BARRIERS AND BRIDGES: SYRIAN WOMEN'S ACCESS TO SEXUAL AND REPRODUCTIVE HEALTHCARE AND MIGRANT HEALTH CENTERS IN TÜRKİYE

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submitted by **MELİKE KAYA** in partial fulfillment of the requirements for the degree of **Master of Science in Political Science and Public Administration, the Graduate School of Social Sciences of Middle East Technical University** by,

Prof. Dr. Sadettin KİRAZCI
Dean
Graduate School of Social Sciences _____

Prof. Dr. Kürşad ERTUĞRUL
Head of Department
Department of Political Science and Public Administration _____

Prof. Dr. Mustafa Kemal BAYIRBAĞ
Supervisor
Department of Political Science and Public Administration _____

Examining Committee Members:

Assoc. Prof. Dr. Asuman GÖKSEL (Head of the Examining Committee)
Middle East Technical University
Department of Political Science and Public Administration _____

Prof. Dr. Mustafa Kemal BAYIRBAĞ (Supervisor)
Middle East Technical University
Department of Political Science and Public Administration _____

Assoc. Prof. Dr. Ozan ZENGİN
Ankara University
Department of Political Science and Public Administration _____

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Name, Last Name: MELİKE KAYA

Signature:

ABSTRACT

BARRIERS AND BRIDGES: SYRIAN WOMEN'S ACCESS TO SEXUAL AND REPRODUCTIVE HEALTHCARE AND MIGRANT HEALTH CENTERS IN TÜRKİYE

KAYA, Melike
M.S., The Department of Political Science and Public Administration
Supervisor: Prof. Dr. Mustafa Kemal BAYIRBAĞ

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This thesis examines the access to sexual and reproductive health services for Syrian women under temporary protection in Türkiye through Migrant Health Centers. Using Levesque, Harris, and Russel's (2013) framework of healthcare access, it intersectionally examines the supply and demand sides of the healthcare access process and analyzes how structural cultural and interpersonal barriers shape access to sexual and reproductive health services. Although Migrant Health Centers stand out as relatively more inclusive and patient-oriented facilities, offering significant advantages in terms of language, location, and cultural adaptation, barriers to access persist due to negative attitudes, bureaucratic obstacles, and structural problems within the centers. Drawing on legal and policy documents and the interviews with representatives of non-governmental organizations, the thesis highlights how systemic inequalities and intersecting vulnerabilities marginalize Syrian women under temporary protection. In conclusion, the thesis advocates for a holistic and intersectional approach to healthcare access and suggests that structural reforms should be combined with efforts to combat social exclusion.

Keywords: Syrian women, temporary protection status, healthcare access, sexual and reproductive health

ÖZ

ENGELLER VE KÖPRÜLER: SURİYELİ KADINLARIN TÜRKİYE'DEKİ CİNSEL SAĞLIK VE ÜREME SAĞLIĞI HİZMETLERİNE VE GÖÇMEN SAĞLIĞI MERKEZLERİNE ERİŞİMİ

KAYA Melike
Yüksek Lisans, Siyaset Bilimi ve Kamu Yönetimi Bölümü
Tez Yöneticisi: Prof. Dr. Mustafa Kemal BAYIRBAĞ

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Bu tez, Türkiye'de Geçici Koruma Altındaki Suriyeli kadınların Göçmen Sağlık Merkezleri aracılığıyla cinsel sağlık ve üreme sağlığı hizmetlerine erişimini incelemektedir. Levesque, Harris ve Russel'ın (2013) sağlık hizmetlerine erişim çerçevesini kullanarak, sağlık hizmetlerine erişim sürecinin arz ve talep taraflarını kesişimsel olarak incelemekte ve yapısal, kültürel ve kişiler arası engellerin cinsel sağlık ve üreme sağlığı hizmetlerine erişimi nasıl şekillendirdiğini analiz etmektedir. Göçmen Sağlık Merkezleri, dil, konum ve kültürel uyum açısından önemli avantajlar sunan, nispeten daha kapsayıcı ve hasta odaklı tesisler olarak öne çıksa da olumsuz tutumlar, bürokratik engeller ve merkezlerdeki yapısal sorunlar nedeniyle sağlığa erişimin önündeki engeller devam etmektedir. Uluslararası ve ulusal yasal mevzuat, politika raporları ve sivil toplum kuruluşlarının temsilcileriyle yapılan görüşmelere dayanan tez, sistemik eşitsizliklerin ve kesişen kırılganlıkların Geçici Koruma altındaki Suriyeli kadınları nasıl marjinalleştirdiğini vurgulamaktadır. Sonuç olarak tez, sağlık hizmetlerine erişim konusunda bütüncül ve kesişimsel bir yaklaşımı savunmakta ve yapısal reformların sosyal dışlanma ile mücadele çabalarıyla birleştirilmesi gerektiğini öne sürmektedir.

Anahtar Kelimeler: Suriyeli kadınlar, geçici koruma statüsü, sağlık hizmetlerine erişim, cinsel sağlık ve üreme sağlığı

To all the women of the World

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LIST OF ABBREVIATIONS

ECHO : European Civil Protection and Humanitarian Aid Operations

EMHC : Extended Migrant Health Center

EU : European Union

FRIT : Facility for Refugees in Turkey

HCBA : Healthcare Access Barriers Model

HUWRIC : Hacettepe University Women's Research and Implementation Center

IOM : International Organization for Migration

ISIL/ISIS : Islamic State of Iraq and the Levant / Islamic State of Iraq and Syria

LFIP : Law on Foreigners and International Protection

MHC : Migrant Health Center

MHPSS : Mental Health and Psychosocial Support

MUD : Moral Underclass Discourse

NGO : Non-Governmental Organization

PMM : Presidency of Migration Management

RED : Redistributionist Discourse

SGBV : Sexual and Gender-Based Violence

SID : Social Integrationist Discourse

SIHHAT : Improving the Health Status of the Syrian Population under Temporary Protection and Related Services Provided by Turkish Authorities

