

Barriers to and
Facilitators
of Migrant
Communities' Access
to Health Care in
Istanbul



Barriers to and Facilitators of Migrant Communities' Access to Health Care in Istanbul Field Report

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ABBREVIATIONS

AFAD	Disaster and Emergency Management Authority
DGMM	Directorate General of Migration Management
EU	European Union
GHIS	General Health Insurance Scheme
IOM	International Organization for Migration
IPS	International Protection Status
LFIP	Law on Foreigners and International Protection
MHC	Migrant Health Center
SGK	Social Security Institution
TPR	Temporary Protection Regulation
TPS	Temporary Protection Status
TTB	Turkish Medical Association
WHO	World Health Organization

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EXECUTIVE SUMMARY

THIS REPORT, TITLED “UNDERSTANDING BARRIERS to and Facilitators of Migrant Communities’ Access to Health Care, Social and Legal Services in Istanbul” aims to identify the legal, social, economic and practical disparities in and obstacles to migrant community healthcare service access throughout the stages of provision. Another aim is to inquire into the existing or potential facilitating mechanisms which migrant communities, civil society organizations, civil initiatives, activists, NGOs and individual volunteers have developed in an attempt to overcome existing barriers. In doing so, 50 in-depth interviews were conducted in four districts of Istanbul, namely, Tarlabaşı, Esenler, Zeytinburnu and Fatih. While 17 of the interviewees were NGO workers, members of civil initiatives and academics who have done research on the subject, we talked to seven healthcare professionals and 26 refugees from different national backgrounds, legal statuses and socio-economic backgrounds.

This report argues that although legal status is a strong determinant shaping migrant access to healthcare, it is not the only element. The report adopts a multilayered and intersectional approach to migrant healthcare access and takes into consideration other factors such as government migration policies, policies on healthcare provision (whether or not the healthcare system is universal, free, multilingual and human-rights-based), legal status, migrant living and working conditions, and migrant capacity to access social networks and information.

The Turkish government’s refusal to recognize the refugee status of persons of non-European origin poses a risk of deportation for migrants who do not have the necessary documents or who are not in their city of registration. Seeking healthcare, exposes migrants to much higher visibility, poses a substantial risk to their security. Alongside the risk of deportation, the financial burden imposed on undocumented migrants by the Health Tourism Regulation is usually unaffordable. Moreover, the complications of the Turkish healthcare bureaucratic system and the lack of multilingual and multicultural rights-based approaches, renders navigating the system all the more difficult for those who are not familiar with it.

Differential treatment and the lack of rights-based approaches pave the way for intersectional patterns of discrimination which impose further obstacles to migrant healthcare access. Female migrants, for example, face gender-based discrimination which is coupled with racism and discrimination against migrants. People who already face marginalization in their own communities, are discriminated against, both in their own communities as well as in the host community. Persons with disabilities, the elderly, persons with HIV+ or any other communicable diseases, LGBTQI+ persons, persons who are member of ethnic or linguistic minorities within the migrant communities (such as Roma people) face such patterns of discrimination more frequently.

Our observations show that the current healthcare system systematically excludes migrant communities except for those who are under temporary protection.¹ Facing these problems, migrant communities (especially undocumented migrants and migrants who are subjected to multiple forms of discrimination) appear to be deterred from applying for formal healthcare services and develop their own alternative strategies.

Besides these obstacles, there are also actors and networks which facilitate migrant access

¹ Of course, this does not necessarily mean persons who have TPS are entitled to full and free healthcare services. They face similar problems to those undocumented migrants especially in areas such as the treatment of chronic diseases, facing discrimination in public healthcare facilities, workplace injuries, etc.

to healthcare services. Migrant networks play a crucial role not only in obtaining and disseminating information about healthcare services but also in establishing solidarity networks such as creating an informal insurance fund for healthcare expenses, accompanying each other to hospitals and offering translation services for non-Turkish speaking migrants. Additionally, living in neighborhoods where migrant communities are densely populated is important to healthcare access in three respects. Firstly, it offers the possibility for access to integration with the local community as well as information on healthcare through neighborhood networks. Secondly, particularly in the case of Istanbul, neighborhoods where migrants densely settle usually have Migrant Health Centers and Family Health Centers (FHCs) providing primary health services to migrants. Finally, neighborhood networks are also helpful during hospital visits. In some cases, Turkish speaking neighbors or non-migrant neighbors accompany non-Turkish speaking migrants to the hospitals and help them navigate the hospital bureaucracy, talking to healthcare personnel and doctors.

Civil society organizations, civil initiatives, voluntary healthcare professionals and pharmacists prove themselves critical in facilitating healthcare services and disseminating relevant information. NGOs and civil initiatives use social media effectively in order to disseminate information on different subjects. Additionally, some civil society organizations and civil initiatives organize training on self-care and healthcare in community spaces. However, since the scope and resources of these groups are usually limited, their outreach capacity also remains limited. Considering the size of Istanbul's migrant population and the lack of social policies addressing migrant community needs, only a limited number of migrants can ever utilize these civil society resources. Nonetheless, it must be noted that besides the funding shortages and restrictive government policies on civil society, NGOs offer a crucial support for migrant access to healthcare services – especially for the undocumented migrants and migrants who are subjected to multiple forms of discrimination and excluded from the public healthcare system.

Having been conducted during the COVID-19 period, this research has also explored whether and how migrant access to healthcare services has been affected during the pandemic. Our research showed that during COVID-19, migrant communities usually preferred to not engage with healthcare services for several reasons. Firstly, due to lack of access to sufficient information about the new structure of regular healthcare services, they had problems determining which healthcare facilities remained available. Secondly, migrant groups were concerned about the discriminatory attitudes that associate migrants with the spread of communicable diseases. Finally, as part of the quarantine measures, migrant communities took their own measures and did not go to hospitals unless it was an emergency.

However, the main problem migrant communities faced during the pandemic was less health-related than economic. Many refugee households lost their jobs and did not have any regular income. Access to food was reported as a pressing issue by some of our interviewees. This lack of support during the COVID-19 might cause future health problems such as malnutrition or psychological conditions. Another problem compounded by COVID-19 was the inequalities in basic access to hygiene, clean water and self-care. Finally, COVID-19 quarantine measures also affected NGOs' and civil initiatives' outreach capabilities. Regular support and communication with refugee communities has been interrupted. In order to fully grasp the impact of COVID-19 period on migrant communities' health condition as well as access to healthcare services, long-term health-related, economic and social impacts of the COVID-19 should be explored and addressed accordingly.

“Besides the disparities in healthcare access due to legal status, there are also intra-community stratifications and differentiation based on age, gender, ethnicity, sexual orientation, and access to social networks, which create further hardships.”



INTRODUCTION


THE AIM OF THE PROJECT TITLED “Understanding Barriers to and Facilitators of Migrant Communities’ Access to Health Care, Social and Legal Services in Istanbul” is threefold. First, it aims to identify legal, social, economic and practical differentiations in and obstacles to migrant access to various stages of healthcare provision. Secondly, it sets out to investigate the existing and potential facilitating mechanisms which migrant communities, civil society organizations, civil initiatives, activists, NGOs and individual volunteers have developed in an attempt to overcome the current problems in the area in question. The final aim of the project is to provide a comprehensive set of policy recommendations for the actors who are fully or potentially active in the field to strengthen not only the provision of healthcare services but also migrants’ capacity to be informed about and fully access the healthcare services.

This research project starts with a meta-analysis of the existing literature on migrant access to healthcare services in Turkey, more particularly in Istanbul. The meta-analysis included an examination of academic articles, MA and Ph.D. theses and edited volumes to develop a comprehensive understanding as to previous and ongoing research on the subject. As well as policy papers and country reports written by Turkish NGOs, materials published by public institutions and international organizations such as IOM, UNHCR and WHO are examined in order to understand the legal and political framework which conditions the practical access to healthcare services.

A perusal of the relevant literature shows that although the right to health for everyone (regardless of race, sex, language, religion or country of origin) is recognized by the Turkish constitution (Article 56) and international conventions to which Turkey is party, there is a gap between the legal regulations and actual provision of services. Moreover, given Turkey’s asylum system, which entails differentiated and stratified rights and entitlements for different legal statuses (conditional refugee, subsidiary protection, temporary protection, persons who reside in Turkey with the residence permit, and undocumented migrant groups), each legal status entails differential access to healthcare services. This differential treatment does not only render the healthcare services challenging to navigate for migrants with various legal statuses but also creates barriers and disparities in migrant access to healthcare services. Besides the disparities in healthcare access due to legal status, there are also intra-community stratifications and differentiation based on age, gender, ethnicity, sexual orientation, and access to social networks, which create further hardships. In addition to service access issues are the pre-existing health conditions of migrants. These are conditioned by a number of factors such as the health conditions in their country of origin, nature of their journey, traumatic experiences at home and during the migratory journey. In the host country, legal status, living and working conditions in Turkey, access to social and economic networks and access to information also impact on these health conditions.

That said, there has been extensive research on the legal aspects of how and to what extent the Turkish state grants healthcare rights and services to migrant communities. Moreover, academic and non-academic research almost exclusively focuses on the healthcare access of persons who hold temporary protection status.² Considering the magnitude of the population

² For more detailed information on the healthcare access of persons under Temporary Protection Regulation, see the Literature Review.



under temporary protection as well as the comprehensiveness of healthcare rights and services provided to them, this is understandable. However, persons who hold other statuses (or no legal status whatsoever) are often neglected in terms of healthcare rights and services. It can even be argued that, although not all Syrian refugees have temporary protection status and there is a considerable population of Syrians who do not have any documents whatsoever, the literature seems to overlook the differences within the Syrian community in Turkey. In the literature, vulnerable groups, as well as persons who are subjected to discrimination or differential treatment within their own communities, such as disabled persons, LGBTI+ persons, persons with HIV+, the elderly, ethnic minorities such as the Romani, are counted under general categories according to legal status which, in turn, neglects the specificities of healthcare needs and problems of these groups. Finally, another point that has been largely neglected in the literature are the strategies that migrant communities develop in order to overcome barriers accessing healthcare. To address the gaps mentioned above, we conducted in-depth interviews with academics, civil society employees, members of civil initiatives, healthcare professionals and migrants from various backgrounds.

This report is structured as follows: drawing on our field observations and our interviewees' evaluations, the first section outlines structural and systemic issues pertinent to migrant healthcare access. In so doing, this section aims to provide a more nuanced analysis of systemic and structural factors that shape (if not determine) migrant access to healthcare services. We believe that these evaluations will be complementary to what has been analyzed in the literature review and provide a more nuanced background analysis of how migrants and other actors involved in the field navigate the gaps and discrepancies between the law and the practice. The second section provides a detailed analysis of migrant access to healthcare services and the problems they face with a particular focus on the differentiations among the migrant communities that are based not only on legal status but also on gender, age, sexual orientation, disability, and socio-economic conditions. This section aims to present an intersectional analysis of migrant access to healthcare services. The third section maps out the barriers to migrant healthcare access and the fourth section focuses on those factors which help facilitate migrant healthcare access in Istanbul. Finally, the report presents a brief analysis of challenges faced by migrants during the COVID-19 pandemic. The report concludes with the policy recommendations. The next section discusses the research methodology before moving on to the findings.



METHODOLOGY

THIS STUDY ADOPTS A qualitative research method. For this research, 50 in-depth interviews were conducted. Of these, 17 interviewees were NGO workers, members of civil initiatives and academics who have done research on the subject. The remainder included seven healthcare professionals and 26 refugees from different national backgrounds, legal statuses and socio-economic backgrounds. We conducted interviews in four districts of Istanbul where refugee populations are strongly represented: Esenler, Zeytinburnu, Tarlabaşı and Fatih. While the interviews that were in English and Turkish were conducted by the researchers, interviews in Arabic and Farsi were conducted with the help of the interpreters.

The research interviews began with the scholars, healthcare professionals, and workers from NGO and civil initiatives using snowballing sampling. We asked our interviewees to provide us contacts with refugee communities. Although this helped us in terms of forming trust between us and the interviewees, it also posed a limitation: we faced some difficulties in reaching out to certain communities who do not have access to NGOs or civil initiatives. Thus, the interviews with refugees provided us with additional information as to their experiences, assessments and observations. We must stress that this data does not claim to be representative or generalizing. Migrant communities in Istanbul as well as other actors in the field of migrant healthcare access are very diverse. As such, this research cannot fully comprehend the full breadth of diversity in migrant experiences. This being the case, what we aim to present is a nuanced analysis of the data we collected while paying due attention to diversity, differentiations as well as commonalities among and within migrant communities.

