugees, organizations and people in the street. The organizations dealing with refugees in the city explained that this rumor may be created in connection with the fact that there are some refugees in the city living in very luxurious apartments in quite popular neighborhoods and go skiing regularly at the nearby expensive ski resort. Despite my efforts, I could not contact any of the refugees living in the mentioned conditions, so this observation could not be confirmed in the field study.

Many health professionals shared the same idea since they hear that from many people, and they indicated, some of their refugee patients wear a lot of make-up, are nicely dressed and look wealthy. “They like it here, they are very comfortable, living in nice apartments and they do not have to follow the rules in their own country,” said one physician. Truly, some of the health professionals thought that the refugees came to Turkey to avoid wearing the headscarf and to be more free about their behaviors, and the makeup is one sign of that. The same idea can be observed in the words of the official working for the organization providing help to Somali and Afghan refugees, quoted above, referring to the Iranians as people who have migrated from their own country in search of a better life, as well as blaming the Iranians for engaging in behaviors that are disapproved by the general public and thus creating a false image about all refugees.

Recurrently, it was told that the majority of the locals thought that the refugees have migrated because they betrayed their country and then left. The pharmacist working at the drug store in the city, which cooperates with the UNHCR, said that most other pharmacists do not want to work with refugees because they think the Iranians are in Turkey because they betrayed their country. “I do not know about that, but these people are humans too, I do my job, I try to help them, if they are bad, that is their own business,” he said.

The health professionals thought both female and male refugees are nicely dressed and some considered it “too much” for men. One physician said that Iranian men, particularly the younger ones, care too much about their hair, “like they are on MTV.” Similarly, another physician said, “The men do not look like what we are

used to see among Turkish men. They are, I should say, more feminized. They do not have the manly appearance of Turkish people and I wonder why this is so."

During my interviews with the staff of the main NGO working with refugees in the city, I learned that the prejudices against Iranians are worst against the members of the LGBTT group. The official from the NGO with LGBTT refugees said that in general there are many cases of beatings by the local people in many satellite cities and most LGBTT refugees are afraid to go out because of that, particularly in the evenings. "Because you know, the city that your research is on, and some other satellite cities, they are quite conservative with regards to social structure. They are not places that I or my friends would like to live in," she said. But she added that the same prejudices and discriminatory behavior can be observed among other Iranian refugees as well.

> If you think about it, the refugee must have been subject to some human rights violations as well, but that doesn't mean that he or she will be respectful to the other people that have been subject to human rights violations. They repress the weaker ones in the group. They exclude the LGBTT refugees from the social support mechanisms they have established for the refugee group.

Unfortunately, during my field study, I could not meet any refugee member of the LGBTT group and could not incorporate their problems into the research. This may be considered a confirmation of the fact that LGBTT refugees are excluded from the social networks of other refugees, since it was usually the refugees who referred me to other refugees to make an interview.

The health professionals usually did not report any encounters with the members of the LGBTT group as their patients, but said that they would not treat such a person in a way different from the way they treat all patients. This is a point to be elaborated further in the next section of the chapter but it should be noted here that almost all of the health professionals said that their attitude towards refugee patients is and can be in no way different from their attitude towards other patients. I asked the physicians interviewed, at the end of the interview, to make a definition of the term refugee, not just as a legal one, but also a social one. Some of the physicians gave a correct definition of a refugee in the legal sense of the term, such

as “a person who had to leave his/her country because of problems in the country,” or “a person who came from another country, was forced to leave his/her country and is in need of assistance in many aspects.” However, there were other definitions as well. One physician stated, “A refugee is a person who has migrated to Turkey with his/her own will and was accepted to be legally settled in Turkey,” while another one made a more interesting definition by saying, “A refugee is a person who does not know who he/she is, is searching for himself/herself, and could not fit himself/herself to a certain national identity.”

As the definitions made by the physicians indicate, there is a general lack of knowledge about who the refugees are, although refugees have been settled in this city for more than five years now. The health physicians interviewed frequently asked questions about whether the term refugees covers foreign people that have come to visit a nearby touristic place or the foreign students that study in the imam hatip high school in the city, since both groups of patients also form a large group. In a similar vein, the statistics provided by the state and university hospital about the number of refugees that applied to the institution in the last year included some names that are in languages not spoken in the countries where the refugees come from and it was told that some tourists or students were recorded under the same category as refugees as well.