SRH : Sexual and Reproductive Health

TPR : Temporary Protection Regulation

UNFPA : United Nations Population Fund

UNHCR : United Nations High Commissioner for Refugees

UTP : Under Temporary Protection

WGSS : Women and Girls Safe Spaces

WHO : World Health Organization

CHAPTER 1

INTRODUCTION

1.1. Background of the Study

Migration, particularly forced migration, continues to reshape societies worldwide. As of mid-2024, there are 122.6 million forcibly displaced individuals globally due to persecution, conflict, violence, human rights violations, or significant disruptions to public order (United Nations High Commissioner for Refugees, 2024, October 8) Among them, 37.9 million are refugees, 8 million are asylum seekers, and 5.8 million are waiting for international protection (UNHCR, 2024, October 8). 6.3 million of these forcibly displaced population is from the Syrian Arab Republic and Türkiye hosts 3.148.663 forcibly displaced people (UNHCR, 2024, October 8). According to the latest data of the Türkiye Presidency of Migration Management (PMM) dated November 2024, 2.936.252 of the forcibly displaced people are from the Republic of Syria (Presidency of Migration Management, 2024, November 21). These displaced populations face unique challenges in their host countries related to public services such as accessing healthcare. For women among those displaced populations, challenges are often compounded by intersecting vulnerabilities, including cultural barriers and gendered inequalities. In the Turkish context, the ongoing great waves of migration from Syria have increased concerns, necessitating a focused exploration of how displaced populations navigate healthcare systems. As Türkiye hosts the second largest number of refugees globally (UNHCR, October 8), examining their healthcare access, particularly for Syrian women, offers critical insights into broader global trends and challenges.

The Syrian crisis began in March 2011 when the first protests called for political reform and greater freedoms were met with violent repression by the regime of

President Bashar al-Assad. Under government pressure, the events that began escalated into a full-scale civil war by 2012, involving a wide range of local and international actors. By 2015, the war had attracted significant international involvement; Russia and Iran supported Assad, while the United States, Türkiye, and the Gulf States supported various other groups. The civil war transformed into a major humanitarian crisis involving many influential external actors, displacing millions of Syrians. The displaced Syrians created a significant flow of refugees, often to neighboring countries such as Türkiye and later to Europe.

In 2014, following the activities of the Islamic State of Iraq and the Levant (ISIS/ISIL) in Syria and the Kobani incidents, the influx of refugees accelerated, and the number of Syrians arriving in Türkiye exceeded 1.5 million. In 2016, the Türkiye-EU Agreement, signed on March 18, came into effect. Through this agreement, Türkiye committed to limiting the refugee influx to Europe, and in return, the EU provided financial support to Türkiye. After Türkiye's Peace Spring Operation in 2019, a small portion of Syrians began returning to the safe zones established along the Syrian border. Under the temporary protection (UTP) framework, the number of Syrians in Türkiye peaked at 3,737,369 in 2021. It started to decline after that date.

Türkiye has played a crucial role throughout the Syrian crisis due to its geographical proximity and historical ties to Syria. Hosting just below 3 million Syrians, Türkiye, from the beginning, has established refugee camps and urban integration programs, providing healthcare, education, and social services. This crisis has had profound impacts on public services and social cohesion within the country as well. Public services, particularly healthcare and education, have faced significant strain as they strive to accommodate both the local population and the growing number of Syrians. Since the first arrival date of Syrians to Türkiye, studies about access to health have continued to be carried out regarding both the general health system and specific health areas such as mental health, sexual and reproductive health, chronic diseases, etc. Especially in the field of health, a lot of quantitative studies were conducted not only by social scientists but also by people working in the health sector as well (Abohalaka & Yeşil, 2021). There are many problems that determine access level to

health services, even though healthcare is demonstrated as one of the most accessible services among other public services (Erdogan, 2020). According to the related literature, the most encountered problems that Syrians in Türkiye face in the health sector are language barriers (Abohalaka & Yeşil, 2021; Assi et al., 2019), operational and scale efficiency (Achiri & Ibrahim, 2022), registration procedure regulations (Alawa et al., 2019), and costs (Karasapan, 2018).

In order to respond to the problems in that area, quite a lot of projects were conducted. One of the most comprehensive one among them is SIHHAT (Improving the Health Status of the Syrian Population under Temporary Protection and Related Services Provided by Turkish Authorities). This project started after the 18 March EU – Türkiye Agreement, and it aims to reduce the burden on healthcare institutions by funding Migrant Health Centers. Other supported areas are personnel employment, medical devices for primary and secondary health care facilities, vaccines, and vitamins. Within the scope of this project, gradual improvement of the current health services provided to migrants[1] is aimed. Migrant Health Centers, first established in 2015, are being expanded throughout Türkiye. In addition, training and external outreach activities were carried out to increase the accessibility of the activities conducted within the scope of the project and to develop health literacy among migrants.

Migrant Health Centers are the focus of this thesis, serving as primary healthcare providers linked to Community Health Centers. Initially, they are opened in provinces with the highest Syrian populations and subsequently throughout the whole of Türkiye. According to the scope of the agreement, Migrant Health Centers (MHCs) only serve Syrians Under Temporary Protection (UTP), offering services in their native language from Syrian doctors. Some of the established or supported MHCs are “Extended” Migrant Health Centers (EMHC). These centers, which will be examined in more detail in subsequent sections, also provide internal medicine, gynecology and obstetrics, pediatrics, oral and dental health services, psycho-social support services, laboratory, and x-ray services.

[1] The reason I use the term "migrant" as a concept in this part is that this concept was preferred to be used in the project descriptions for the groups planned to be served within the scope of this project.

Although E/MHCs were designed to provide health services to Syrians UTP, it may not be the right approach to consider Syrians as a single homogeneous group when evaluating the effectiveness of these services. Factors such as different ethnic backgrounds, sexual orientations, physical and mental disabilities, levels of education, age, and gender play significant roles in accessing public services, including healthcare. Women within the already vulnerable Syrian population in Türkiye, due to war and migration, become subjects of many additional gender-based problems (Muhanna-Matar, 2022) and they continue facing significant obstacles in accessing healthcare, compounded by both migration-based and gender-based discrimination (Cankurtaran, 2019).

Despite relatively high satisfaction rates among Syrian women with healthcare access compared to other public services (Erdogan, 2020), ongoing challenges persist. The demand for healthcare services is especially prominent due to the huge numbers of the Syrian population in Türkiye (Chen, 2021).

The latter, in turn, stretches the system to a breaking point and accentuates its weaknesses that already exist. Within this framework, more effectiveness can be revealed when referring to E/MHCs since they are designed specifically to serve the Syrian population. However, depicting procedures attached to the legal elements such as identity cards and registration can cause Syrians to not be able to benefit from these services even if they are entitled to them (Assaf, 2018; Chen, 2021). Yet, other than capacity problems and administrative issues, sociocultural factors impose new problems on service accessibility in the first place (Ayhan Baser et al., 2021; Sürmeli et al., 2022).