Since the research was conducted during the COVID-19 pandemic which started in mid-March 2020³, we conducted most of the interviews via internet, two of the interviews were conducted on the phone and 25 interviews were conducted face to face. During the interviews we made sure to adhere to the social distancing so as to minimize risk to all participants. For that reason, interviews were usually held in open air public spaces rather than in households. COVID-19 measures and our adherence to no harm principle, as expected, posed some limitations on the research: firstly, we were not able to reach out to certain institutions which also provide (mostly primary) healthcare services such as pharmacies and unaccredited healthcare institutions. Secondly, migrant communities who do not have full access to internet and technological means were out of reach, which we have hoped to compensate in our field visits conducted after the restrictions were largely lifted on 1 June 2020. Finally, reaching out to healthcare personnel during a global pandemic was another limitation. For that reason, we reached out to healthcare professionals through the snowballing method, that is, through establishing contacts via other interviewees. Using intentional sampling, we reached out to people whom we know to have professional experience in the field of migrant healthcare. Thus, healthcare professionals we talked to are, almost exclusively, people who have contacts with civil society organizations and civil initiatives and who have been offering volunteer healthcare services to migrant communities, especially to those who do not hold any official status in Turkey.

Finally, while conducting this research, we have taken into consideration the fundamental

³ In Turkey, the first official COVID-19 positive case was reported on 10 March 2020 and (albeit not a full lockdown) restriction measures started on 11 March 2020. For more detailed information on the course of COVID-19 measures taken in Turkey, see “COVID-19 Salgınının Türkiye’de Mülteciler Üzerindeki Etkilerinin Sektörel Analizi”, SGDD-ASAM, May 2020. Last accessed on 1 September 2020 from http://panel.stgm.org.tr/vera/app/var/files/a/s/asam_covid_anket_raporu_200518_2_tr.pdf

principle of doing no harm and not asked questions that might trigger traumas or that might compel the interviewees to disclose information that they do not want to. In line with the ethical framework of this research, the report does not include any statements that might disclose the identities or personal information of the interviewees including both the refugees and the professionals. Thus, we anonymized the names of the interviewees throughout the report and did not share their identities with anyone outside the project team





FINDINGS

THIS RESEARCH ADOPTS A MULTILAYERED and intersectional approach to migrant healthcare access. In contrast to narrower approaches that delimit healthcare to accessing healthcare facilities and subsequent treatments, we adopt a broader approach which claims that migrant access to health is conditioned by broader elements and actors. It is well-known that government migration policies, types of healthcare systems and policies (universal, free, multilingual and human-rights-based), legal statuses, living and working conditions, and migrant capacity to access social networks and information determine the extent to which migrants can access healthcare services. Also, it must be noted that migrant health conditions are determining for other components of their lives such as working, making their living, caring for people who are dependent on them (in Turkey or in other places) or leaving Turkey as the transit country to arrive at a destination country. In this section, we will present the findings regarding the healthcare access of migrants. In the next sub-section, the report outlines the findings pertaining to the more systemic issues shaping access to healthcare.

1. STRUCTURAL AND SYSTEMIC FACTORS

1.1 LEGAL REGULATIONS

Before the implementation of the Law on Foreigners and International Protection (LFIP hereafter) in 2014, healthcare rights for migrants were not legally specified. Migrants had to cover their own healthcare expenses: “especially in cases of chronic disease, attaining sustainable, necessary and affordable treatment was very difficult”, reports Emel, a LGBTQI+ rights activist and lawyer. Where they could not afford healthcare, assistance was possible through individual initiatives from civil society organizations, voluntary healthcare professionals and other social networks. The LFIP granted a comprehensive set of entitlements not only to those whose International Protection Status (IPS) had been approved, but to everyone who applying for International Protection.⁴ A similar regulation passed in 2014, giving full and free access to public health services to persons under Temporary Protection. As a result, persons who hold the necessary documents (IPS or TPS) are deemed insured by the General Health Insurance Scheme (GHIS) and are able to access healthcare services. This new regulation was found laudable and widely praised by civil society organizations in the field as well as our interviewees. For example, Demet, a public health expert in a private university in Istanbul, comments that “the primary healthcare provision to Syrian refugees [persons under temporary protection] is exemplary, and the secondary healthcare provision is free.”

However, owing to their irregular status, undocumented migrants in Turkey are not fully entitled to public healthcare services. They are expected to cover their own healthcare expenses.

⁴ On December 29, 2019 the law was changed. Accordingly, before December 2019, healthcare access of international protection holders did not have any temporal restrictions, that is, they were deemed to have health insurance as long as they continue to hold the international protection status. However, with the law amendment in December 2019, this provision was restricted to a one-year period following the application. As a result, many international protection status holders have lost their health insurance and are expected either to cover their own healthcare expenses or to pay their own premiums to have health insurance.

The costs of health care services for non-citizens who do not have international or temporary protection identity documents, or general health insurance coverage in Turkey are determined by the “Regulation Concerning International Health Tourism and Tourist Health”, also known as “Health Tourism Regulation”. Under this regulation, healthcare services cost three to four times higher than the regular fees available for citizens and/or registered migrants. The only exceptions to this are emergency services and treatment for communicable diseases such as tuberculosis and more recently COVID-19⁵ that are free of charge for everyone. However, some of our interviewees reported that in practice, even in cases of emergency, hospitals charge patients and report those who cannot afford the hospital bills. Thus, access to emergency services also becomes financially and legally risky for undocumented migrants. This means that free public healthcare services are often, if not always, inaccessible for undocumented migrants in Turkey.

1.2 GOVERNMENT MIGRATION POLICY

As mentioned by our interviewees, government migration policies are deeply implicated in migrant access to healthcare services. Our observations show that the current healthcare system is based on exclusion of migrant communities except for those who are under temporary protection.⁶ Persons under TPS (at least on paper) are granted the same rights and entitlements as citizens while the other migrant groups are not included in social policy mechanisms. Although health is defined as a universal right in the Turkish Constitution, granting full access to healthcare services regardless of one’s status seems to be regarded as a “pull factor” by the government. As Hakan who has been working with a solidarity initiative (City Solidarity Platform, hereafter) for more than ten years remarks:


“The government does not see refugees [those who are not under temporary protection] a matter of policy-making. It rather sees refugees as a group whose problems should be handled by civil society organizations, associations, foundations and other funding mechanisms. It does not develop comprehensive and sustainable policies. The government thinks that had they developed policies; these non-European migrants would stay in Turkey. Instead, it wants them to go wherever after staying here [in Turkey] for a while. [...] There are lots of legal provisions [on healthcare provision] but no one puts them into practice.”

This lack of social policy which is combined with the government’s refusal to recognize the refugee status of persons of non-European origin poses a risk of deportation for migrants who do not have the necessary documents or who are not in their city of registration. Seeking healthcare, heightens migrant visibility, posing a substantial risk to migrants. Alongside the risks of deportation for undocumented migrants, financial burdens imposed by the Health Tourism Regulation are usually unaffordable. As Ömer who has been a volunteer in a civil initiative and conducting academic research with African migrants, reports, “they tend to over-estimate the hospital [expenses] a lot. They think that they’ll have to spend all their savings on the hospital. [...] So, the African community in Turkey has developed a system that is based on *not* going to the hospital.” For İhsan, a pulmonology professor at a medical

“Also, it must be noted that migrant health conditions are determining for other components of their lives such as working, making their living, caring for people who are dependent on them (in Turkey or in other places) or leaving Turkey as the transit country to arrive at a destination country.”

5 During the global COVID-19 pandemic, following the increasing rates of infection in Turkey, on April 13, 2020 Turkey issued a presidential directive which stipulates that everyone, regardless of their health insurance coverage and legal status, has free access to a COVID-19 test, diagnosis and treatment, as well as protective material. For further information, see <https://tr.boell.org/tr/2020/05/18/gocmen-ve-multecilerin-pandemi-gunlerinde-turkiyede-saglik-hizmetlerine-erisimi> accessed on July 18, 2020.

6 Of course, this does not necessarily mean persons who have TPS are entitled to full and free healthcare services. They face similar problems to those undocumented migrants especially in areas such as the treatment of chronic diseases, facing discrimination in public healthcare facilities, workplace injuries, etc.



school in Istanbul and an activist offering free healthcare services to migrants since 2005, this is related to the central contradiction at the heart of Turkey's migration policy: "Turkey needs informal and cheap labor; but does not want to take the international responsibilities entailed by that."

Although it is more comprehensive and inclusive⁷, healthcare provision to persons under Temporary Protection is not without problems. Yasin, a Syrian graduate student who came to Turkey in 2013, recognizes that a good proportion (if not majority) of persons under TPS are not part of the integration policies and "they will never get a Turkish ID, they will work in the black market and live in poor areas." Also, Malik Samaan, a Syrian doctor who runs a private clinic in Fatih argues that the majority of Syrian migrants, especially those who are above the age of 40 will not learn Turkish and will not be part of the Turkish society. That is, their health conditions and access to healthcare services (especially to the secondary and tertiary healthcare services) will be hindered by their access to (or lack thereof) language skills, better socio-economic, living and working conditions. Moreover, Hakan reports that "in cases of chronic and critical health conditions, Syrian people [who have the necessary documents] are not always supported by the state. In cases which require long-term and intensive treatment, they are excluded from the system and their problems only get solved if human rights activists become involved and do advocacy work."

Maybe even more importantly, persons who hold TPS also distrust the system. Especially those who seek healthcare access outside their city of registration⁸ face the risk of being deported or being sent to their city of registration. As Şenay, a medical doctor in a Family Health Center remarks "They [the Syrian people] do not know where to go when they or their children get sick. They especially distrust the public hospitals, there are police in the hospitals. With the fear of being sent to Syria or to the border cities [...] they prefer to access healthcare services in non-public places. They prefer to find out roundabout ways in the healthcare system; going to hospital is a last resort."

1.3 GOVERNMENT HEALTHCARE POLICY

There are important differences between government healthcare policies and how they are actually implemented which impact on migrant healthcare access. Yeliz, a medical doctor working in public and migrant health, argues that "on paper Turkey grants more rights than many countries, nonetheless at the level of implementation this does not come to realization." She argues, the main reason behind it is the lack of rights-based approaches to health. "Migrants [except for the persons under Temporary Protection] are regarded as temporarily residing in Turkey, and healthcare provision to them is handled through temporary measures. [...] People's approach to foreigners is very problematic in terms of service provision: they see it [not offering healthcare services] as if they are protecting the state, the public resources." Also, according to Toprak, the Turkish healthcare system is not designed to be inclusive of mobile populations whether across international borders or within Turkey.

Şenay makes similar comments. She argues that, while providing care to migrant communities, doctors do not regard it as a right: "Right-based approaches are not established among the doctors. Once we start thinking that Syrians are taken care of by the government, we cannot start discussing human rights and patients' rights. Even doctors do not consider migrants' access to healthcare as a right. This, in turn, creates discrimination and racism." While suggesting that the

7 See the Literature Review.

8 For relevant regulation, see the Literature Review.

doctors and healthcare personnel should be given training on rights and values, Sönmez contends that medical practices should not be left to the conscientious judgements of doctors. Nonetheless, both the healthcare professionals and scholars we talked to also underline that putting the blame on the healthcare personnel is also not a solution, as Yavuz, a medical doctor running a private clinic states: “For the healthcare personnel to change their attitudes, there must be a policy change. It is not helpful to put all the blame on the healthcare personnel.”

Furthermore, as mentioned in the literature review, throughout the 2000s, Turkey’s healthcare system underwent significant reforms aiming at restructuring the health system and individuals’ access to health. All these reforms coincided with a globally influential broader reform, that is, implementation of market-oriented health systems while gradually abandoning community-oriented approaches.⁹ Accordingly, real or potential health risks are individualized and social, political, economic and environmental factors effecting personal well-being are largely neglected.¹⁰ Accessing healthcare has been deemed an individual effort which must be undertaken through the means available to patients. Introduction of performance-based systems also creates problems especially for undocumented and impoverished migrants who cannot afford healthcare expenses. According to İhsan, “performance of the hospital (and of individual doctors) is determined by money the hospital earns and not by the number of recovered patients.” Therefore, in some cases, hospitals see undocumented migrants not as patients but as financial burdens.