4.5 Are refugees different patients than locals?

Subject to various health risks and adverse conditions before their migration, during their journey and while they are settled in Turkey, I investigated in the research whether the fact of the refugees are regarded differently by the health professionals. Almost all of the health professionals indicated that all patients are regarded as equal while they examine them and they do not mind whether a patient is a refugee or a citizen while he/she is a patient of them.

However, one physician who have examined and treated many refugee patients said that the fact that the patients are refugees gain importance considering the

environmental factors that may adversely affect their health in general. Criticizing the government policy and officials of not being sensitive to the health problems of refugees, she argued that there are significant loopholes in the legislation and difficulties in implementation regarding the issue.

> The refugees should have a thorough examination when they enter the country, should be examined in a fully equipped state hospital with regards to epidemics and in a tuberculosis clinic with regards to tuberculosis risk and should be given reports as a result of these examinations. This provision is in the law. I discussed that with the governor, the director of the Provincial Health Directorate and the head of the Provincial Security Directorate. They said that the refugees are sent from the central organization and must have had such examinations after they applied to the headquarters of the Security Directorate.

Refugees argued that a detailed examination after they enter the country is necessary and would solve many of the health problems they have when they come to Turkey, and the social insurance should be valid as soon as they enter the country because they live in so poor conditions and be subject to various health risks.

During my interviews with the physicians however, some have indicated that there are some aspects of refugee patients that make them different patients from the nationals. One physician said for example that the majority of patients that applied to him did not have serious problems, arguing that if the same problems were experienced by Turkish patients, they would not bother to come to the hospital. Asked why he thinks the refugees come to the hospital for such minor problems, he said:

> I think that is because they have nothing to do, they are always at home and they use the hospital to get some fresh air, to go outside for some time and meet a person. They come to the hospital to get some social support and to establish some social relationship. I do not think somatization is the case, I think they want to get social support.

He also went on to argue that some of his patients look depressed and apply to the doctor for socialization purposes.

Related with the psychological problems the refugees are thought to be experiencing, one internist commented that it is common for the refugee patients he examines to have functional diseases, which are not related with any organic cause, but emerge as a result of stress and anxiety. He commented that such functional diseases are more common among refugees than among locals and that the treatment for such diseases is usually psychological.

One of the reasons why refugees feel that the fact that they are refugees should be taken into account is the reluctance of the physicians to issue medical reports about their health problems. Medical reports are important for refugees since they can only get the costs of their medications covered by the UNHCR through a medical report (although a medical report does not guarantee that such costs will be covered), and serious and chronic diseases can sometimes speed up their process of refugee status determination by the same organization. However, the issuance of medical reports is a problem mentioned both by refugees and physicians. Refugees argue that physicians are not willing to issue medical reports because they do not care about their problems, while the main refugee organization states that many doctors ask for an official letter requesting a medical report to prepare a report, while getting this official letter from UNHCR is almost impossible. The organization interprets the reluctance of the physicians to issue medical reports as the reluctance to take responsibility about the situation of the patient.

Meanwhile, health professionals argue that there are some refugees that go to the hospitals very frequently with different complaints and argue with the doctor when there is no health problem detected in the examinations and tests. The health professionals argue that such people want to abuse the system through getting a medical report in order to speed the process up at the UNHCR.

4.6 Psychological Problems and Trauma

Related with the traumas experienced before migration and the stress of waiting for a very long time “in limbo,” many refugees reported experiencing psychological

problems. A significant number of refugees interviewed were using antidepressants, mostly prescribed by the psychiatrist working in the private clinic working in cooperation with the UNHCR. The health professionals also indicated that they observe signs of depression among many patients they have examined.

One significant example of psychological problems is the case of torture victims and the continuing psychological effects of such trauma. During the field study, I encountered some torture victims and did not conduct interviews for the research with some of them because of the continuing acuteness of their problems. All of the torture victims met said that they need psychological counseling and therapy to talk about their problems and I tried to refer them to the human rights organizations running torture rehabilitation centers. But such services were available only in big cities and they needed a report from the state and university hospital indicating the diagnosis to be able to get outside the city. The torture victims were concerned that such a report may result in UNHCR's suspension of their case files until they have improved psychological status and did not choose to apply for psychological counseling.