As it is emphasized, the gender dynamic plays a critical role, as forcibly displaced women often encounter heightened vulnerabilities and require targeted support to ensure equitable access to essential health services. The experiences of them, who face unique health needs and problems due to the adverse effects of war and migration, with these specially designed institutions, are crucial for the future of the healthcare system. For the same reasons, the issue of sexual and reproductive health is highly important, as it is already a sensitive issue in terms of women's health.

1.2. Sexual and Reproductive Health

Sexual and Reproductive Health (SRH) services are a cornerstone of overall health, particularly for women, since they contribute to gender equality and have consequences for both mothers and children. Therefore, access to these services is essential for attaining comprehensive health objectives and enhancing the quality of life for individuals, especially within disadvantaged groups (Khozah & Nunu, 2023; Ravindran & Govender, 2020). The provision of SRH services, which also includes services such as family planning, prenatal and postnatal care, and protection against gender-based violence, is key for fostering healthy communities. However, the increase in forced migration often disrupts access to these essential services. Displaced women frequently encounter additional barriers such as access to protection and response services for sexual and gender-based violence, low levels of health literacy, insufficient cultural competency among healthcare workers, stigma (World Health Organization, 2024), social isolation, work and family duties, systemic discrimination (Vissandjée et al., 2001) all of which hinder their ability to obtain necessary care.

The impact of gender on the migration experience cannot be overstated. Women and girls face distinct risks, including sexual and gender-based violence, exploitation, and limited agency over their reproductive choices (Council of Europe, 2022; United Nations Women, 2021). Also, early marriage, insufficient contemporary contraceptive utilization, and unmet family planning needs are among the problems Syrian women have been facing in Türkiye related to the subject of SRH (Çöl et al., 2020). These vulnerabilities increase in the great migration influxes where healthcare systems are strained, and SRH services may not be prioritized. Consequently, displaced women end up experiencing higher rates of maternal mortality, unintended pregnancies, and sexually transmitted infections (Tazinya et al., 2023).

1.3. Health as More Than a Biological Function

Health is a complex notion that encompasses not just biological processes but also a diverse range of social, economic, and environmental aspects, so comprehending

these variables is crucial for formulating effective public health strategies and interventions designed to enhance health outcomes and mitigate health disparities among communities (Nicolau & Marcenes, 2012). For forcibly displaced Syrian women, access to SRH services is crucial not only for their physical well-being but also for their social and psychological resilience. However, barriers such as cultural differences, language barriers, socioeconomic constraints, and the precarious legal status of Syrian women complicate access to these essential services (Assi et al., 2019). Therefore, social exclusion literature will be integrated to gain a more holistic view for tackling the multiple nature of healthcare hurdles for Syrian women. Social exclusion refers to the exclusion of individuals or communities from important areas of social, economic, political, and cultural life. This exclusion negatively affects individuals' well-being and quality of life by preventing access to basic rights and opportunities, such as access to public health services. Furthermore, disadvantaged groups may experience the effects of social exclusion more intensely (Biggs et al., 2019).

It is evident that while E/MHCs represent a relatively inclusive and patient-centered model, significant barriers persist across both primary and secondary healthcare settings. With this study, I aim to explore the accessibility and quality of Sexual and Reproductive Health services, especially in (E/MHC) available to Syrian women under temporary protection in Türkiye. However, sexual and reproductive health services cannot be analyzed alone without discussing and examining the general health system that those services are part of. Therefore, I will not avoid looking at the general healthcare system and institutions other than E/MHCs.

I plan to do this analysis through the lens of Levesque, Harris, and Russell's conceptual framework for healthcare access (Levesque et al., 2013). This healthcare access framework provides a comprehensive tool to evaluate how well healthcare systems meet the needs of populations. It looks at the factors affecting access both from the supply and demand side and lists dimensions. Moreover, by placing similar factors into the five dimensions they have identified on both sides, it provides the opportunity to clearly show what the problems are related to. Additionally, it will be seen that at what stage in the access process these problems arise related to those

dimensions. By applying this framework, it can be systematically assessed the extent to which the Syrian population in Türkiye can access, use, and benefit from SRH services and the impact of E/MHCs. Analyzing this issue through the lens of E/MHCs is highly valuable for evaluating service delivery models for displaced persons and the most vulnerable groups in society.

1.4. Why Migrant Health Centers

Migrant Health Centers (E/MHCs), functioning as the primary access point for healthcare services for Syrians UTP in Türkiye, are crucial to my research. First, they are designed outside the general healthcare system and later integrated into it, representing a unique example of a healthcare service provision model. Second, these facilities were created specifically to serve the requirements of the Syrian population, which provides an atmosphere that reduce the unique challenges they encounter, including language and other cultural problems. They provide services to the Syrian population in their own language and by Syrian doctors and staff who share similar migration experiences, which makes them sensitive to the needs of Syrian women. Moreover, they are deliberately situated in regions with high Syrian population concentration, ensuring both geographical and social accessibility for Syrian women. The features of E/MHCs that I have mentioned here are related to the acceptability and, availability and accommodation dimensions within the framework of healthcare access that is used in this thesis, which I will explain in more detail in the following sections. Therefore, in relation to the development of these dimensions, this thesis assumes that these centers ease access to sexual and reproductive health services for Syrian women UTP in Türkiye.

Thirdly, E/MHCs are the primary healthcare institutions that represent the most basic and initial level of the healthcare system. This element makes these centers significant as the first point of contact for Syrian women with the healthcare system. For this reason, E/MHCs serve as an excellent starting point for understanding the impact of health policies on Syrians UTP. Lastly, a significant portion of the current literature on Migrant Health Centers consist of project reports and international organizations progress reports that predominantly offer quantitative data. Although

these reports are beneficial, they frequently neglect to encompass the lived experiences of patients and the qualitative dimensions of care delivery.

It is important to note here that even though E/MHCs are the central focus because of their distinct function, the services provided by state hospitals are also taken into account to provide a comparative analysis and analyze their unique position in the healthcare system.

This thesis argues that SRH access for Syrian women in Türkiye is shaped by deeply rooted systemic and interpersonal factors, which include the social dynamics surrounding healthcare interactions. Therefore, addressing the challenges requires a holistic approach that integrates structural reforms with efforts to deal with social exclusion. Moreover, I believe that only through such comprehensive measures can equitable healthcare access be realized for vulnerable populations like Syrian women.