That said, some persistent characteristics of the Turkish healthcare system shape migrant healthcare access: the system lacks a multi-lingual and multicultural healthcare approach and is exclusively structured for Turkish speaking citizens. The language barrier is one of the biggest challenges which migrants face. Also, NGO employees and civil society activists state that the healthcare bureaucracy is very complicated in Turkey: it is based on referrals from various institutions and units to other ones, even within one hospital. Thus, it renders navigating the system all the more difficult for those who are not familiar with it.


This ‘temporary’ approach to healthcare policy, which also defines the government’s migration policy, is reflected in the frequently changing government healthcare policies to temporary protection status holders. Harun, a senior NGO worker in the field of human and migrants’ rights, comments that once the Syrian refugees arrived in 2011, the healthcare system faced a crisis, which the government attempted to solve by permitting NGOs to work in the healthcare system. Related to solving crisis in the healthcare system, Barış, a scholar who has worked on migrant health in Turkey, remarks that after Syrian migrants came, the main discussion on healthcare provision to migrants evolved around the question of “whether they [Syrians] should be integrated into the existing healthcare system or a parallel migrant health policy should be developed.” Until it changed after 2016 as a result of the centralization efforts, NGOs’ involvement in the health sector made civil society an important partner of the public system and made civil society initiatives all the more crucial in healthcare provisions to migrants.¹¹ In 2015, as a result of centralization efforts, the government started opening Migrant Health Centers (MHCs) which were exclusively designed for persons under temporary protection, in other words, migrants coming from Syria. In December 2016, the Turkish Ministry of Health, World Health Organization (WHO) and the EU launched the 36-month-long EU-funded health project titled “Improving the health status of the Syrian pop-

“Throughout the 2000s, Turkey’s healthcare system underwent significant reforms. With the implementation of market-oriented health systems, community-oriented approaches were gradually abandoned. Real or potential health risks are individualized and social, political, economic and environmental factors effecting personal well-being are largely neglected.”

9 MSF, 2017, Migrant Healthcare Literature Review, Unpublished Report.

10 Aşçecan Terzioğlu, 2015, “Hep bu Suriyelilerin yüzünden!”: İstanbul’daki sağlık çalışanlarını gözünden Suriyeli çocukların sağlığı. *Toplum ve Bilim*, 134, pp. 102-118.

11 Turkish Medical Association, 2016 War, Migration and Health: Experience of Turkey. Available at https://www.tb.org.tr/kutuphane/siginmacilar_rpr_en.pdf. Last accessed on 20 July 2020.



ulation under temporary protection and related services provided by Turkish authorities”, also known as SIHHAT Project.¹² Accordingly, MHCs were systematized and increased in number. As of September 2020, 178 MHCs operate in 29 cities. The main aim is threefold: to provide culturally and linguistically accessible healthcare services to Syrians; to lower the burden on the Turkish healthcare system; and to integrate skilled Syrian healthcare professionals in the Turkish labor market through employment in the MHCs.

In MHCs, Arabic speaking healthcare professionals are employed, and they offer primary healthcare services to Arabic-speaking migrants in their own language. Although this is crucial for the majority of the migrant population in Turkey, establishment of MHCs, in a sense, attested to the exclusion of other migrant groups – undocumented persons or persons who have IPS as well as non-Arabic speaking Syrian migrants.

1.4 INTERSECTIONAL PATTERNS OF DISCRIMINATION

Differential treatment and a lack of rights-based approaches has paved the way for intersectional patterns of discrimination which pose further obstacles to migrant healthcare access. Migrants and civil initiatives reported numerous cases of discrimination by healthcare personnel, not only from doctors and nurses but also hospital personnel and other patients in the hospitals. Forms of discrimination range from refusing treatment to physical and sexual assault. Female migrants, for example, face gender-based discrimination which is coupled with racism and discrimination against migrants. Especially in the case of Syrian women, where their health conditions are often reduced to reproductive health, their reproductive health issues are sometimes tackled through discriminatory and racist media discourses. Subsequently, people who are marginalized in their own communities, and who have been doubly discriminated both in their own communities as well as in the host community face such patterns more often. Persons with disabilities, the elderly, persons with HIV+ or any other communicable diseases, LGBTQI+ persons, persons who are member of ethnic or linguistic minorities within the migrant communities (such as Roma people) face such patterns of discrimination more frequently. Thus, even those who hold temporary protection status face exclusion from the public healthcare system and are left to their own solutions.

All these factors combined create an environment of mistrust among migrant communities in terms of their right to health. As Emel, remarks, “Distrust of the health system is very common among refugees. They think ‘no one would look out for me in this country’”. Therefore, migrants either abstain from applying to healthcare services or try to figure out alternative health-seeking ways which will be discussed in the next sections. Against this background, migrants and other actors in the field recognize that the healthcare system for migrants in Turkey is dependent on individuals (migrants themselves, neighbors and friends, doctors, civil initiatives, NGO employees, or even government officers and politicians) taking initiative for making things work. Hakan, for example, argues that “once those who have the power (such as governors, vice governors or municipality officers) want to get things done, things get solved very quickly, even when the person does not have the necessary document”.

For people who do not have necessary documents and/or socio-economic means to access healthcare, individual initiatives become vital for accessing healthcare. However, these initiatives operate through social networks and social capital which are not necessarily accessible to everyone and many migrants do not always have the necessary means, relevant contacts, financial capacity or skills to utilize the available services. Notwithstanding these problems, these social networks prove themselves crucial for helping migrants access healthcare services

¹² For more information, see https://www.sihhatproject.org/proje-faaliyetleri_0-657

particularly in emergency situations. In doing so, they have developed their own strategies and established their own ways of accessing healthcare, and in effect developed informal sub-systems in order to overcome difficulties they face.

Keeping this in mind, while migrant's legal status is a strong determining factor, it is not the only element that shapes migrant healthcare access. Our findings show that migrant communities' access to healthcare services consists of four interrelated layers. Firstly, access to means to ensure their well-being, that is preventive measures, such as improved working and living conditions, healthy social environments for mental and spiritual well-being, clean water and hygiene. Secondly, access to medical examination requires trust in the system as well as health literacy, sufficient information to navigate the health system, and the ability to communicate with first contact healthcare personnel. Thirdly, access to diagnostics requires the capacity to communicate with the healthcare professionals, being sufficiently informed about the patient's current condition, not being discouraged by the discriminatory or exclusionary attitude of the healthcare personnel. Finally, access to treatment and follow-up controls requires the ability to access the necessary medications and other treatments to be able to afford the treatment (economically and timewise), and access to palliative and rehabilitative services. Especially in the case of chronic, communicable, and lethal diseases, these obstacles can be highly detrimental to migrant's health. In each layer, migrant communities face different problems. Some of these problems can be solved through the efforts of civil society initiatives and social networks, whereas others require policy changes.

So far, these general findings of the report have underlined that migrant healthcare access to is shaped by numerous factors that go beyond the legal status one holds. Although legal status is a very important component, it must be noted that it is not the only one and other factors such as access to social networks, access to information, socio-economic means, working and living conditions and being subjected to multiple forms of discrimination are also determining. Moreover, differentiations among migrant communities based on gender, sexual orientation, disability, age, nationality, socio-economic conditions and legal status determine the extent to which various migrant groups access healthcare. In what follows, the report presents migrant communities' access to healthcare services and problems they face.

“The healthcare system for migrants in Turkey is dependent on individuals (migrants themselves, neighbors and friends, doctors, civil initiatives, NGO employees, or even government officers and politicians) taking initiative for making things work.”



2. MIGRANT HEALTHCARE SERVICE ACCESS

2.1 ACCESSING INFORMATION ON HEALTHCARE SERVICES

As indicated above, information accessibility is an important factor in being able to utilize healthcare services. Although each legal status determines the type of healthcare available, there are common patterns that help migrants access healthcare information, which can be briefly summarized as, migrant networks, neighborhood networks, social media, NGOs and civil initiatives.

Although public healthcare access for TPS holders is more comprehensive and accessible in different districts of Istanbul, our interviewees state that they have never been provided healthcare information by the Directorate General of Migration Management, the main public institution responsible for migrants' registration. A similar pattern works for persons who hold IPS. Therefore, although granted access to services, they are not officially given information on how and through which means they can access healthcare. Notwithstanding their legal status, migrant access to information on healthcare services is left to individual efforts. Accordingly, informal information on the healthcare system is widely shared among migrant communities and on social media.

2.1.1 MIGRANT NETWORKS

Migrant networks are crucial for obtaining and disseminating information on healthcare provision. Ahmet, an NGO coordinator who works with the Syrian Roma population (the Doms), argues that:

“refugees have a very strong network. They know the system very well. It is not about not knowing, they are being turned down because of discrimination. Every refugee household has satellite, cell phone or internet connection. These are sine qua non in refugee households. All information on the healthcare system is shared within the networks.”

While referring to Syrian Roma population's access to healthcare, Ahmet says that “the Doms are not accepted to hospitals, so, they go to other hospitals for childbirths, to the hospitals where the owners or managers are usually unknown.”

Also, accessing people who have information is a crucial part of receiving information on the subject. Hasan, a Syrian Kurdish interpreter working at an NGO, states that “before I started working with [this NGO], I had a good level of Turkish and I was helping people in the hospitals. I still do it after my work on the phone.” Besides the beneficiaries of the NGO he works with, Hasan is reached out to as a point of contact about healthcare services in his own network.¹³ He tells them how to get appointment from public hospitals, how to use the MHRS application on their smartphones:

“I help them go to the hospitals, take appointments. These days I talk to them about the new MHRS14 application that you can use in Arabic, English or Turkish. You can put

13 It must be noted that the role of cultural mediators is crucial in healthcare access of migrants. Moreover, since cultural mediation and translation within the health system requires familiarity with the medical terminology, languages of the patients and the healthcare professionals as well as strong command on the cultural specificities of each context, cultural mediation becomes all the more important for equal and quality access of migrants to the healthcare system. In order to address this issue, in May 2020, Ardiç Association started a project titled “Health Mediators: Intercultural Health Mediation Training Project” and provides training to health mediators. For more detailed information, see <http://www.ardic.org.tr/projeler/saglik-arabuluculari/>

14 Republic of Turkey Ministry of Health Centralized Doctor Appointment System. Available at <https://www.>

your info -name, surname, ID number- and you can take appointments. It is easier than calling 182.15 There are videos on YouTube on how to create an account and use it. Whenever they ask for it, I send them the link [for the application] and the YouTube videos.”

Hasan states that language is the most important thing for people who do not necessarily have access to migrant networks or people who know the system. He states, “If they do not know Turkish, it is difficult to know where to go. First it was asking their employers, neighbors or asking me. I took thousands of appointments before I started working here.” In a similar vein, Sezen, an NGO employee, states that learning from other migrants who have been in Turkey for longer period of time is an important component of migrant life in Istanbul – not only in terms of health but in other components, too. Breadth of information sharing is related to the size, relations and experience of migrant communities. For example, while commenting on various communities which have been in Turkey for decades, Malik Samaan points to the Iraqi community and remarks that “there is a difference between the Iraqis who came after 2003 and who came more recently in terms of knowledge and capacity to navigate the system.” Aziz agrees:

“The Iraqi community has a very strong network and can more easily navigate the system compared to other migrant communities since their experiences of being a migrant in Turkey is longer (since 2003). [...] Syrians are not experienced in such areas. They attempt to empower themselves in social media groups, neighborhoods and within the migrant community.”

Different migrant groups establish their solidarity networks on the basis of other factors, as well: nationality, ethnicity, religion, language and/or sexual identity. Barış also comments on such solidarity ties in various contexts: “Migrants who come from former Soviet countries have very strong ties; so much so that they can afford to stay away from other groups which exclude them.” In the African community, Ömer and İhsan similarly comment, solidarity is very strong. For example, according to İhsan, “the Senegalese spiritual community in Istanbul has firm ties and they organize annual meetings which host more than 1500 people. They created their own social insurance hedge fund. They collect money for the healthcare expenses of their friends.” Ömer also states that the ties between African migrants in Turkey are usually conditioned by linguistic ties: Anglophones and Francophones are different groups which do not necessarily have active interaction.

Likewise, Çağrı, a scholar working with LGBTQI+ refugees in Turkey comments that national, ethnic and linguistic ties are very strong and play a crucial role among LGBTQI+ refugees. They provide support to each other in terms of accommodation, financial support, and psychological support.” Agreeing with Çağrı, Emel points out that “solidarity among Iranian LGBTQI+ refugees is very strong: they have accumulated knowledge on Turkey. They have their own information-sharing network. They share information on hospitals, hormone treatments [for gender confirmation processes], security, and even on real estate agencies.”