One torture victim interviewed for the study did not regard torture rehabilitation favorably either, because he said that the torture of uncertainty and waiting in Turkey is ongoing and he needs that problem to be solved first to consider applying to rehabilitation. Another victim of torture and sexual abuse started psychological counseling in the city but indicated that the psychologist made her feel worse about herself. Other than the torture victims, there are many refugees who underline that they need regular therapy to cope with the difficulties they experience.

The major cause of such psychological problems, as stated by the refugees themselves, is the long waiting periods for the RSD process and to be resettled in a third country. In this waiting period, the refugees do not know what is ahead of them, and, in many cases, fear for their lives if their application is rejected and they are deported back to their own country. The refugees interviewed frequently complained about the indifference of the UNHCR and its implementation partners

about their attempts to learn about their case and to let the organization know about their situation in Turkey, which may, according to them, speed up the process.

The complaints of the refugees about the UNHCR are not limited to the slowness of the procedures run by the organization. Another frequent complaint is the way the UNHCR staff treats refugees in the interviews and the effect of such treatment on their psychology. "UNHCR makes me and other refugees feel bad about ourselves," said Mahyar in the interview, because in the interviews, UNHCR staff does not care about the problems of the refugees, but only about whether they are liars or not. Massoud said that the way the UNHCR lawyer conducted the interview felt like an interrogation, "and this is exactly the cause of my fleeing from Iran," he added. He went on to argue that UNHCR personnel believe all refugees are liars and their job is to detect the lies told to them. Similarly, Petos complained about the bad treatment he received from the UNHCR lawyer that conducted his interview, saying, "The lawyer was doing the interview not to help me, not to accept me, but to judge me and make me fall into the trap he was setting."

In the long waiting process, refugees usually cannot work or engage in any productive activity and are usually left on their own without any financial or social support. As a result of that, one point raised in the interviews was the sleep problems of refugees and their tendency of watching TV all night long because of not having anything to do. Refugees indicated that this is one of the sources of their psychological problems and they would feel better if they had something to keep themselves busy.

Health professionals interviewed, as well as the representatives of the NGOs working with refugees, also pointed to the frequency of psychological problems, such as depression, among refugees. The statements by physicians such as the tendency of refugees to apply to the hospital only to get social support and the frequency of functional diseases resulting from stress and anxiety, both statements referred to above, were also linked to the psychological problems the refugees may be experiencing by the same physicians. However, encountering such cases, the physicians do not ask for a consultation from a psychiatrist or a psychologist, make

referrals to physicians with such specialties, or make interviews with the refugees to investigate such psychological problems further. As observed by Lin *et. al*., physicians tend to emphasize the biomedical problems and overlook psychosocial ones (Lin *et. al*. 1985, 1080). This trend can be partially explained by the hesitation of physicians to deal with issues that are in their area of specialty. Vocational trainings on the symptoms and signs of psychological problems may facilitate the detection of psychological problems, particularly the trauma victims, and enhance the capacity of physicians to take steps in order to treat such conditions. This would be particularly useful in the case of refugees, since they refrain from applying to psychiatrists for psychological problems that do not affect their functions, out of the fear that a psychiatric report may delay their procedures at the UNHCR.

Psychiatric and psychological treatment is a double-edged sword for refugees, since the medical reports about severe psychological problems that may affect their memories and thinking processes can result in a delay in their transactions with the UNHCR and make the waiting period even longer. However, they need psychological counseling, which is hard to have access to in the city the field study is conducted. Particularly, psychologists and psychiatrists that have experience with the victims of torture and sexual abuse are a great necessity in the city.

4.7 Health services for refugees – Sufficient and appropriate?

The problems in accessing the health care services, as explained in the third chapter, prevent the refugees from solving their health problems. Among the interviewed refugees, there were many who did not even attempt to solve their health problems because of the known problems or who have debts to the state hospital and so do not apply to health institutions again for another or the same health problem.

The health institution administrators interviewed agree that the system does not always have the definite answers for the problems or cases of refugees and the decision is left to the decisions of persons involved. They argue that the provision

of health services should not depend on the conscience of the related officer but to a standard implementation in the system but there are no fixed standards in the system. An administrator argued that the residence permit procedures for asylum seekers should be speeded up so they can have social insurance coverage faster. Many administrators recalled the earlier system, according to which the UNHCR used to cover most of the health costs for refugees, and argue that a separate fund to be established by the state or the UNHCR can solve the problem of accessing health care services without any costs on the refugee.