1.5. Scope of the Study

This study examines the access of Syrian women UTP to healthcare services in E/Migrant Health Centers in Türkiye. The main focus is on E/MHCs due to their special function in meeting the needs of the Syrian population, but the services provided by state hospitals are also evaluated for comparative analysis. This approach provides a better understanding of the healthcare system that Syrian women have access to in Türkiye. Also, SRH services are examined as part of the whole without being completely separated from the context of other healthcare services. With this, I aim to understand the behaviors and needs of Syrian women in seeking healthcare in more depth.

Since my aim is to analyze the complex dynamics affecting access to healthcare, the concept of social exclusion is used as an analytical tool, considering the impact of gender as well. However, the framework that forms the basis of my study is the healthcare access model developed by Levesque and others (2013). This framework provides a comprehensive methodology to analyze the barriers and facilitators on the

supply and demand side of healthcare services. The findings aim to contribute to understanding both the structural problems of the health system and the experiences of individuals in seeking health.

1.6. Significance of the Study

This research contributes to both academic and practical domains. Practically, analyzing access to SRH services for Syrian women UTP is very important. First of all, it shows the urgent medical issues, and so, in the long run, lowers the risk of negative effects for women UTP and their households. Second, since the study underlines the importance of culturally sensitive, gender-responsive healthcare policies and interventions, the results may support the formulation of more inclusive healthcare models for marginalized populations, therefore contributing to the larger objectives of public health and social integration.

Theoretically, first, my theoretical framework allows me to study the intersection of supply and demand in healthcare services. Studying the dimensions of supply and demand in healthcare together helps us understand how these two areas interact. Instead of treating them separately, my analysis fills a gap in the literature by looking at how these two sides of access jointly affect healthcare access. Second, instead of seeing healthcare access as a result, like a utilization or satisfaction ratio of a specific service, focusing on the dimensions of access as a process allows for a deeper understanding of the concept of access in the healthcare literature. Third, it is particularly valuable as it highlights at which stages and in relation to what factors, barriers to healthcare services in Migrant Health Centers emerge. Last, this focus allows for a more detailed and in-depth examination of how systemic, interpersonal, and institutional factors intersect at different points of healthcare provision, thereby offering targeted insights for addressing these challenges effectively.

1.7. Structure Overview

The following section of this thesis will outline the theoretical framework. In the first part, social exclusion as a concept will be discovered, and the perspectives I

prefer to adopt will be examined. Following this, I will discuss the effects of phenomena such as gender and migration on social exclusion and health and elaborate on how the concept of "access" is defined within the scope of this study. The final part of the theoretical framework introduces Levesque, Harris, and Russell's (2013) conceptual framework on healthcare access, which forms the foundation of my analysis (Levesque et al., 2013).

The methodology will follow the theoretical framework, where I outline the methods used in this study. In this section, I detailed the data collection and analysis processes. Furthermore, here, it is explained how and why Levesque and his colleagues' conceptual framework is applied to analyze healthcare access.

The subsequent section explores the general situation of Syrians in Türkiye. In this section, their legal status, rights, and access to services are described with respect to international and national laws and regulations. As healthcare access for Syrians differs from that of other non-Syrian asylum seekers due to distinct legal arrangements, this section will provide a detailed account of their position within the Turkish healthcare system and will set the stage for more focused analyses in later chapters.

The following section, starting with a more detailed overview of E/MHCs, will followed by the international and national reports that serve as policy documents related to the healthcare access of Syrians. European Commission reports on health sector policies and SIHHAT Project reports prepared by the Republic of Türkiye Ministry of Health Directorate General of Public Health will form the foundation of this reports analysis section. Here, a comparison between E/MHCs and state hospitals will be made by using the healthcare access framework I adopted.

In the final chapter, I will analyze the interviews conducted with field experts, including representatives from local and international NGOs who have experiences with Syrians' access to healthcare. With the help of the theoretical framework that was developed earlier, interviews will be examined, and a comparative analysis will be generated accordingly with Levesque and his colleague's (2013) healthcare access framework.

CHAPTER 2

THEORETICAL FRAMEWORK

To organize the foundation of this thesis, I first looked at the changing meanings of social exclusion as a concept. Here, I see the intersectional nature of social exclusion and its relationships with different subjects. Following this discussion, I explained the relationship between the perspective I chose for the concept of social exclusion and "access" as a concept and discussed what kind of effects it has on access to public services in practice. In the following section, after showing what kind of relational connections social exclusion can establish in access to health services, which is also the subject of this thesis, from within public services, I touched on the possible negative health outcomes. Then, I move on to discuss how these outcomes can be affected by factors such as migration and gender and studies that show how they can create intersectional forms of exclusion and multiply, creating a vicious cycle. Finally, I examined how I can use access operationally in the subject of this thesis and why it would be more useful to use which conceptual framework in light of the issues I discussed.

2.1. Social Exclusion

First of all, the way in which you define the problems is one of the main issues while dealing with public policy. However, definitions continue to change with different processes. The definitions of the concept of social exclusion are also changed, narrowed, or expanded by different circles. Social exclusion is a multifaceted issue that results in individuals or groups being systematically marginalized from societal activities, leading to unequal access to resources, opportunities, and rights (Reimer, 2004). In his work, Reimer underlines that social exclusion “is not a condition of individuals in isolation, but an integral part of the relationships in which they are

embedded" (Reimer, 2004 p.77). From this definition of Reimer, it is understood that social exclusion has a relational meaning rather than implying something static. Also, Fraser (1998) argues that social exclusion is a form of injustice that extends beyond mere economic deprivation, occurring at the intersection of poor distribution and lack of recognition. Therefore, addressing this two-dimensional injustice requires policies that incorporate both redistribution and recognition (Fraser, 1998). The exclusion of particular groups is an indicator that the politics being considered does not always assume a representational structure (Bracking, 2005, p. 1015). If these groups cannot be represented, are they simply excluded? We cannot take the fairness of the representation systems for granted if it is going to be called inclusion. While the system in itself excludes some of the groups to be represented, it also undermines many strategic uses of power by the excluded (Bracking, 2005, p. 1022).