National, ethnic and/or linguistic connections operate not only within migrant communities but also between the locals and the migrant communities. While commenting on such networks, Barış comments:

“The most advantageous group is the Sunni Muslim [Syrians], particularly if they live in a Sunni Muslim majority districts. [...] If a Syrian Kurdish community lives nearby a Kurdish community in Istanbul, they can easily develop strong solidarity networks and

“Learning from other migrants who have been in Turkey for longer period of time is an important component of migrant life in Istanbul – not only in terms of health but in other components.”

mhhs.gov.tr/Vatandas/

15 182 is the phone number of the Centralized Doctor Appointment System. It is a phonenumber offering services in Turkish, Arabic, Russian and English. However, our interviewees suggested often that it is very difficult to reach to interpreters for migrants who do not speak Arabic or Turkish.



build a community.”

As far as the LGBTQI+ migrant community is concerned, the solidarity between the local and the migrant LGBTQI+ communities is often established through NGOs and/or civil initiatives. Emel explained that transgender persons from Turkey accompany transgender refugees to the hospitals and offer them support almost at every step of their medical needs including providing interpretation at the hospitals, consultation on the Turkish healthcare system, psychological support as well as fundraising for medical treatments.

This network of information among migrant communities is operational in preferences to go to private clinics, MHCs or unregistered clinics instead of public hospitals. Iman, a Syrian migrant in her early 30s, comments while explaining why she chooses to go to a private clinic run by a Syrian doctor:

“I have been living in Turkey for eight years. I live in Arnavutköy. I prefer not going to public hospitals but sometimes we have to. The doctors are fine but the language is a problem. We face discrimination especially for not speaking the language. We hear about healthcare from our neighbors and social media. My husband does not have an ID, so we have to come here [private clinic].”

Migrants who have had or heard of previous negative experiences in public healthcare facilities and who do not have necessary documents or who cannot afford treatment expenses prefer taking other measures such as going to private clinics, trying to find medical solutions at home, or asking pharmacies for medication. Information about these alternative solutions is also widely shared among migrant communities. For example, Çağrı conveys:

“Trans women prefer not to see doctors due to discrimination, human rights violations, etc. They learn about the hormone treatments from each other. They share information on which hormone should be taken and they buy it from the pharmacies. They collect money when someone is in need of support.”

2.1.2 NEIGHBORHOOD NETWORKS

Developing access to migrant networks is also related to place of residence. Migrant interviewees as well as volunteers and NGO employees widely state the important role of neighbors. Living in neighborhoods where migrant communities are densely populated is important in healthcare access in two respects: firstly, they offer useful social integration opportunities as well as information on healthcare through neighborhood networks. While conveying his experience, Halim, a Syrian interpreter and cultural mediator working at an NGO, states that migrant women especially use neighborhood networks effectively for healthcare access:

“Women usually adopt much faster because they are the ones who undertake child-care. They learn the language [Turkish] faster, too. They receive information from their neighbors and disseminate that information to other neighbors. For example, when a woman has received some information on vaccination, she gathers other women and takes them to the health center.”

This information network works through migrant relations with non-migrant communities, too. Hasan remarks that Syrian Kurdish community lives in Kurdish populated districts of Istanbul and asks for help from Kurdish speaking neighbors when they have health related issues.

Conversely, Ferzad, an Afghan university student working as a part-time interpreter at various NGOs for Farsi-speaking refugees in Istanbul, comments that Afghan refugees live in different districts and far away from each other which inhibits information sharing and solidarity

building:

“Afghans do not know much about it [healthcare services], communication networks among them are weak. Civil society also cannot help them since they cannot find Farsi interpreters. Afghan migrants are dispersed all around İstanbul, so it is difficult for them to come together. It is easier in other cities.”

Secondly, particularly in the case of İstanbul, neighborhoods where migrants densely settle usually have Migrant Health Centers and Family Health Centers (FHCs) providing primary health services. Although they are structured to offer services exclusively for persons under TPS, our interviewees, while sharing their observations, report that depending on the district and the healthcare personnel working there, MHCs usually do not reject offering care to other migrant communities and Syrian migrants who do not have TPS. Especially in the case of pregnancy care and infant and childcare, most MHCs offer services to other migrant groups living in the district. Tufan, a medical doctor who works for the Ministry of Health and supervises MHCs, remarks that “[undocumented] migrants usually establish good relations with the FHCs and MHCs in the districts they live, and somehow manage to receive [primary] healthcare services.” Therefore, the neighborhood to settle in becomes crucial to knowing and accessing healthcare services. Sara, a scholar who has conducted studies on MHCs, observes that many MHC doctors and nurses offer healthcare services to persons who do not have TPS, especially to undocumented Syrian migrants but also to other migrant communities. However, offering services to people without the necessary documents depends on the individual initiatives of the doctors and nurses as well as on the district, visibility and resources of the MHCs. Sara conveys:


“MHCs’ approach was to accept everyone. Especially Syrians who do not have registration or Syrians who are registered in other provinces... Priority was much more the public health. However, since September 2019, this changed too. MHCs were given orders that persons who are not registered will not be offered support. Whether or not the doctors themselves are still giving it [after September 2019], I don’t know. [...] It depends on the area. In 2019, they opened one in Zeytinburnu and I imagine they are getting lots of Afghans.”

Neighborhood networks are also especially helpful during hospital visits. In some cases, Turkish speaking neighbors or non-migrant neighbors accompany non-Turkish speaking migrants to the hospitals and helps them navigate the hospital bureaucracy, talking to the healthcare personnel and to the doctors. Seval, a professor of anthropology of health who has been working on Syrian women’s healthcare services, states that it is important for migrants to have someone to accompany them, which also assists relieve the burden on doctors. While referring to discriminatory attitudes of the healthcare personnel, Seval, also, emphasizes the importance of neighborhood networks: “Doctors and nurses have preconceptions about ‘good Syrians and bad Syrians’. They think that if a Turkish neighbor accompanies them, they must be good Syrians.” Our observations and interviews also demonstrate that neighbors play an important role in hospital visits. Mona (18), a Palestinian woman who has been in Turkey for two years with her family says:

“We have a Kurdish neighbor”, she tells us. “We are getting along well with our Turkish neighbors. When we need to get an appointment, our neighbor calls. She tells us where to go and what to do. There is no one else who tells us about health.”

Similarly, Selma (30), an Afghan migrant who has been living in Turkey for five years with her three children says, “I have neighbors here, they are Afghan and have Turkish citizenship. They help me.” Fatma (39, Afghan) also explains that the daughter of her neighbor accompanies

“Turkish speaking neighbors or non-migrant neighbors accompany non-Turkish speaking migrants to the hospitals and helps them navigate the hospital bureaucracy, talking to the healthcare personnel and to the doctors.”



her to hospital: “There isn’t an interpreter at the hospital, my neighbor’s daughter always comes with us.”

2.1.3 SOCIAL MEDIA

Social media also plays an important role for obtaining information on healthcare. Almost all of our interviewees mentioned different social media tools such as Facebook, YouTube and WhatsApp as important channels of disseminating information. Yasin relays, “Syrian people use Facebook a lot to learn about Syrian doctors in Istanbul.” Similarly, Aziz, while commenting on the Iraqi community in Istanbul says that social media is playing multiple roles: “They have Facebook groups. They have separate groups for resettlement programs, for the US and Europe. They have groups for job-seeking and also for sharing information on everything.” Sezen shares a similar observation:

“Syrian people usually do not trust information disseminated on TV or through Turkish channels. There are some Syrian social media accounts, almost like ‘influencers’ who know a lot about Istanbul and the migration system of Turkey. So, Syrian migrants follow those accounts on social media.”

Social media channels are crucial for NGOs and civil initiatives which provide information and help to migrant communities. Especially WhatsApp groups stand out as an important network through which migrants can seek solutions to their problems and share information. Nuri Bey who has been volunteering for a solidarity network in a migrant-populated neighborhood of Istanbul comments, “[African migrants] share their problems on WhatsApp groups, try to help each other out. If anyone in the group knows us, they make contact with us so that we can reach them.”

Moreover, NGOs which work with particular groups such as LGBTQI+ refugees actively use social media. Emel explains that Lambda Istanbul LGBTI Solidarity Association has Facebook groups in various languages for offering help and consultation to LGBTQI+ refugees. It must be noted that various migrant communities use different social media channels for establishing solidarity with other migrants and non-migrant communities, as well as for seeking solution to their problems. Emel relays that even dating applications can be a tool for organizing among LGBTQI refugees. However, Emel warns that there is an unequal distribution of social media use among LGBTQI+ migrants as well; while gay men can actually organize much better through social media, lesbian women are much more invisible.

However, it must also be noted that this information sharing sometimes causes further distrust in the system when migrant communities share their adverse experiences of the healthcare system. Malik Samaan points out, “Social media does not always work in positive ways. Once people share their experiences of discrimination, racism or not getting their due, other people become frustrated.” Thus, hearing about the negative experiences of other people affect one’s health-seeking behavior and trust in the system. Nevertheless, especially during the COVID-19 lockdowns, social media was still is an indispensable platform for all kinds of networks.

2.1.4 CIVIL SOCIETY ORGANIZATIONS AND CIVIL INITIATIVES

NGOs and civil initiatives play a significant role in migrant healthcare access. NGOs, community centers, civil initiatives and volunteers prove themselves critical in accessing healthcare and relevant information. As mentioned above, NGOs and civil initiatives use social media effectively in order to disseminate information on different subjects. Additionally, some civil society organizations and civil initiatives organize training on self-care and healthcare in community

spaces. Alya is a director of a community center for migrants and local communities in Fatih. The community center collaborates with Koç University and a US university on healthcare services. She tells us that they organize weekly health screenings for the beneficiaries together with volunteers from Koç University and direct people to relevant institutions. This referral mechanism works as an important part of the information-sharing network among migrants. Also, the community center organizes healthcare and self-care training to women and children, which, according to Alya, have very high participation rates.

In a similar vein, Aziz, a Syrian migrant working as an Arabic-Turkish interpreter at an NGO, states:

“NGOs play a very positive role. They offer consultation. We meet with social workers at the hospitals. We give training on healthcare access to beneficiaries. We do advocacy. [...] We need to teach people the entire procedure. We accompany them to hospitals a few times and encourage them to go by themselves. Empowerment is very important.”

Our observations showed that especially for undocumented migrants and migrants who are subjected to multiple forms of discrimination, NGOs and civil initiatives play an essential role. Several comments that NGOs which offer support on healthcare access to undocumented migrants are crucial because they do not cause fear among migrants. Thus, migrants consult them on which hospital to go.

When we asked if undocumented migrants prefer to go to public hospitals or MHCs, Ömer who works with a solidarity platform replies: “They do not go to any of these. They come to Nuri Bey when they have a problem. Depending on the problem, he takes them either to MHCs or calls İhsan and takes them wherever he tells him.”

However, since the scope and resources of these groups are usually limited, their outreach capacity also remains limited. Considering the size of migrant population in Istanbul and lack of social policies addressing migrant community needs, a limited number of migrants can have access to civil society. A majority of migrant interviewees stated that they do not receive any help from NGOs or do not have any contact with civil initiatives. Several argue that access to NGOs is based on many factors such as class, language, or social networks: “[To be able to have access to NGOs], migrants need to know people; they must establish a network with the locals and other migrants. They need to be literate. Also, where they come from matters a lot. For example, women who came from rural parts of Syria do not have any connection with NGOs.”

“Especially for undocumented migrants and migrants who are subjected to multiple forms of discrimination, NGOs and civil initiatives play an essential role. Since NGOs which offer support on healthcare access to undocumented migrants do not pose a deportation risk, migrants can consult them on their healthcare problems.”



3. BARRIERS TO MIGRANT HEALTHCARE SERVICE ACCESS

The availability of healthcare information is an important factor in accessing services as well as for finding alternative access avenues. However, as noted above, although information sharing and dissemination is a common practice within migrant communities, differences between communities bring about differential access. As identified in the literature review, there are certain obstacles shared by various migrant groups: language and cultural barriers, mobility restrictions, uneven health infrastructure, discrimination and racism, gender-based problems and lack of psychosocial support. In an effort to contribute to the literature through a more nuanced analysis, this section maps out how differentiations among migrant communities create further obstacles to their healthcare access. It particularly focuses on the access of migrant groups who are partially or fully excluded from the public healthcare services due to legal, social, gender-based and financial reasons, that is, undocumented migrant groups and those who are subjected to multiple forms of discrimination.