The pharmacist interviewed, working at the drug store which sells drugs to refugees through cooperation with UNHCR, explained that the sole regular assistance of the UNHCR to refugees is the monthly provision of two packs of cotton to recognized refugees. According to the agreement between the UNHCR and the drug store, the UNHCR sends the list of refugees with recognized status as such every month to the drug store and the refugees can take the cottons from the drug store by paying 20 percent of its original price. However, the pharmacist thinks that this is not an appropriate service for refugees, since one pack of sanitary napkins can be more useful than two packs of cottons for refugee families with at least one woman. So, on his own initiative, he started to sell sanitary napkins on the same price as the packs of cotton to refugees. He argued that this particular service is a sign that the UNHCR does not care about refugees' needs. He is even more critical of the state policy towards refugees, stating, "The state takes money from the UNHCR to assist the refugees but that fund is not used to meet refugees' needs, they leave the refugees on their own, in a very hard condition."

Some of the refugees interviewed were also criticizing the government policy, as well as the UNHCR, about the situation of refugees and their health problems that cannot be resolved in Turkey and are left to be resolved in the third country they will be settled in. The words of one refugee are noteworthy in this context.

> There should be health examination of refugees as soon as they enter the country and health insurance. This should be done with a change in the law. Turkey does not care about us. If Turkey does not want refugees in the country, it should stop accepting refugees, but if it continues to accept refugees, that is a responsibility, Turkey should feel the responsibility to care about the refugees.

As explained throughout the dissertation, most of the refugees in the Midtown cannot have access to the available health services and the ones that can have access are usually subject to various complex procedures, applying to various institutions to get examined and to get funding for the health expenses. In addition to that, refugees cannot reach special health services for their cases, such as trauma counseling and comprehensive medical screenings. The more fortunate refugees with regards to access to health services, encountered in the field study in the Midtown, were the refugees that were assisted by the local NGO helping out to Somali and Afghan refugees. In these cases, the refugees were usually taken to private hospitals and their medicine costs were covered through charity organizations. However, access to health services is a right that should be recognized for all asylum-seekers and refugees, rather than being a matter of charity.

CHAPTER V: CONCLUSION

This study focused on the dynamics of the medical relationship between health professionals and refugees and the obstacles refugees face in accessing health services. As one of the basic public services provided by the state, the health services must be available to all people regardless of their nationality, legal status, race, sexual orientation or any such considerations. However, based on field research in the Midtown, which was considered as one of the more fortunate satellite cities in terms of the resolution of the problems of refugees, major obstacles and difficulties were found in the refugees' access to health services.

Under the legislation in Turkey, the asylum seekers whose status as such is recognized by the Ministry of Interior can register with the SGK to get general health insurance and the list of people recognized as asylum seekers will be sent to the institution by the related institution for registration. However, in practice, the SGK asks asylum seekers that apply for registration to present a valid residence permit, which have to be extended every 6 months upon a charge. Since most refugees cannot pay the residence fee or are awaiting the result of their application for exemption from the residence fee, they do not have general health insurance and have to cover their health expenses on their own account, or in some rare cases, by the UNHCR and the Social Solidarity Foundation. Since the law on general health insurance, the system about the registration of asylum seekers cannot be fully implemented yet, and refugees "fall through the cracks in" the national health system (Belvedere *et. al.* 2008, 248).

The procedures for applying to the hospitals, to related institutions for the coverage of health costs and to the SGK are overly complex and many refugees do not know about the available services, such as the SGK registration or the family physician system. A significant necessity of guidance about the available services was observed among refugees in the field study. The most severe problem about health services was having access to prescribed medicines and some refugees use the

medicines brought from Iran or ask their relatives or acquaintances to bring the medicine from this country.

Despite the fact that I was usually referred to refugees experiencing serious health problems, observations and the statements of health professionals indicated that refugees are healthy in general compared to the local population. Yet, malnutrition and the conditions in the places they live lead to some health problems. Dental and psychological problems were found to be common among refugees, a finding that is consistent with the findings of other studies in the literature. Refugees experiencing chronic diseases were also interviewed in the study. For such health problems that require regular use of medication, NGOs usually intervene to provide the required medicine.