Focusing on how the ideological foundations of the concept of social exclusion have changed over time and how these changes are reflected in different policies and actions, Levitas (2005) has grouped the most used discourses today into three distinct groups. The first one, named redistributionist discourse (RED), highlights poverty as the main cause of exclusion, emphasizing that poverty denies individuals full citizenship rights and responsibilities. This group is thus critiquing broader social inequalities. The second one, which is the moral underclass discourse (MUD), attributes poverty to cultural factors and individual behavior and blames the poor for their situation. Furthermore, this perspective argues that welfare benefits foster dependency and undermine self-sufficiency. The last one, which is the social integrationist discourse (SID), views social inclusion primarily through labor market participation but neglects inequalities among the workforce, particularly gender disparities (Levitas, 2005, p. 14-26). Therefore, I need to examine these definitions, recognizing that the concept of social exclusion is interpreted differently by various groups across different times and geographies. As Schierup, Krifors, and Slavnic (2015) emphasize, social exclusion is both a political and analytical concept that must be understood in relation to global economic and social processes and is closely linked to issues of migration, citizenship, labor market changes, and welfare state transformations which means that it is an issue of public policy. Since this thesis is

related to the topic, I will further explore the relationship between social exclusion and migration in the following paragraphs.

Current definitions of social exclusion typically address various dimensions, such as social, economic, cultural, and political, and consider different levels, including micro (individual, household), meso (neighborhoods, cities), and macro, which refer to national and global levels (Popay, 2010). This framework views social exclusion/inclusion as a continuum operating across these diverse dimensions and levels. In their study, Crawford and others (Crawford et al., 2023), by reviewing 60 papers related to social exclusion, identified the factors affecting the social exclusion process for immigrant and refugee women in three degrees very similar to the above-mentioned levels. At the micro level, individual factors such as education, income, language ability, and personal experiences of discrimination are influenced by intersecting social identities like age, gender, ethnicity, and family roles. At the meso level, community influences include access to social and settlement services, ethnocultural organizations, and community support networks. Macro-level factors involve national policies, economic conditions, immigration laws, and societal norms impacting the broader context of social inclusion and exclusion (Crawford et al., 2023). Rather than only viewing it in levels, it is beneficial to revisit Reimer's perspective, which explains social exclusion through various relational clusters on a more equal plane. From his viewpoint, we can understand the forms of social exclusion an individual or group might encounter based on their position. His proposition provides insight not only into the interactions of intersecting identities but also into how different domains interact with one another. Reimer (2004) reveals in his work that the relationality of social exclusion is very strong and has firm ties with lots of other different components that are constantly affecting each other, and mentions four types of social relations, which are market, bureaucratic, associative, and communal, and concludes that being excluded from one form of support often leads to exclusion from other forms as well (Reimer, 2004, p. 85).

2.1.1. Social Exclusion and Access

The relationship between Bill Reimer's domains of social exclusion and the concept of access is critical in understanding how various forms of exclusion can limit

individuals' ability to access and utilize public services. Each domain of social exclusion, market, bureaucratic, associative, and communal, interacts with access in distinct ways and influences the opportunities available to individuals and groups. Exclusion from market relations, for instance, which correspond to the market domain, hinders people's ability to access necessary resources such as jobs, which affects their economic stability and ability to afford some of the essential services. This means lack of access to healthcare, education, and other public services may be the result of economic exclusion (Dykxhoorn et al., 2024). The bureaucratic domain refers to the relations with formal institutions. Exclusion in this domain may be the result of problems related to rights and regulations or lack of information and insufficient support from service providers. Those can significantly undermine accessing public services such as healthcare and social support (O'Donnell et al., 2018).

Associative relationships are based on shared interests and community participation. Social exclusion in this area can lead to a lack of social networks that facilitate access to public services, as socially isolated individuals may have difficulty finding information about available services or seeking guidance within the health system. Therefore, they may also experience problems related to access. One study emphasizing the role of social networks in terms of civic participation argues that social exclusion from associative relations has strong bonds with negative health outcomes since it hinders access to relevant public health services (Sacker et al., 2017).

The communal domain encompasses shared identities and collective experiences and is also related to culture. Individuals who feel disconnected from these may experience exclusion related to accessing public services. This may also create reluctance to access services due to discrimination or stigma, and in such a position, the individual may enter further into a cycle of exclusion (Precupetu et al., 2019). As I explained, social exclusion is closely related to the concept of access since economic, bureaucratic, communal, and associative factors play a role in individuals' ability to use public services effectively.

In order to overcome social exclusion, a multidimensional policy design is necessary that addresses barriers to access and participation for marginalized groups (Galindo

& Rodríguez, 2015). Multidimensional policy design recognizes that social exclusion is not a solitary issue but a complex interaction of multiple elements, including economic, social, cultural, and geographic dimensions. Vela-Jiménez underscores the necessity of recognizing and comprehending these complex difficulties to guide effective social policies and solutions (Vela-Jiménez & Sianes, 2021). Furthermore, policies should be designed in an intersectional manner so that the experiences of diverse groups in society can be seen and addressed (Lombardo & Rolandsen Agustín, 2016). However, it should be noted that both addressing intersectional problems through an intersectional framework in policymaking and failing to adopt such a framework or even producing no policy at all regarding a specific issue are themselves forms of policy.

From the above discussions, the conclusions drawn for the direction of this thesis are social exclusion is not a static condition experienced at a single moment; deficiencies experienced in different areas can impact other areas and contribute to overall social exclusion; exclusion may have different influencing factors at various levels; and it is dependent on mutual relational dynamics rather than a simple cause-and-effect relationship. Last but not least, social exclusion has close links with the concept of access, in our specific subject, access to public services. Thus, I can conclude that concepts such as this one are not only used to explain phenomena in academic literature but can also become policies that directly impact the daily lives of individuals.

2.1.2. Social Exclusion and Health

Social exclusion has strong bonds with public health. The World Health Organization (2010) reports that poverty and social exclusion are the primary drivers of health inequities in the European region. It impacts health directly through its effects on the healthcare system and indirectly by exacerbating economic and social inequalities that affect health, which, in turn, contribute to the processes of social exclusion, creating a vicious cycle (Mathieson et al., 2008). World Health Organization suggests some key actions to further decrease the impact of social exclusion in the health sector. First, health systems should collaborate with other

sectors in order to address the social determinants of health and ensure that marginalized communities are involved in the decision-making process. Moreover, health services should take into account the varying levels of exposure to health risks and access to high-quality healthcare for marginalized groups and design those services as a way to address the distinct needs of these groups. Finally, it is essential to incorporate the social determinants of health into the education of healthcare professionals and to guarantee that high-quality medical personnel and infrastructure are available in underserved areas (World Health Organization, 2010, pp. 10-11).