3.1 LEGAL STATUS: UNDOCUMENTED MIGRANT HEALTHCARE ACCESS

As mentioned in the literature review, undocumented migrants are not entitled to public healthcare services in Turkey. There are two legal limitations to their access to healthcare services. Firstly, they must register with any healthcare facility before they receive any services. However, registration also runs the risk of being reported to law enforcement and facing deportation. Secondly, even when the undocumented migrants overcome problems related to registration, they are expected to cover their own healthcare expenses which are determined by the Health Tourism Regulation. That is, they are expected to pay three to four times higher prices than normal rates.

Although the exact population of undocumented migrants living in Turkey or in İstanbul is unknown, there is considerable group living undocumented in Turkey. According to figures provided by AFAD and IOM, as of 2019 this figure amounted to 347,825.¹⁶ As Harun states “there are undocumented migrants in every nationality group. The government does not give information about the exact figures and NGOs which work with these groups are actively circumvented.” In a similar vein, Malik Samaan asserts “Temporary Protection Status of Syrian people who went to Syria and came back after a short period [after the Sochi Summit] were suspended and they cannot get their IDs back. Also, newly arriving Syrian refugees have difficulties with registration and getting their IDs here.”

It must be noted that there are also differentiations among undocumented migrants. While those who have economic means can have relatively better access to healthcare, those who live in impoverishment have further difficulties. Nevertheless, besides the differentiations, there are certain common problems they all face.

According to Hakan, undocumented migrants often have acute health problems:

“For one thing, undocumented migrants are usually traumatized. We don’t know what they encounter during their journey. When they arrive, they catch an illness here. And when it happens, they wait until the very last minute. When they finally go to hospital, they might be at a lethal stage.”

¹⁶ IOM (2019). “Supporting Turkey’s Efforts to Manage Migration: Migration and Health Report”, p.11.

Combined with the informal working conditions and poor living conditions, these problems exacerbate. Although according to legal regulations emergency, immunization and natal services are free of charge for anyone, in practice these services are left to hospital discretion. Demet, who volunteered tuberculosis screening services and treatment to undocumented African migrants for a long time starting from 2005, asserts, “Undocumented migrants are not granted any access to healthcare except for the most basic services. Emergency services are provided rather arbitrarily. Healthcare services are provided by the NGOs, but their budget and scope are limited.” She also mentions a group of voluntary doctors who offer healthcare services to undocumented migrants. While recounting how City Solidarity Platform addresses undocumented migrant health problems, Nuri Bey explained that the emergency services either reject the patient or ask for money. Similarly, Harun recounts that “undocumented migrants are provided free healthcare services at very critical stages – when they are about to die. Otherwise, they are offered care by humanitarian organizations.” Nilüfer, the head of an Istanbul-based NGO which has been working to provide healthcare services to undocumented migrants, particularly to the African community, states that “We cannot hospitalize people when they have a problem. They charge them with Health Tourism rates and they either confiscate the passports of those who cannot afford or report them to the police. Thanks to people that İhsan knows, we send them to a public hospital.”

Jamal is a Palestinian who has Turkish citizenship and he is the head of a humanitarian organization working with Palestinian migrants in Istanbul. While commenting on healthcare access problems Palestinian migrants face in Istanbul, he says that

“Our priority is families that do not have IDs here. Since they have taken irregular routes, they do not have IDs to submit to the public hospitals. That’s a big problem in private hospitals, too. In such cases, we direct them to bigger humanitarian organizations or take them to private clinics run by Syrian doctors. [...] If they had IDs, they could have accessed treatments at the public hospitals.”

As mentioned above, living and working conditions directly impact migrants’ health conditions. In this sense, tuberculosis is widely mentioned. According to Dr. Assane, who is a Senegalese doctor offering healthcare support to migrant communities with Nilüfer, states that tuberculosis is very widespread among the African community: “Their living conditions are really bad. They live in crowded houses because the rent is too expensive. In a crowded place, they all get infected.” Hakan also makes a similar comment: “We see lots of tuberculosis cases among Africans. They cannot get used to weather conditions here. They live in humid spaces. Since they do not have work permit, they work in dark and closed places with no ventilation.” Although tuberculosis treatment is free for everyone regardless of one’s legal status and relatively much more accessible thanks to efforts of Anti TB Associations, İhsan states, “diagnosis is difficult, and they charge people for the tests.” Therefore, people who have tuberculosis either do not go to hospital until the very last minute or they try to find connections with the NGOs and civil initiatives.

As far as other healthcare problems are concerned, healthcare problems which undocumented migrants face are usually related to unhealthy working and living condition, lack of access to hygiene and preventive measures. Yavuz, who runs a private clinic in Kumkapı and provides affordable (sometimes free) healthcare services to migrants says, “undocumented migrants are usually young people; they will either go to Europe or work in Turkey. Chronic diseases are rather rare in this group.” According to him, the hardest cases are Hepatitis B, cancer, HIV+ and cirrhosis. The treatment of these diseases might be very intense, time-consuming and extremely expensive hence, unattainable for undocumented migrants. Yavuz explained that when he encounters such diseases, he tells migrants:

“We cannot struggle with these diseases, either. I tell them to either go back to their

“It must be noted that there are also differentiations among undocumented migrants. While those who have economic means can have relatively better access to healthcare, those who live in impoverishment have further difficulties.”

countries or to register in the system. Family support is important, given that they cannot have it here. Especially HIV+ treatment is extremely expensive.”

However, risk of deportation usually causes undocumented migrants to refrain from not only applying to formal healthcare services but also applying to the DGMM for registration. Emel points out that, by this stage, connection with an NGO is significant because deportation is not allowed while the illness and treatment continue.”

Based on these statements, undocumented migrants’ best chances to access healthcare occur through social networks that are established by individual efforts. Therefore, facing these problems, undocumented migrant communities refrain from seeking healthcare. In utterly pressing cases, they pursue alternative avenues.

Saliha (Afghan, 28) states:

“When I was in Afghanistan, I had a heart problem. My heart aches. Then I came here [Turkey]. They ask for money for examination, so I didn’t go. I went to hospital when I was in Afghanistan, the doctor said that I had a heart problem. But here hospitals are very expensive, so, I cannot go.”

Hooriyah (Afghan, 27) makes a similar statement: “They do not accept us in the public hospitals, so we go to private hospitals. We pay for the examination. They don’t receive us well anyways [in public hospitals]”

Another problem that migrant communities (documented or undocumented) face is discrimination. However, it must be noted that discriminatory patterns are intersectional. That is to say, anti-migrant attitudes, which are often grounded upon racist attitudes towards the foreigners, more often than not couple with other discriminatory patterns such as gender-, ethnicity-, and sexuality-based discrimination. Hoping to present a more nuanced analysis of discriminatory patterns, the next section will focus on intersectional and multilayered patterns of discrimination.

3.2 INTERSECTIONAL PATTERNS OF DISCRIMINATION

As briefly outlined in the literature review, while accessing healthcare, migrants face discrimination from healthcare professionals, hospital personnel and other patients. Discrimination stands out as an obstacle to migrant healthcare access for various reasons: first, it poses the risk of affecting the quality of the healthcare; healthcare professionals neglect the migrant patients’ problems which might have adverse - even lethal - effects. Secondly, it causes an interruption to the healthcare services. As Yeliz puts, “Accessing service is not equal to accessing hospital; a doctor’s discriminatory attitude causes a break in the service.” Finally, it discourages migrants from applying to healthcare services.

In the case of Syrian refugees, discriminatory media discourses which widely disseminate misinformation about Syrian refugee healthcare access have a considerable impact on how Syrian refugees (and more generally Arabic-speaking refugees) are received in the hospitals. Healthcare personnel as well as other patients accuse refugees (more particularly Arabic speaking refugees) of receiving free healthcare services, hence, of being an extra burden on the public healthcare system and of pushing the limits of the available infrastructure by contributing to long waiting periods, inadequate services and delayed treatments.¹⁷

Of course, discrimination, as an obstacle to accessing healthcare services, is not solely faced

17 Ayşecan Terzioğlu, 2019, Hastalıkta ve Sağlıkta Mülteci Olmak: Türkiye’de Suriyelilerin Sağlık Hizmetlerine Erişiminde Yaşadığı Sorunlar, *beyond.istanbul: Mekanda Adalet ve Mültecilik*, vol.7.

by Syrian refugees. Confirming what has been emphasized in the literature, our observations and interviews demonstrated that discrimination is one of the most pressing problems migrant communities face. However, it must be noted that being the largest migrant population in Istanbul and having relatively less constrained access to healthcare services, their encounters with discrimination is more often noted and underlined in the literature. This was also the case during the fieldwork.

Aziz relays numerous cases of discrimination in the hospitals, regardless of whether they are public or private. He shares that even those who have Turkish citizenship face discrimination: “those who have non-Turkish names and who do not speak Turkish face hostile attitudes.” While elaborating on the causes, he remarks that Turkish citizens are misinformed about the Syrians’ healthcare access. According to Aziz, many Turkish citizens believe that Syrian refugee healthcare access is covered by the Turkish state, hence, by taxes. However, it is the EU funds that cover the healthcare expenses:

“Turkish citizens have the perception that the foreigners receive healthcare for free. This is because of misinformation. Misinformation is very widespread. Healthcare services are not free but they [Turkish citizens] think it is. [...] However, this information is not disseminated. People try to keep this information hidden for political purposes. This causes discrimination even among refugees. Afghan and Iraqi people say that ‘Why don’t we have these rights?’.”

For Hasan hearing discriminatory discourses from other patients is very common: “People say that ‘Syrians are making places crowded’; ‘Syrians are making hospitals crowded’; ‘Syrians do not pay for coming to hospitals; they take medicine for free’.” As far as the Syrian patients are concerned, Seval asserts that there are shared accusations: “They are accused of bringing illness from Syria, and women and children are particularly subjected to discriminatory discourses on the grounds of stereotypes of lack of hygiene and posing an extra burden on the hospitals.”

Seval states that although there are doctors and nurses who adopt a rights-based perspective, in some cases healthcare professionals have discriminatory attitudes that amount to rejecting care to patients. Hasan, a Kurdish and Arabic interpreter working at an NGO recounts that:

“We hear lots of discrimination stories. One in a public hospital happened... I was with a beneficiary, he had only a passport, not an ID. We paid money and talked to the social worker there. It was not free. We went to see the doctor and she said “If he does not have an ID, get him out of here. We don’t serve people without an ID. These Syrians are becoming a pain... I was shocked, I took her name. Talked to my supervisor and we agreed not to go to her again. We go to other doctors. It was my first time hearing it from a doctor.”

Dr. Oğuz who has been offering voluntary healthcare screening and primary services to migrant communities shares a similar experience:

“I have seen more discriminatory attitudes than I expected. Especially against Syrian migrants. I’d expect healthcare professionals to get over it; they have contact with extremely different groups of people. [...] Especially in bigger hospitals, some doctors do not offer patients support since the patient does not speak the language or cannot communicate her problems. When some doctors come across patients whose language they do not speak, they act in a discriminatory way instead of trying to find a solution to the patient’s problem.”

Besides the misinformation and discriminatory media discourses, the language barrier was also pointed out as a major cause of discrimination. According to Hasan, “If the Syrian people do not have translators with them, it becomes hard to talk to other people at the hospitals. Most of the issues happen because of this, because of lack of understanding between the two

languages.” Syrian interviewees we talked to pointed out similar reasons. Sureyya (27) states, “Of course, we face discrimination almost every time. But it is because we do not know the language.” Thus, they avoid going to public hospitals. Iman, a Syrian migrant who has been living in Arnavutköy for eight years says, “We don’t prefer public hospitals because we don’t know the language. We go when we have to. [...] If there isn’t an interpreter at the hospital, it is really difficult for us.” Jamila (Syrian, 30) makes a similar comment: “Unless it’s an emergency, we do not go to public hospitals. When my daughter broke her arm, we, of course, went to public hospital.” For Aziz, Turkish-speaking migrants are also negatively affected since they directly hear the discrimination directed at them. Seval also states, “Syrian migrants are well aware of the stigmatization. They say, ‘we do not bring illnesses from Syria, we have them because of bad living and working conditions here in Turkey’.”