NGOs and charity organizations working with refugees try to fill the gaps in health service provision and assistance but cannot provide all necessary services and solve all problems given their limited resources. There are two major NGOs in the Midtown, one a larger one providing psycho-social assistance to refugees and the other one providing aid only to certain groups, having Islamic orientations. The latter organization assists the refugees to solve their health problems, by taking them to private hospitals and providing the medicine they require. The refugee groups assisted by this organization seem to be more fortunate than other groups with regards to access to health services. However, this organization expects the refugees they help to comply with certain standards of behavior. Overall, a certain degree of mistrust was observed among both parties of the relationship between NGOs and refugees.

In the encounter between health professionals and refugees, language difference seems to be the most important issue, since communication is of key importance to health care services. For refugees who do not speak Turkish, a friend or a relative usually acts as a translator, but since they do not usually have full competence in the Turkish language, so there may be some complications in the examination, diagnosis and treatment procedures. Moreover, the failure to provide a professional translator may also cause the infringement of the doctor-patient confidentiality. For

these reasons, provision of a professional and trained translator in the medical services, as in the case of court or investigation procedures, is vital. Such translators may also act as cultural interpreters to prevent misunderstandings due to cultural differences and as patient advocates.

Despite the findings in the literature on the effect of cultural differences in medical services, this study found no effect of the cultural differences between refugees and health professionals, which significantly affect the clinical encounter. With regards to this point, physicians commented that the culture of the refugees is very similar to the Turkish culture and the refugees they examine usually have high education levels that prevent the cultural differences from having an effect on the relationship. They added that they experience more cultural differences with the Turkish patients coming from rural areas than refugees. Nevertheless, as argued above in the related section, the complaints of refugees on health professionals not caring about them may be related to the institutional culture of the health care system in Turkey.

Refugees suggest that health professionals do not care about them because of the short examination periods at the hospitals after long waiting hours. They claim that health professionals usually do not know in what conditions the refugees live and they do not ask either. Related with this point, they underline, the physicians usually ask the complaints of the patient, try to make a diagnosis as quickly as possible and write the prescription in a few minutes.

Based on the interviews with health professionals, it can be argued that there is a significant lack of knowledge about refugees in general and their ideas about refugees are usually based on hearsay common in the Midtown. The ideas about refugees among local people in the Midtown lead to prejudices particularly against Iranians and, even more significantly, against the members of the LGBTT group. Such ideas were also mentioned by health professionals in the interviews.

The physicians included in the sample of the study commented on the claim that they do not ask about refugees' conditions stating that all patients are equal for them and they do not mind whether the patient is a refugee or a citizen. Only one

physician argued that refugees are different patients than locals because refugees are exposed to different environmental factors both before their flight and in the country they have arrived. Meanwhile, one physician pointed to the need of refugees to establish social relations and one other argued that refugees usually have functional diseases, caused by anxiety and stress.

Related with these latter comments, it can be argued that psychological problems are quite common among refugees given the long waiting periods, the uncertainty and lack of social and financial support during their stay in Turkey. These psychological problems are also observed by the health professionals but no steps are taken for their treatment through consultation, referral or interviews with refugees experiencing such problems. Many refugees complained about the lack of psychological counseling in the city and, at the same time, refrained from applying to psychiatrists due to the fear that a psychiatric report may delay their procedures at the UNHCR. For victims of torture and sexual assault, the need for psychological counseling and rehabilitation was even more severe, but they are not referred to the health care providers that are experienced with such cases. Thus, rehabilitation services for torture victims are nonexistent in the Midtown.

Overall, there are significant difficulties preventing refugees from accessing the available health services. Moreover, there are no programmes or services specifically designed to meet the needs of refugees, such as comprehensive medical screenings upon arrival and referrals to solve the existing health problems or psychological counseling to rehabilitate the victims of torture and sexual assault and to assist refugees to cope with the effects of the traumas experienced and with the difficulty of living in a new country in an uncertain and precarious situation.

Like all pieces of research, this study has its own shortcomings and difficulties. The first difficulty was to reach the health professionals that had experience with refugee patients and were willing to conduct an interview. The initial contact points at the Provincial Health Directorate, the state hospital and the gynecology hospital were very useful in referring me to the physicians that might have had experiences with refugees. But the majority of the physicians contacted said they could not

help. Moreover, the physicians had no time outside the working hours to do the interview and particularly the interviews with physicians working at the state hospital were interrupted frequently by patient visits and other professional obligations. Finding nurses willing to talk was even more difficult as a process, since I had no prior contacts in this profession and I had to interrupt them in their work at the hospital asking them to answer a few questions about refugees. Although they were very helpful, some did not have much time for the interview.