Primary healthcare services serve as an effective starting point for addressing and finding solutions to the negative health outcomes caused by social exclusion.

> As O'Donnell et al. (2018) argued primary healthcare is crucial for documenting and analyzing social exclusion related to health due to its wide reach in society, and services like general practice help mitigate the causes and effects of social exclusion daily so that healthcare professionals working in the primary healthcare recognize addressing the health issues of vulnerable patients often requires tackling the exclusionary processes they face.

Also, in the WHO Health Report on primary care, it is presented that ensuring universal access to primary healthcare would guarantee that health systems promote health equity, social justice, and the elimination of exclusion (World Health Organization, 2008) . Examining primary healthcare services, particularly migrant health centers, as the main topic of this thesis, will enhance understanding of not only the concrete barriers to access but also the impacts of social exclusion on healthcare utilization and access as a process.

In the above discussions, it is observed that social exclusion impacts healthcare services and can lead to negative outcomes for both individual and public health. How is access to healthcare services affected for groups that may experience compounded effects of social exclusion, such as immigrant or refugee women? This thesis specifically examines the access of Syrian women under temporary protection to sexual and reproductive health services. Therefore, it is beneficial to review studies conducted in other countries in this area and reports and briefings of international organizations on this issue.

2.1.3. Social Exclusion, Gender, and Migration

During the arrival and integration phase in the destination country, social exclusion has a significant impact on health outcomes where migrants' health is affected by the availability, accessibility, acceptability, and quality of services in the host environment (Gushulak et al., 2009, p. 257-258). Many studies conducted on migrants in various countries reveal that migrant women experience more health problems compared to both women in the host society and migrant men (Brabete, 2017; Krieger et al., 1993; Llácer et al., 2007; Malmusi et al., 2010; Trappolini & Giudici, 2021; van Ryn & Burke, 2000). Moreover, migrant women often face unique health challenges related to reproductive health, sexual violence, and access to healthcare services (Cabieses et al., 2024). A significant portion of studies examining the health access of migrant communities in various countries have focused on preventive health services. These studies have explored access to preventive health services by analyzing the utilization rates among migrants and highlighting the differences compared to the host society. For example, immigrant women have been found to participate in cervical screening at lower rates than non-migrant women (Taylor et al., 2001; Webb et al., 2004). It has also been determined that breast cancer tests are performed much less frequently in immigrant women than in non-immigrant women (Holk et al., 2002; Visser et al., 2005). Concerning maternal and child health, for some immigrants, especially those with irregular status, obtaining prenatal care is a critical public health issue (Gushulak et al., 2009, p. 259). Moreover, studies have shown that immigrant women are less likely to attend prenatal care services than non-immigrant women (Darj & Lindmark, 2002; Knudsen et al., 1990).

The problems women have been facing can be in diverse forms and affect each other at the same time, especially because of the gender and migration impact. Moreover, those compounded effects can lead to social exclusion resulting from the discriminatory practices and intersectional barriers women face. Bowleg (2012) emphasizes the need for public health research and policy to adopt an intersectionality framework to better address and understand health disparities among historically oppressed populations. Moreover, Krieger et al. (1993) argue

understanding inequalities in access to health requires considering intersections of multiple forms of discrimination and their cumulative effects over the life course. In order to work with such an approach, I need to better understand the concepts of access and utilization used in the literature mentioned above and determine the conceptual framework I will choose to adopt in this study.

2.2. Healthcare Access and Utilization

In this thesis, I will focus on the concept of access, which is distinct from utilization. Utilization, frequently used as a stand-in for access, is shaped by both the availability and demand for services, as well as individual characteristics such as preferences, tastes, and access to information (Daniels, 2001; Gulliford et al., 2002). Access is a concept that is far more difficult to measure than utilization and goes beyond the mere availability of the services in question (Levesque et al., 2013, p. 2). In healthcare, it is defined as individuals' and communities' opportunity to use relevant services in accordance with their needs (Daniels, 1982). The conceptualization of access in healthcare is far more complex than defining it. Therefore, I am going to look at different conceptualizations of access as a framework in the following paragraphs.

The primary goal of enhancing access to healthcare is to enable individuals to utilize appropriate healthcare services to achieve optimal health (Norredam, 2011, p. 7). Various definitions of access have been formulated. Each one aims to create frameworks that provide researchers with a more detailed and structured approach while studying access. In the broadest sense, access is a concept "that summarizes a set of more specific dimensions describing the fit between the patient and the health care system" (Penchansky & Thomas, 1981, p. 127). A newer definition developed by the Institute of Medicine depends on both the utilization of health services and health outcomes as benchmarks for determining whether access has been achieved. It emphasizes the timely use of personal health services to attain the best possible health outcomes (Institute of Medicine, 1993). Therefore, it can be concluded that utilization is not the only determinant of healthcare access, health outcomes of the populations should also be considered when referring to the degree of healthcare access.

One of the most used models for healthcare access is Andersen's model, which was first formulated in 1968 and lastly revised in 2001. It is the most commonly employed tool for identifying factors related to the utilization of health services. His model is a behavioral model that offers a theoretical framework to understand access to and utilization of healthcare services. It identifies the factors influencing an individual's decision to use or not use available health services and predicts that a combination of predisposing, enabling, and need factors impacts an individual's healthcare utilization (Andersen, 1995). However, this model is mostly criticized by scholars because it does not take into account the healthcare provider's characteristics (Norredam, 2011, p. 7). Also, in this model, the demographic characteristics of individuals receiving healthcare services are highly emphasized. Although I distinguish the research subject of this thesis by gender as a demographic characteristic, I do not seek the answers to the main questions in demographic characteristics since this is not a quantitative study. As will be seen in the following sections, the SIHHAT Project reports examining the healthcare access of Syrians in Türkiye indicate that demographic characteristics do not significantly alter healthcare utilization rates (Republic of Turkiye Ministry of Health, Directorate General of Public Health, 2020, 2022). The most significant differences in utilization and satisfaction levels vary by year, province, type of institution, type of service received, and, in some institutions, by gender (Republic of Türkiye Ministry of Health, Directorate General of Public Health, 2022). Therefore, I believe that using Andersen's model is not appropriate for addressing the questions of this study and the research methodology.