Persons who hold TPS, can struggle with or avoid discrimination, at least in primary health-care, by going to MHCs. Besides offering primary healthcare services in Arabic and carrying out follow-up childcare and natal care, MHCs are important for persons who have TPS since they offer a space free from discrimination. Depending on the district and the personnel, this can be true for persons who do not have TPS to some extent, as well. For Harun, without MHCs, we would have seen more discrimination cases and hostile attitudes at the hospitals. Similarly, Malik Samaan states that before the MHCs were opened in 2015, he would hear five to six case of discrimination a day from his patients. MHCs helped reduce these cases considerably.

While some of our interviewees appreciate MHCs as spaces which help reduce discrimination, others approach them more warily. For Şenay, the existence of MHCs undermines the social cohesion creating parallel systems for different groups. Similarly, Seval argues, “[the MHC system] seems like a good idea but it prevents democratic and inclusive encounters between different groups. A parallel school or healthcare system creates an obstacle to everyday encounters.” In that respect, Şenay and Seval share a common concern that the existence of MHCs can normalize discriminatory attitudes at other public healthcare institutions. Sara tells of a case she observed during her fieldwork that exemplifies such a situation:

“When I was waiting to see the doctor, a Turkish guy came in with a Syrian guy. He was working with him or he was his boss. The Syrian guy had cut his hand very badly and needed bandages changed. The Turkish guy was complaining about that ‘we have already gone to an FHC and they told us to go to an MHC.’”

Running the risk of creating a parallel system only for persons under TPS does not only normalize discrimination against Syrian migrants, for Nilüfer it also attests to the exclusion of other migrant groups who cannot officially receive healthcare from MHCs. Similarly, Emel points out, “MHCs were designed for Syrians. The government did not work to integrate non-Syrian refugees. People cannot access healthcare services in their own languages.” Therefore, undocumented migrants or migrants who do not have TPS face difficulties to avoid or struggle with discrimination and racism in the healthcare system. Problems are usually solved through migrant network solidarity mechanisms, civil society and civil initiatives as well as individual efforts of healthcare professionals who work at MHCs, FHCs, public hospitals or private clinics.

According to Barış, healthcare is a field of visibility for migrants and, hence, discriminatory attitudes surface more often in the provision of healthcare services. The lack of multilingual, multicultural and human rights-based approaches to healthcare reinforces and reproduces discrimination as a systemic problem. Moreover, as many of our interviewees pointed out, discrimination in Turkish healthcare is not limited to migrant communities. Various groups that are Turkish citizens, such as LGBTQI+ persons, ethnic and linguistic minorities, that is, those

“While some people who are active in the field appreciate MHCs as spaces which help reduce discrimination, others approach them more warily. For the latter, the existence of MHCs undermines the social cohesion creating parallel systems for different groups.”

who are subjected to discrimination in the broader society are also excluded from the healthcare system. These discriminatory patterns double when migrants are member of these groups, that is to say, they become subjected to multiple forms of discrimination. As Tufan puts it, “There is no legal restriction to the access of various groups such as LGBTQI+ people or Roma people. However, these groups -whether migrant or citizen- are disadvantageous.” In what follows, we will focus on these intersectional patterns faced by migrants who are legally and socially excluded from the healthcare services.

3.2.1 GENDER-BASED DISCRIMINATION

Some of our interviewees comment that healthcare can be a field of empowerment and socialization for migrant women. For example, Seval states, “women can make friends with other migrant women at the MHCs or hospitals, they are keen to learn how to navigate the healthcare system and also their language skills develop while seeking healthcare in the facilities.” However, migrant women also face gender-based discrimination at the healthcare facilities that is coupled with their migrant status.

As far as Syrian refugees are concerned, our research showed that gender-based discrimination usually surfaces in reproductive health areas. Syrian women’s reproductive health becomes a site for discrimination, and more specifically for directing racism at their birth rates. For Sara, “delivery and birth become instances of racism especially towards Syrian women”. According to Sara, in such cases, healthcare personnel resort to discriminatory discourses such as “they give lots of birth, etc.” Putting such attitudes in a historical perspective, Yavuz states that “although they can go to other institutions, pregnant women still come to my clinic. The reason why is clear: a vulgar racism. Back in the day, people would do the same things to Kurdish women, too.” Sara conveys a similar observation:

“[Discrimination against Syrian women] came up in the hospitals located in the regions where Kurdish people live. Doctors and nurses were directing their racism towards the Kurdish and now, Syrian women are coming in. But it is the perpetuation of that same racism.”


Similar to Yavuz’s remarks, Sara observes that migrant women [mostly Syrian women but also women from other countries, too] choose to go to MHCs instead of FHCs or public hospitals: “they choose to go to MHCs because there is less confrontation and less stress of having to deal with the language factor but also hearing something [discriminatory] at the public institutions”.

Demet explained that as part of the SIHHAT Project¹⁸ she gave training on struggling against discrimination on the basis of pregnancy and reproductive healthcare to 1200 healthcare personnel. Her remarks and the training attest to the fact that the government also recognizes this problem; however, our research shows that it has not been solved.

A different, yet interrelated problem is shared by Şenay, a medical doctor working at an FHC: “[in the healthcare system] woman automatically equates to birth and reproductive health”. Coupled with language and cultural barriers as well as discriminatory attitudes, such an approach occludes the examination and treatment of other problems that migrant women have. For Seval “women have and might have many other health issues, especially women above 55, but they cannot easily access healthcare since women’s health is under-

“Discrimination in Turkish healthcare is not limited to migrant communities. Various groups that are Turkish citizens, such as LGBTQI+ persons, ethnic and linguistic minorities, that is, those who are subjected to discrimination in the broader society are also excluded from the healthcare system. These discriminatory patterns double when migrants are member of such groups.”

18 See the literature review and Section 1.3 in this report. For further information, see https://www.sihhatproject.org/proje-faaliyetleri_0-657.



stood as reproductive health.” According to Seval, this points to an intersectional discrimination pattern since it, first, reinforces racist and discriminatory media discourses and, second, reduces women’s health to reproduction and natality care.

Another problem migrant women face is abortion. It must be noted that abortion is a controversial issue in Turkey. In recent years, abortion in Turkey was made *de facto* forbidden regardless of a woman’s legal status. Coupled with the language barrier and other obstacles to women’s access to reproductive health, Alya argues, migrant women are driven to informal clinics for abortion. Although Alya does not elaborate on that matter, a similar point was brought up by Seval as well. She said, “women are not allowed to have abortions, so they prefer informal clinics.”

Besides these problems, two of our interviewees reported physical and sexual violence cases. Lamia is a Syrian woman who has been in Turkey since 2014. She came to Istanbul three days after she arrived in Gaziantep from Syria. She reported that when she went to a public hospital, a janitor assaulted her. She wanted to have an X-ray and asked a janitor where she could find the x-ray unit. The janitor asked her if she was Syrian and said, “Come with me”. He took her downstairs and sexually assaulted her. After that experience, Lamia said that she has not been to hospitals but has been to MHCs.

Sahar (Afghan, 27) reported a case of physical violence at a public hospital:

“I was sick, and I couldn’t stand that. I started shouting. There, the doctors hit me. They slapped me in the face, twice. I didn’t have anyone with me. I talked to my husband later, but he didn’t know anything and he couldn’t say anything. [...] The nurses were not nice to us either. I can speak their language. They were saying ‘Why do Afghans give birth to so many children’.”

These two cases of discrimination as well as others show that the discrimination migrant women face is not solely about them being migrants but also combines with other forms of gender-based discrimination.

Finally, the lack of gender-sensitive understanding in interpreter services as well as lack of gender-sensitive psychosocial support negatively affects migrant women’s access to healthcare services.

3.2.2 DISCRIMINATION TOWARDS LGBTQI+ PERSONS

As mentioned above, in accessing healthcare, LGBTQI+ migrants face multiple forms of discrimination because they are discriminated due to both their migrant status and their LGBTQI+ identities. As Emel aptly points out, “discrimination and racism [LGBTQI+ migrants face] comes with homophobia and transphobia.” Demet also states that especially gender confirmation procedures create further problems: such a discrimination leads to psychological violence towards transgender refugees and in some cases causes interruption of their gender confirmation processes.

The level of discrimination, according to Çağrı, varies in accordance with visibility. For him, being more visible, trans women have further difficulties. Having accompanied trans refugees to the hospitals, he shares his experience:

“for refugees, procedures are really very long. Due to language problems, they have to spend twice as much time with the doctors. If they do not work with LGBTQI+ NGOs, interpreters can sometimes exert violence on the refugees, their privacy is violated.”

He continues with further experiences:

“trans women’s access to healthcare services are blocked due to discrimination. It is not only about hormone treatment. It is also violating their rights and running HIV tests without their consent. The attitude is truly terrifying: you catch other patients and doctors’ eyes on you all the time.”

This being the case, Demet observes that “LGBTQI+ refugees do not want to apply to healthcare services until the later phases. They do not want to reveal their sexual identities. They are concerned about stigmatization, fear of exclusion and healthcare personnel attitudes.”

Moreover, the lack of LGBTQI+ sensitive healthcare policies in Turkey causes a double violation simultaneously: the violation of their right to health and violation of right to privacy. For Emel, LGBTQI+ refugee access to healthcare is often conditioned by other problems such as stigmatization and bad treatment: “If [LGBTQI+ refugees] want to access healthcare, they take the risk of stigmatization, and bad treatment. Doctor’s attitudes, doctors who refuse to provide treatment, maltreatments... [...] The system reproduces stigmatization through its formal and informal institutions. If one is a refugee, they are subjected to much greater stigmatization and they do not have alternative access.”

Subsequently, NGOs undertake the responsibility of healthcare access of LGBTQI+ refugees. However, for Çağrı, this causes extra burdens for NGOs who have been undertaking greater workloads and responsibilities than their actual budget and resources allow. They are then in the position of having to determine which health conditions to prioritize with their limited resources. Notwithstanding these problems and their limited budget, it must be noted that NGOs and solidarity networks in the field offer outstanding solidarity with LGBTQI+ refugees. Yeliz asserts that “LGBTQI+ refugee healthcare access is achieved through civil society solidarity. They do not have resources, but their solidarity is very strong.”


3.3 WORKING CONDITIONS AND WORKPLACE INJURIES

As mentioned above, working and living conditions directly affect their migrant community health conditions. The intensity of work, workplace health and safety, working hours and workplace security are all important factors which determine workplace related injuries and diseases. Nuri Bey’s testimony on a Ugandan refugee conditions attests to the interdependency of health and working conditions:

“A Ugandan woman came here [Istanbul] to take care of her four children. She was working in a factory, in the painting department. She caught an infection at the factory – something related to chemicals. Where she lives is humid. So, her infection worsened at home. We helped her to go to the hospital.”

Our observations and interviews showed that the types of work that migrant communities engage in are usually daily or weekly jobs with low payment and harsh working conditions. As Harun comments, “to be able to work in such workplaces, they have to be in good health; however, they cannot access healthcare services. In other cases, they work in labor-intensive sectors such as textile and construction for 10-12 hours a day in the informal sector without insurance and under harsh working conditions. In such cases, they are likely to have work-related diseases such as respiratory diseases, loss of organ function, formation of *oedema* in certain organs and other workplace related injuries. However, since they often work without insurance, workplace accidents are not reported and are usually kept in the dark by employers. While sharing his observations about workplace accidents, Ferzad says, “when something like that happens, employers usually take migrant workers to doctors or hospitals they know, they don’t make it official.” In cases of undocumented migrant workplace injuries

“The discrimination migrant women face is not solely about them being migrants but also combines with other forms of gender-based discrimination. Also, the lack of gender-sensitive understanding in interpreter services as well as lack of gender-sensitive psychosocial support negatively affects migrant women’s access to healthcare services.”



they are expected to cover their own expenses and face the risk of losing their jobs. Even when they do not lose their jobs, since migrants who work in the informal sector are paid on the daily or weekly basis, they usually lose their income when they have a work-related disease or injury.

Dr. Oğuz recounted a situation he witnessed in one of the houses he visited during voluntary health screenings: “In one of the houses, eleven young male Afghan refugees were living. All of them work in a textile factory, doing ironing all day. Four of them had function loss in their hands. They needed physio-therapy, but they did not have insurance”. In another example, Sahar explains the challenges posed by her husband’s workplace accident:

“Once a cloth batch fell over my husband [at the workplace]. He had to rest at home for two weeks. We know an Iranian doctor; he gave him some medication. The employer did not care about him at all. And my husband does not have ID or insurance, so, he didn’t say anything. He doesn’t have any documents.”