For the interviews with refugees, I had to rely on the referrals of the NGOs working with refugees in the city at the initial contacts and then used the snowball technique to find more refugees. As argued before, the topic of the research led my informants to refer me more to the refugees with serious health problems. In addition to that, because of my reliance on my informants, who were either NGO personnel or refugees, to find interviewees, I may not have been able to contact the refugees who are out of the social networks of my informants or are not clients of the NGOs I talked to. In only a few cases, I had to interview the refugees with the representative of an NGO present, which may have prevented the interviewees from indicating some of the things they had to say.

With regards to interpretation, I was lucky enough to be assisted by excellent translators, who had full competence either in Turkish and English and also acted as a cultural interpreter in the interviews. Losing valuable information in the interpretation was a risk I had to take in cases of refugees whom I could not talk to in Turkish or in English. However, one particular difficulty was explaining these refugees that I did not represent the UNHCR or any other organization and could not have an influence on their case at the RSD or third country resettlement procedures.

Overall, the case of women with regards to health problems and access to health services has been invisible throughout the thesis. In the field study, the problems of women was actively investigated in the interviews with health professionals and refugees. The health professionals did not report any specific difficulties, problems or situations related to women. Meanwhile, most of the female refugees

interviewed were interviewed with their family members or friends present and this may have prevented them from disclosing information that are confidential. Therefore, although the study has aimed to analyze the specific cases of women, as explained in the introduction part and chapter two, there was no findings coming out of the field research in this regard and no specific information was provided in this regard in the remaining parts of the dissertation.

The study also had the shortcoming stemming from the questions on the clinical encounter between health professionals and refugees, which is a rather confidential relationship. Although I have tried to respect confidentiality by keeping all names and personal information confidential and not asking about any such details, some health professionals hesitated to give specific information about specific cases. A similar shortcoming was present in the interviews with refugees as well. Apart from a few refugees who wanted to conduct the interview outside away from their houses, all refugees interviewed had some family members or friends with them, so that may have also prevented them from speaking about private information on their health. Finally, some refugees met in the field study had quite acute problems, so I thought asking them questions about their lives in Turkey seemed inappropriate to me and I had not included them in the sample.

Encountering such shortcomings and difficulties, this study still aimed to record the experiences of people in the field and develop some recommendations about the health services. The most important recommendation to be developed out of any study about refugees in Turkey would be the shortening the waiting period for the RSD and the third-country resettlement procedure, due to its heavy toll on the lives and health of refugees. With regards to health services during their stay in Turkey, all asylum seekers whose status as such should be registered with the SGK to get general health insurance coverage, without any further requirements, which is basically the application of the law, and the extension of general health insurance coverage to all foreigners who have filed an application for asylum in Turkey. Moreover, special health related services should be developed for refugees, such as comprehensive medical screenings on arrival, torture rehabilitation services for victims of torture, and psychological counseling during their stay in Turkey. To

remove the concerns of the refugees, such psychological counseling should be provided in a way that will not delay their RSD or resettlement procedures at the UNHCR.

To improve the quality of the services provided, guidance should be available to all refugees in their own language about the available health services in the satellite city they are settled. This guidance can be provided by the UNHCR, its implementation partners in the satellite city, if there are any, or the local police station's foreigners' department. Equally important to this point is the provision of professional and trained translators in the health institutions. These translators may also act as cultural interpreters and patient advocates. Given the high costs of providing translation service in a diversified health system, the services of the translators can be coordinated by the Provincial Health Directorates.

Last, but not the least, the awareness of the state personnel, including health professionals, should be raised about the situation of the refugees and the conditions they come from and live in. In particular, the health professionals should be trained through vocational trainings about the common psychological problems, their symptoms and signs, and the signs of trauma among refugees. Such attempts to raise the awareness on the issue should be supported by larger awareness raising campaigns aimed at the general public about refugees. Additional measures for the members of the LGBTT group should be taken, such as their resettlement in larger metropolitan areas, where they can get more social support.

This study has only focused on the relations between health professionals and refugees, but there are other areas that are in need of further investigation. The relations between the state officials and refugees should be studied in other sectors as well, such as education and security. One area which has been striking in this piece of research but could not be investigated thoroughly was the relations between the NGOs working with refugees and the refugees, which has numerous dynamics, including a significant lack of confidence among the two parties to this relation. Finally, further research is needed about the perceptions of the local

people about refugees in satellite cities, particularly those where reception centers will be established in the near future.