Another healthcare access model that is applicable to migrant and refugee communities is the Healthcare Access Barriers Model (HCBA) developed by Carrillo et al. (2011). They suggest a classification system that identifies three types of barriers to healthcare access: financial barriers, which include the cost of care and health insurance status; structural barriers, which encompass institutional and organizational obstacles; and cognitive barriers, which involve knowledge and communication challenges (Carrillo et al., 2011). This system offers a method that emphasizes the causal links between access barriers and negative health outcomes

but, because of this, fails to account for the overlap among various determinants of healthcare disparities.

Levesque, Harris, and Russell's (2013) healthcare access framework gives a comprehensive framework that is also used in different qualitative studies that explore healthcare access of different groups in society, such as refugees and migrants (Cu et al., 2021), which I am going to adopt in this study as well. Their healthcare access framework considers both the patient-related determinants and healthcare provider features. Thus, offers us the opportunity to examine Syrian women's access to health from both sides. Before I start examining their model, it is useful to see the concept of access with their definition so that we can see what the two-way dimensions in the model mean for access. In their definition, access is "the possibility to identify healthcare needs, to seek healthcare services, to reach the healthcare resources, to obtain or use healthcare services, and to be offered services appropriate to the needs for care" (Levesque et al., 2013, p.4). Such a comprehensive view of access, encompassing the entire pathway from recognizing the need to receiving benefits from care, is not always adopted in the studies assessing healthcare access. Accessibility of services and individuals' abilities are reciprocal that constitute the different sides of the access process and have related dimensions with each other. On the one side, there are "approachability; acceptability; availability and accommodation; affordability; appropriateness", and on the other side, there are "ability to perceive; ability to seek; ability to reach; ability to pay; and ability to engage" (Levesque et al., 2013; see Figure 1).

According to their definitions, those dimensions covered such features (Levesque et al., 2013):

> Approachability refers to the accessibility of health services, including aspects such as information availability, outreach efforts, and transparency. On the other hand, the ability to perceive mostly refers to individuals' capacity to recognize the importance of seeking healthcare and is largely influenced by their level of health literacy.
>
> Acceptability encompasses how well services align with an individual's cultural background and social circumstances, ensuring fair and suitable

service delivery. On the other hand, the ability to seek reflects an individual's inclination to seek healthcare, including factors like autonomy and knowledge about healthcare and mostly related to the cultural circumstances of the group or groups the individual belongs to.

Availability pertains to the physical and timely accessibility of services and providers, as well as their capacity to deliver services. The ability to reach, on the other side of the table, is influenced by an individual's mobility and ability to travel.

Affordability refers to both direct and indirect costs associated with accessing services, including payment methods and available resources. Affordability is determined also by the ability to pay that is an individual's ability to cover service costs without facing financial strain.

Appropriateness by considering factors such as adequacy, quality, and effectiveness relates to how well services meet patient needs. The ability to engage, on the other hand, involves personal communication and an individual's capacity to actively participate and make informed decisions regarding their healthcare.

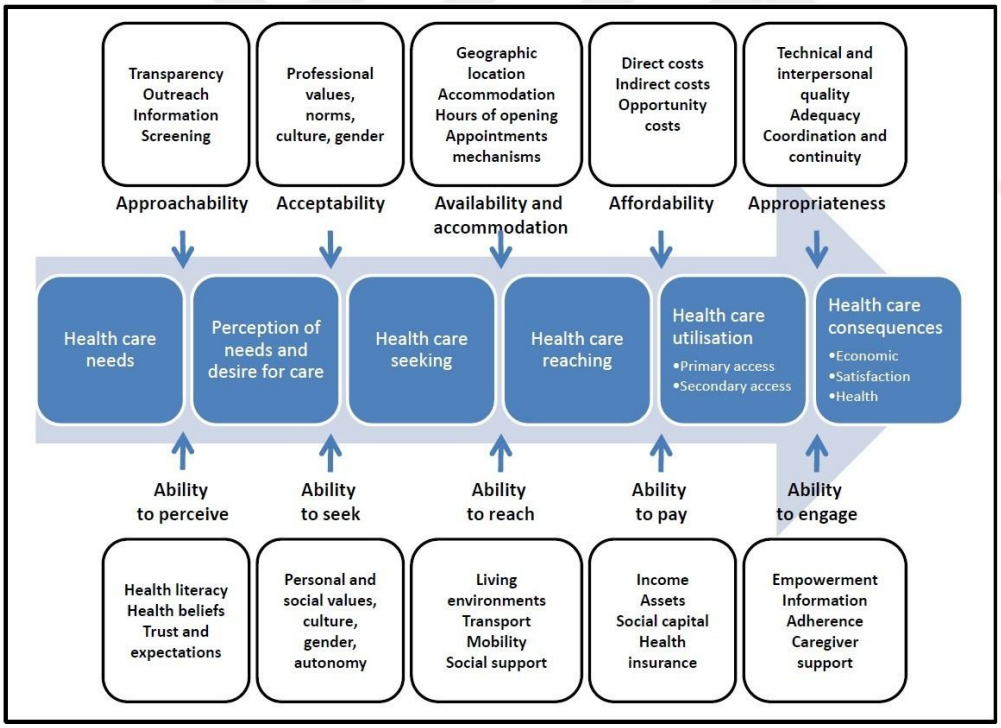

Figure 1. Healthcare Access Framework

Source: Levesque et al. (2013) Figure 2.

The reasons for selecting Levesque and his colleagues' framework for healthcare access within the scope of this study:

- The framework, rather than exclusively concentrating on shortcomings within the healthcare system, allows researchers to explore barriers to healthcare access stemming from factors like individuals' comprehension, inclination to seek, ability to access, financial means, or active engagement.
- The model defines access as the opportunity to identify, search for, obtain, secure, and utilize healthcare services that contain all the steps to meet the individuals' healthcare needs.
- It stands out as the most all-encompassing framework for understanding healthcare access.
- They conceptualized "access" not as a static notion but as an ongoing process or journey.
- The framework is adaptable to diverse societal groups, such as refugees, LGBTI+ individuals, and recent mothers utilizing maternal health services, among others.
- The framework depicts a bilateral and reciprocal relationship between the service provider and the potential service recipient, thus avoiding a one-sided perspective. Therefore, this approach will help us gain relevant insights from both sides, considering the fact that I will be interviewing intermediaries who facilitate access to services, not the service providers or receivers.