As these examples show, in cases of work-related diseases and injuries, access to healthcare services are attained through individual efforts of migrants, volunteer doctors, and civil initiatives. These individual efforts are one of the main pillars of migrant community access to healthcare in Istanbul. They greatly serve to facilitate migrant healthcare access as well as offer psychological, emotional and financial support to migrants who have trouble accessing healthcare. In what remains, the report will present the facilitators of migrant healthcare access: namely, NGOs, civil initiatives and voluntary healthcare professionals.

“In cases of work-related diseases and injuries, access to healthcare services are attained through individual efforts of migrants, volunteer doctors, and civil initiatives. These individual efforts are one of the main pillars of migrant community access to healthcare in Istanbul.”

4. FACILITATORS OF MIGRANT HEALTHCARE ACCESS IN ISTANBUL

4.1 MIGRANT HEALTH CENTERS AND PRIVATE CLINICS

The Turkish government started opening MHCs in October 2015. In December 2016, MHCs were systematized and expanded under the three-year EU-funded health project titled “Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities”, also known as SIHHAT Project.¹⁹ As of today, there are 178 MHCs in 29 provinces and 31 in Istanbul. MHCs, modelled on the Family Health Centers, were designed to provide primary healthcare services to Syrian refugees in Arabic. Each migrant health center is planned to serve 4000-6000 patients and offer “first-rate diagnosis, medical treatment and rehabilitation services, vaccination and other protective health services, monitoring services and health education services”.²⁰ The main aim of the MHCs is threefold: to provide culturally and linguistically accessible healthcare services to Syrians; to lower the burden on the Turkish healthcare system; and to integrate skilled Syrian healthcare professionals in the Turkish labor market through employment in the MHCs. Sara also adds, “Another aim of the MHCs was to stop informal clinics to be able to govern these spaces. The government thought that ‘we should ensure to know who is prescribing what, to whom and for how long.’”

As mentioned, MHCs were established for providing primary healthcare exclusively to persons who have TPS. This being the case, many Syrian migrants prefer MHCs to access primary healthcare and most often childcare and natality care. Our interviewees state that the reason behind this is not only accessing primary healthcare in Arabic but also accessing healthcare services without facing discrimination that they might face in the public healthcare facilities. Tufan who works for the Ministry of Health as a supervisor of MHCs says that among Syrian migrants, satisfaction rates are as high as 85%. Hasan comments that “MHC is a new system. People try to go there for primary healthcare. Doctors and nurses speak Arabic. All documents are in Arabic. 80% of the issues get solved there.” Drawing on his familial experience, Hasan tells:


“We have a MHC in Başakşehir [where he lives]. My wife took our children to take their yearly shots and she said to me that it was very busy. [...] People do not want to go to hospitals if not super necessary, they go to the MHCs.”

Notwithstanding the regulations that restrict MHCs scope to persons holding TPS, depending on the district and the attitude of the healthcare personnel, MHCs welcome other migrant groups, too. Sara says, “the MHCs approach was to accept everyone. Especially Syrians who do not have registration or Syrians who are registered in other provinces. Priority was much more the public health.” Doctors at the MHCs, according to Sara, endeavor to make it work when non-Syrian or non-Arabic speaking patients come:

“[At the MHCs where she conducted research] There were Turkmen people coming, Uyghur people coming. They [the doctors] were telling me that ‘The worst case is not the Syrians when it comes to documents. It is the Uyghurs. Because their wives give birth at home, children do not have birth certificate. Parents are probably not registered.’”

19 For further information, see https://www.sihhatproject.org/proje-faaliyetleri_0-657. Last accessed on 20 July 2020.

20 Yıldırım, C.A., Komsuoğlu, A. and Özekmekçi, İ. (2019) The transformation of primary healthcare system for Syrian refugees in Turkey. *Asian and Pacific Migration Journal* 28(1), 75-96.



Also, she relays that doctors at the MHCs recognize the need for other languages, but they nonetheless make it work with their own efforts. Doctors who can speak French, Turkish, Kurdish or English resort to their own means to provide healthcare to non-Arabic speaking communities.

Drawing on his own experience with Afghan migrants, Ferzad comments:

“MHCs give support to Afghan families, regardless of their legal status. But MHCs are for Arabic speaking people. Knowing Turkish or Arabic is required. No one speaks Farsi. [...] Still, if they can communicate, minor diseases are treated at the MHCs. They can get medications.”

Similarly, İhsan and the City Solidarity volunteers say that they know of specific MHCs that are very helpful to undocumented migrants. But as Sara’s remarks also show, they state that this depends on the healthcare professionals’ good will and it is not systemically supported. Yavuz also makes a similar observation: “Some FHCs do not accept migrants. Especially for vaccinations and obstetrics, I direct patients to MHCs. We encounter cases of communicable child’s diseases such as measles. MHCs are very valuable, they must be sustained.”

However, dependence on the attitudes of the healthcare professionals as well as offering only primary healthcare, migrants sometimes choose to go to private clinics. Jamal explains the situation:

“Kayşehir, for example. I heard that they were giving healthcare only to Syrians but then I learned they give service to all migrants. It is a good healthcare service and there isn’t a language barrier. However, these are limited services. [...] MHCs are not full-fledged hospitals. So, migrants apply to public or private hospitals. Besides, there aren’t MHCs in every city or every district.”

While some MHCs give support to all migrants, they are widely perceived as healthcare facilities for Syrian migrants. This, in turn, drives other migrant communities away from the MHCs and they resort to private clinics.

Yavuz’s clinic is one of them. Yavuz, a medical doctor, has been providing healthcare services to those who do not have access since 1996. He worked with MSF Belgium between 1996-2002 providing healthcare to internally displaced persons in Istanbul and Adana. Later, they collaborated for providing healthcare after the 1999 Marmara Earthquake. After 2002, he started working with undocumented migrants and started his private polyclinic. He says that “It is a private clinic but it adheres to certain principles: it is an open-door clinic, it gives healthcare to undocumented migrants, as well.” Yavuz estimates that approximately 60% of the clinic’s patients are migrants and it is increasing each year. Among the patients are people from Bangladesh, Pakistan, Afghanistan, Iran, Tibet, Sri Lanka, African migrants and people from post-Soviet countries. Yavuz’s clinic has contacts with NGOs and civil initiatives such as the City Solidarity and Nilüfer’s NGO offering affordable or free healthcare to undocumented migrants referred to them by these solidarity networks.

Another private clinic, which is popular among Arabic-speaking migrants in Istanbul, is a clinic in Fatih, established by Malik Samaan, a Syrian doctor who went to medical school in Istanbul and has been working with humanitarian organizations from before 2011. In 2013, he opened his private clinic in order to respond to the healthcare needs of Syrian migrants. Yet, the clinic offers healthcare not only to Syrians but also to all Arabic speaking migrants. When we talked to patients we met at the clinic, we saw that Arabic speaking, especially women, prefer going to the clinic not only for language-related reasons but also because they trust doctors at the clinic more. Aliya (Syrian, 20) says “they received us well when we went to the [public] hospital. But for gynecology, I come to this clinic.” Similarly, Esmâ (Egypt, 30) says, “Here things are faster. I am pregnant and my husband is working. Doctors are experienced and the place is

clean. So, I come here for my regular examinations.”

4.2 NON-GOVERNMENTAL ORGANIZATIONS

As often underlined throughout the report and the literature review, civil society organizations play a crucial role in migrant healthcare access. Previously, NGOs were permitted to provide primary healthcare to migrant communities through private NGO clinics. This was a result of migrant population increases and expansion of multilingual demands in the system. Therefore, NGO partnership in healthcare provision was welcomed by the state until 2015. NGO healthcare provision was particularly helpful to undocumented migrants or other marginalized migrant groups since they would be able to access free and anonymous primary healthcare without the risk of deportation. Also, these clinics were providing healthcare in ways to overcome language barriers either by employing multilingual doctors or employing interpreters and cultural mediators.

Starting from October 2015, the government started opening MHCs, among other things, aimed at centralizing healthcare. The Turkish government did not retain NGO partnerships in the new model, and in 2017, functioning NGO clinics were transformed into migrant health centers to operate under the centralized health system. Today, NGOs and voluntary organizations mostly undertake the psychosocial and physiotherapy support to migrants which is largely neglected by public institutions. They also provide more general support facilitating access to the broader system. To briefly summarize, NGOs offer consultation and training on healthcare services, help migrants access information on healthcare services, assign interpreters for migrant hospital visits, provide psycho-social support to migrant communities as well as organize advocacy for improving migrant rights. According to Malik Samaan, NGOs played a very important role for improving migrant healthcare. In fact, for him, it is thanks to civil society that today people under TPS have free access to all healthcare services.

However, employers and activists with whom we talked also underlined some problems NGOs are facing. Especially in terms of advocacy works, they emphasize that the recent policies and restrictions on civil society limits their space for advocacy. According to Harun, “increasing authoritarianism has greatly affected NGOs and international organizations. In 2012, IMC was shut down, Mercy Corps’ office was shut down; the Danish Refugee Council was fined \$6 million and the Norwegian Refugee Council was also shut down.” He relays that “the role of NGOs and international organizations was reduced to humanitarian aid. Human rights violations regarding refugee health rights cannot be reported, published or debated. Critical, rights-based NGOs lost their ground for dialogue and were marginalized.”

This being the case, NGO employers and other interviewees state that the government-civil society partnership has become much more difficult and its scope has been restricted. Tufan points out, “the government is very selective about the NGOs it will work with. For example, the government is very inflexible about working with the TTB (Turkish Medical Association).”²¹ Moreover, Harun comments, “NGOs which work with refugees and migrants are supposed to get permission for their activities and the number of NGOs which can actually get this permission is very low.” Therefore, the number of NGOs working in the field and their scope has been reduced. They have to work with lower budgets and a narrowing range of approved activities while supporting migrant healthcare access.

21 TTB was established in 1953 as the professional organization of the physicians. Today, 88% of physicians in Turkey are members of the association. For more detailed information, see https://www.ttb.org.tr/menu_goster.php?Guid=706e317c-7698-11e7-9986-54b29146220c.

“While in some cases civil initiatives are more restricted in terms of financial and human resources, not acting under the auspices of funding or project requirements, they can undertake their actions more independently. While helping migrant communities to access healthcare services, civil initiatives usually work with various networks such as migrant networks, hospitals and private clinics, voluntary doctors and other NGOs as well as politicians and human rights activists.”

Nonetheless, it must be noted that besides the funding problems and problems with the government, NGOs offer a crucial support for migrant healthcare – especially for the undocumented migrants and migrants who are subjected to multiple forms of discrimination and excluded from the public healthcare system. LGBTQI+ associations and solidarity networks are particularly important in offering this support. There is an Istanbul-based NGO which has been working with undocumented migrants since 2011 and offers primary healthcare services mainly to African migrants. They also cover migrants’ medical expenses, supply their medications, offer translation and establish connections with other NGOs, civil initiatives and hospitals for creating a network which will provide affordable healthcare services to undocumented migrants. Nilüfer and Dr. Assane, founders of an Istanbul-based NGO, state that they do not receive any financial support, but they have created a solidarity network with the African community that also receives assistance from migrants who volunteer in the office. Both doctors who work at the clinic are migrants. Although they labor to support migrants, their budget and legal restrictions limit the scope of their actions as well as the scope of their support to migrants.

Recognizing this problem, İhsan suggests that civil society in Turkey needs to find ways to develop their own local resources in order to offer sustainable healthcare services to migrant communities. For İhsan, establishing connections and collaboration with metropolitan and district municipalities is one way of achieving local and sustainable resources. In doing so, civil society can overcome many of the structural limitations posed on them by policies, budgets and short-term project funding.

4.3 CIVIL INITIATIVES AND VOLUNTARY HEALTHCARE PROFESSIONALS

Another group that has been greatly helpful for facilitating migrant healthcare is civil initiatives. Since they do not have the legal status of association or foundation and they carry out their activities voluntarily, in this report, we make a distinction between NGOs and civil initiatives. Moreover, while in some cases civil initiatives are more restricted in terms of financial and human resources, not acting under the auspices of funding or project requirements, they can undertake their actions more independently. While helping migrant communities to access healthcare services, civil initiatives usually work with various networks such as migrant networks, hospitals and private clinics, voluntary doctors and other NGOs as well as politicians and human rights activists. In doing so, they aim at not only figuring out new ways for migrants, particularly undocumented migrants, to access healthcare but also share rights violations through social media.