APPENDIX A. PROFILE OF THE INTERVIEWED REFUGEES							
Name	Sex	Nationality	Religion	How long in Turkey?*	Case status	Health insurance	With family or alone?
Bahar	F	Iranian	Islam	12 years	Refugee	Waiting for exemption	Family of 3, 2 children
Farhad	M	Iranian	Islam	3 months	Asylum-seeker	No residence permit yet	Alone
Mahyar	M	Iranian	Christianity	11 months	Asylum-seeker	No residence permit yet	Family of 4, 2 children
Maryam	F	Iranian	Islam	4 years	Asylum-seeker	Could not pay residence fee	Family of 4, 2 children
Muhammed	M	Iranian	Islam	2.5 years	Refugee	Could not pay residence fee	Family of 4, 2 children
Farah	F	Iranian	Islam	5 months	Asylum-seeker	No residence permit yet	Family of 4, 2 children
Fatma	F	Iraqi	Islam	10 years	Refugee	Could not pay residence fee	Family of 7, 5 children
Erasto	M	Somali	Islam	17 months	Asylum-seeker	Yes	Family of 9, 7 children
Ayan	F	Somali	Islam	2 years	Refugee	Exempt from residence fee, does not know about SGK	Lives with 3 Somali women and 1 child
Sultan	F	Afghan	Islam	2 years	Asylum-seeker	Waiting for exemption	Family of 5, 4 children
Mustafa	M	Afghan	Islam	1.5 years	Refugee	Waiting for exemption	Family of 5, 4 children
Nargis	F	Afghan	Islam	5 months	Asylum-seeker	No residence permit yet	Family of 4, 2 children

Negar	F	Iranian	Islam	10 months	Asylum-seeker	No residence permit yet	Alone
Petos	M	Iranian	Christianity	9 months	Asylum-seeker	No residence permit yet	Family of 3, 2 children
Siavash	M	Iranian	Christianity	7 months	Asylum-seeker	No residence permit yet	Alone
Martiya	M	Iranian	Christianity	2 years	Refugee	Paid residence fee, does not know about SGK	Alone
Emanuel	M	Iranian	Christianity	6 months	Asylum-seeker	No residence permit yet	Family of 4, 2 children
Laleh	F	Iranian	Baha'i Faith	27 months	Refugee	Exempt from residence fee, does not know about SGK	Family of 3, 1 child
Yahya	M	Iranian	Baha'i Faith	15 months	Refugee	Waiting for exemption	Family of 4, 2 children
Musa	M	Iranian	Baha'i Faith	28 months	Refugee	Paid residence fee, does not know about SGK	Family of 6, 2 children
Massoud	M	Iranian	Islam	6 months	Asylum-seeker	No residence permit yet	Alone
Rezagul	F	Afghan	Islam	2.5 years	Refugee	Waiting for exemption	Family of 7, 3 children, 1 grandchild
Zeynep	F	Afghan	Islam	2.5 years	Refugee	Waiting for exemption	Family of 6, 5 children
Leyla	F	Iranian	Baha'i Faith	1 month	Asylum-seeker	No residence permit yet	Family of 4, 2 children

*As of December 2009

APPENDIX B. COMMON QUESTIONS POSED IN INTERVIEWS WITH REFUGEES

1. When did you arrive to Turkey and to Midtown?

2. What is your case status at UNHCR? (If the person had a main interview with UNHCR) When did you have your interview with UNHCR? (If the person is granted the refugee status) When were you accepted as a refugee and how many months after your first/second interview?

3. Did you get a residence permit from the Ministry of Interior?

4. Are you alone or with your family? (If the person is in Turkey alone) How old are you? (If the person is with family members) How many people are there in your family and how old are you and family members?

5. What is your nationality and religion?

6. Are you covered by the general health insurance at the Social Security Institution? (If the person is not registered with SGK) Do you know about the general health insurance/why were you not registered with the SGK?

7. Do you get any financial or any kind of assistance from any governmental or non-governmental institution?

8. Do you/did you have health problems in Turkey? What are the health problems you have/had?

9. Did you apply to any health institution in Turkey? Could you describe the experiences you had with health institutions?

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