The City Solidarity Platform is one of the well-known civil initiatives in Istanbul. They usually work with migrant communities from Africa but also with other migrant groups in the same neighborhoods. When we talked to the volunteers of the City Solidarity, they told us that they have created an informal healthcare network for migrant communities. In Nuri Bey’s words,

“When they are helpless [and cannot postpone their health problems anymore], migrants go to hospitals. At that stage, we hear. We direct them to clinics. Sometimes, the problem is beyond the means of the clinic. Then, we call İhsan. He tells us to send the patient to a private hospital. Sometimes, the problem is beyond them, too. They cannot solve it, either. If they have the means, they will help but it is not a fully-fledged hospital. After that the doctors say the patient has to go to a training and research hospital or a public hospital. But we know what is going to happen there. If we go there, at the very beginning we’ll have to pay 250-300TL, then comes the tests, maybe we’ll have to hospitalize the patient. They don’t accept the

patient without the registration fee. We know that and we use the emergency services. I call 112, explain the situation. I tell them, ‘look, this is urgent, the patient is at risk. You decide, if the patient dies, we’ll publicize this at the social media’. After all these things, an ambulance gets the patient. But then again, the hospital asks for money at the hospital. Even at the emergency services. Migrants usually cannot afford that, that’s why they came to us in the first place.”

In these situations, volunteers of City Solidarity tap into their own network and try to find solutions. They say that the voluntary efforts of healthcare professionals who have connections with City Solidarity usually find solutions either in the hospitals they work or through their own connections such as calling their colleagues at other hospitals. When the network connections fall short of finding a solution, they do advocacy work and reach out to the politicians, human rights activists and resort to social media. Ömer comments:


“There is this thing, we met a woman from Sierra Leone. She had rheumatoid arthritis. Up to a certain point she was handling her condition. But her shots are very expensive, and she cannot afford it. Her injection doses were not enough after a while. She had to go to hospital which is also unaffordable. The only solution is getting a residence permit. She applied but got rejected. We made a fuss out of it. We made so much noise that we finally found a contact with the vice governor. He issued a humanitarian residence for her and she could finally stay in hospital. Sometimes this is the only way. Sometimes, we have to deal with the DGMM.”

Besides supporting migrants for their individual health problems, City Solidarity also undertakes public health responsibilities in the face of lack of public effort. Nuri Bey tells:

“when someone has complaints that might be TB or AIDS, we take them to the hospitals. However, they [the hospitals] don’t even tell us. If only they were... There are other people living with them. These people live with us. [...] When we learn about TB cases, we do not stop there. We ask the patient ‘where do you live, how many people live in the household, where is your address’. I find the address and take other people in the household to take the tests. I explain the situation. We follow the cases so that there won’t be other infections, they can protect themselves.”

In order to undertake all these responsibilities, City Solidarity has developed close connections with the doctors who volunteer free or affordable healthcare services to migrants. İhsan, whose name was mentioned very frequently during the fieldwork, is one of these doctors. He is a pulmonology professor at a medical school and has been working with the Anti-TB Association for a long time. He has been supporting migrant communities and offering them free TB tests and treatment since 2005. He is also active in Dr. Hafız Cemal Lokman Hekim and Sabiha Lokman Hekim Health Foundation, a foundation which offers health support to those who do not have health insurance. The Foundation covers the healthcare expenses of people who cannot afford it. It has an agreement with Yavuz’s clinic. The foundation sends the applicants to that clinic for childbirth, emergency cases, infections and women and child’s health. Other than these institutional networks, İhsan uses his personal networks for supporting migrant healthcare access. However, he also notes that the current way of tackling migrant healthcare is not sustainable. It works thanks to the voluntary efforts of healthcare professionals. However, he asserts, “the healthcare system needs to be restructured so that migrant healthcare access is institutionalized and will not be at the discretion of healthcare personnel.”

Dr. Oğuz also agrees with İhsan’s comments about the healthcare system. Given the absence of an inclusive and free healthcare system, Dr. Oğuz has been working with City Solidarity for 4-5 years since he was a medical school student. While recounting how he became a part of the solidarity network, he explained:



“It must have been 2015 or 2016 that I met with City Solidarity. They came to us and said that ‘we support migrants socially and economically but there is a problem with accessing healthcare.’ So, we decided to do a one-time health screening in the neighborhood. We planned that people would come to us and we would either solve their problem or direct them to relevant institutions. We were able to help many people at that health screening but we saw how big the problem was. It was not possible to solve these problems with a screening.”

After that, he and his colleagues started a makeshift primary healthcare clinic in the neighborhood on Saturdays. They offered primary healthcare services to undocumented migrants and helped them access medications through pharmacy connections or through İhsan’s foundation. However, after 1.5 years, they decided to offer healthcare in the hospitals where they work due to technical reasons. Since then, he helps migrants to access healthcare at the hospital, using his own networks there.

4.4 PHARMACIES

Our research and interviews showed that pharmacies are important facilitators for migrant healthcare access. Especially for undocumented migrants, pharmacies function as a first point of contact for medical advice where they can access medications for minor diseases. Ferzad conveys:

“Afghans consult pharmacies when they need to. They pay for medications from their own pockets. But it is not everywhere. It is usually more common in the migrant-populated neighborhoods like Zeytinburnu, Esenler, Esenyurt, Küçüksu. In districts where Afghan migrants often live, pharmacies employ Afghan migrants.”

Similarly, Babak (Afghan, 24) says, “Here [Zeytinburnu] there are Afghan and Iranian pharmacies. I go there.” Seval also comments that pharmacies are crucial for migrants: “they can supply promotion medications they have for free or give medical advice.”

Moreover, civil initiatives and voluntary doctors say that they establish contacts with the pharmacies to be able to provide medication to migrants who cannot access them. Ömer explained, “Sometimes pharmacists call us and say ‘we had a patient who died, his family gave his medications to us’. We go and get those medications, store them and give them to patients after consulting to doctors.”

Throughout the report, we have highlighted that supporters of migrant healthcare access usually make use of their own networks and means. Their support to migrants is dependent on their human and financial resources as well as their accessibility to migrant communities.

5. MIGRANT HEALTHCARE ACCESS DURING COVID-19

Our research showed that during COVID-19, migrant communities often avoided healthcare services for several reasons. Firstly, due to a lack of access to sufficient information about the new healthcare service arrangements, they had problems with figuring out what healthcare facilities are accessible. Hasan stated that “especially during the pandemic, people do not go to hospitals because for a couple of months, hospitals were only for COVID-19 patients.” Secondly, our interviewees state that migrant groups were concerned about the discriminatory attitudes that associate migrants with the spread of communicable diseases. This has been a widespread discourse in Turkey especially in terms of communicable child’s diseases such as polio, measles, etc. Finally, as part of the quarantine measures, migrant communities took their own measures and did not go to hospitals unless it was an emergency. Esmā (Egypt, 30) remarks, “during the COVID-19, we did not leave home at all. I had a problem with my finger, but I did not leave home. I waited as much as I could and had my treatment later.” In particular, it was reported that Syrian migrants seeking healthcare at MHCs, especially for children, significantly delayed their visits.

However, the main problem migrant communities faced during the pandemic was less health-related than economic. Many refugee households lost their jobs and did not have any regular income. Yahya (Egypt, 34) is an Arabic teacher who has been living in Istanbul for 7 years. He states, “we had lots of economic problems during the COVID-19, everybody did.” Aziz shared a similar observation:

“Refugees do not work in stable jobs. Many of them lost their jobs. Penalties [of going out] are intimidating. They lost their incomes. They can’t afford their rent and expenses. Some of them take the risk and go out. Most of the time they borrow from their acquaintances or they receive assistance from NGOs. For rent, many people take on debt.”


Access to food was reported as a pressing issue by some of our interviewees. This lack of support during the COVID-19 might cause future health problems such as malnutrition, as well as psychological problems. Another problem that was compounded during COVID-19 was inequalities in access to hygiene, clean water and self-care. Living in crowded houses with insufficient infrastructure might cause further spread of the diseases. Nonetheless, since we do not know exact figures of COVID-19 cases among migrant communities, it is hard to judge the health impacts of the virus itself.

Finally, COVID-19 quarantine measures also affected NGO and civil initiative outreach capabilities. Regular support and communication with refugee communities has been interrupted. Our interviewees reported that in order to protect themselves and their beneficiaries, they are usually offering support via phone. Dr. Oğuz remarks:

“During COVID-19, Nuri Bey reached us via phone. COVID-19 positive people could not reach the testing stations; when they go to hospital, they are not tested but rather told to go home, rest and do not have contact with anyone. But they do not know if the patient is positive or not. COVID-19 medications are also not given. They are given individually; you cannot find them at the pharmacies. Thus, we couldn’t supply medications either. In such a case, City Solidarity also had to take a step back and protect themselves.”

Nonetheless, some NGOs and civil initiatives undertook the task of providing information to migrants regarding the pandemic. They set up WhatsApp groups and posted English, French,

“The main problem migrant communities faced during the pandemic was less health-related than economic. Another problem that was compounded during COVID-19 was inequalities in access to food, hygiene, clean water and self-care.”



Arabic and Farsi brochures on COVID-19. They went to refugee households and handed over masks, gloves and disinfectants. However, this remained a very limited activity since it could not be institutionalized and fully organized.

6. POLICY RECOMMENDATIONS

Throughout the report, we have underlined that migrant community access to healthcare services is differentiated and dependent on legal status, socio-economic conditions, access to social networks and access to information on the healthcare services. We have also outlined the problems various migrant communities face in their efforts to access healthcare. In what remains, the report will propose some policy recommendations for the improvement of healthcare services.

1. The article 56 of the Turkish Constitution which stipulates that “everyone has the right to live in a healthy and balanced environment” should be adhered to and implemented for everyone regardless of legal status.
2. Healthcare should be tackled from a holistic perspective: it must be addressed not as merely absence of disease or infirmity but as a state of complete physical, mental and social well-being. Therefore, in order to strengthen migrant community healthcare access, they should be supported in a way that improves their working and living conditions as well as provides them with access to hygiene and clean water.
3. Migrant Health Centers should be open to all migrants, regardless of their legal status.
4. The Turkish healthcare system should be restructured to offer multilingual healthcare services.,
5. Everyone regardless of one’s legal status, race, religion, language, ethnicity, gender, sexual orientation and disability, should be provided with gender-sensitive, human rights oriented free translation and interpreting services at healthcare facilities.
6. In order to combat discrimination and racism towards migrants while accessing healthcare, healthcare personnel (doctors, nurses, managers and hospital personnel) should receive training on awareness raising training. Legal sanctions should be implemented to proven cases of discrimination against migrants in the healthcare system. Existing projects tackling the problem of discrimination in migrant access to healthcare services (such as those of Turkish Medical Association) should be supported.
7. The healthcare system should employ social workers in order to support migrant communities regarding their health conditions and individual measures to improve health conditions.
8. The Health Tourism Regulation, one of the main obstacles to undocumented migrant access to healthcare, should be revised and restructured.
9. The Health Tourism Regulation should be amended to ensure that migrants can register in hospitals without facing the risk of being reported to law enforcement. Healthcare professionals and hospital personnel who are already overburdened in the healthcare system should not be forced to bear the burden of reporting undocumented migrants to law enforcement.
10. NGOs and international organizations should develop closer relations and further collaborate with civil initiatives, voluntary healthcare professionals and pharmacists for reaching out to migrant communities as well as for improving migrant healthcare access.



11. Given the importance of neighborhood networks, local institutions should be mobilized to enhance migrant access to healthcare services. Metropolitan and district municipalities are appropriate focal points for coordinating and establishing networks.
12. Mobile healthcare services to provide health screening to migrant communities should be offered in neighborhoods where migrants are densely populated.
13. Information brochures should be shared with community leaders who can disseminate them on social media in order to raise awareness.
14. Intercultural health mediator roles in migrant communities should be strengthened.
15. It must be noted that in emergency situations such as the COVID-19 pandemic, migrant community vulnerability increases, and their healthcare access suffers further interruption. Actors facilitating migrant community healthcare access need to make preparations, especially for information dissemination, for situations where emergency contingencies are likely to impact vulnerable migrant groups.
16. The long-term impacts of the COVID-19 pandemic on migrant community access to healthcare and livelihood should be researched and addressed accordingly.





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