Levesque and others (2013) healthcare access framework links supply-side dimensions (health systems and services) with demand-side abilities (patients' capabilities) to analyze access problems. The IMPACT study, conducted in Canada and Australia, applied this framework to examine interventions improving primary healthcare (PHC) access for vulnerable populations (Richard et al., 2016). The findings revealed that most interventions focus on organizational aspects like appropriateness, approachability, and availability, which shows a significant supply-side dominance. On the other hand, demand-side dimensions, such as the ability to engage, perceive, and seek, received limited attention. Few policies paired supply- and demand-side dimensions, reducing their overall impact. Specific dimensions were found often linked to particular groups: approachability-focused initiatives targeted marginalized and culturally diverse groups, including refugees, to address challenges in identifying appropriate services, often through health literacy and

education. Acceptability interventions focused on Indigenous populations emphasize culturally aligned care. Interventions aimed at improving the ability to seek and engage targeted individuals with chronic diseases by enhancing autonomy and participation in care processes. Moreover, they concluded that multidisciplinary and integrated approaches that help ensure the appropriateness of services benefited populations with complex healthcare needs. The study also revealed the need for a balanced focus on both supply and demand-side dimensions to avoid limited integration between health and social care. At the end of their study, they also added that Levesque's framework successfully identifies access gaps but requires further refinement to fully capture social determinants and multilevel initiatives (Richard et al., 2016) .

Levesque and others' work includes a tiered approach; however, this particular study does not distinguish between micro, meso, and macro levels. Instead, its primary focus is on developing a conceptual framework that identifies eight levers for change in healthcare systems based on performance information. In this study on performance information and healthcare improvement, Sutherland et al. (2017) identify eight levers of change, which are "cognitive, mimetic, supportive, formative, normative, coercive, structural, and competitive". These levers illustrate how performance measurement can be integrated into quality improvement programs to drive systemic enhancements.

Jean-Frederic Levesque's research extensively applies his conceptual framework to analyze healthcare access and performance evaluation. In another significant work about experiences and outcomes of hospital care between Aboriginal and non-Aboriginal patients in Australia, he and his colleagues examine the differences in hospital care experiences and outcomes (Sutherland, Hindmarsh, Moran, and Levesque, 2017). The findings in this study show us clear inequalities and highlight the need for targeted interventions to address inequities in healthcare delivery. According to this study, there are significant disparities in hospital care experiences between Aboriginal and non-Aboriginal patients. Aboriginal patients were less likely to report that doctors always answered questions understandably (66% vs. 74%), provided sufficient home care information (68% vs. 73%), or made adequate

discharge arrangements (64% vs. 70%). Fewer Aboriginal patients felt that care was effective (70% vs. 77%), and more reported complications from care (22% vs. 16%). Additionally, cultural or religious respect was slightly lower for Aboriginal patients. In the end, the authors emphasized the significance of patients' care experiences, highlighting that they not only reflect how well healthcare providers meet patients' expectations but also influence clinical outcomes. Moreover, they added that effective communication and respectful interactions by clinicians enhance treatment adherence, educate patients about symptoms, involve them in decision-making, and ultimately lead to improved health outcomes (Sutherland et al., 2017, p. 17).

The findings of the study can be effectively linked to Levesque's dimensions of appropriateness from the supply side and ability to engage from the demand side. The inequalities in hospital care experiences are directly correlated with how appropriate the services are to the group’s needs and their ability to engage in the healthcare process. The appropriateness dimension, as I have said before, focuses on the quality, adequacy, and cultural relevance of care. The study reveals that Aboriginal patients were less likely to report positive care experiences, such as understandable communication, adequate discharge arrangements, and cultural or religious respect. It shows that poorer care experiences and a higher incidence of complications result because of health services that do not address the specific needs of Aboriginal patients. The ability to engage dimension emphasizes patients' capacity to participate actively in their care. Factors like effective communication and respectful interactions are critical for building trust and enabling patients to make informed decisions about their treatment. The study shows Aboriginal patients' limited engagement as a result of barriers like unclear communication or insufficient involvement in care decisions, and this negatively impacts their adherence to treatment plans and overall health outcomes.

Levesque's (2013) conceptual framework can be utilized not only for comparisons between different groups but also for comparisons across various diseases. Another article that investigates the financial burdens faced by individuals with chronic illnesses in Australia demonstrates that high out-of-pocket expenses cause some patients, particularly those with mental health conditions, to forego necessary care

due to cost concerns (Callander et al., 2017). According to the study, people with depression, anxiety, and other mental health conditions are 7.65 times more likely to skip healthcare due to costs, while those with asthma, emphysema, or chronic obstructive pulmonary disease have 6.16 times higher odds of abandoning care compared to individuals without health conditions (Callander et al., 2017, p. 4). The findings underscore the necessity for enhanced focus on the affordability and accessibility of care, especially for mental health services, since financial obstacles inherent in Australia's healthcare result in an unequal burden on those with chronic conditions.

There are also studies that he is a part of measuring and analyzing the influence of different healthcare access dimensions. One of Levesque's articles attempted to develop a new criterion to minimize the differences that may occur in rural and urban areas when evaluating the availability and appropriateness of health services. The criterion they developed evaluated the physical accessibility of the points where patients first contact health services, waiting times, and the sensitivity of the services to the community they serve (Haggerty & Levesque, 2017). With the criterion they developed, they improved the validity of the dynamics related to the availability of the health service model from the supply side and the ability to reach from the demand side. These two dimensions became more compatible with each other after the study.

Another study, in which Levesque was also an author, focused on whether the gender of the employees in primary health care institutions affected the patients' experiences and conducted an analysis on the acceptability dimension. As a result, they observed that the gender element was not very effective on this dimension, and found that other factors were more effective in evaluating the quality of care experiences (Pineault et al., 2017). The inference that can be made from this is that the acceptability and appropriateness of services to the patient's needs may depend more on reasons independent of gender and that different factors may come to the fore in different contexts. The results of similar studies may vary due to different elements that affect appropriateness and acceptability dimensions, such as religion, culture, and patient's gender.

In the aforementioned studies, I observed methodologies illustrating the application of the conceptual framework across diverse topics. Levesque and others' healthcare access framework facilitates the examination of healthcare access barriers among different populations with varying demographic characteristics, presents health reform trends from a policymaker's perspective, and delineates supply and demand aspects as distinct yet interconnected entities. Additionally, it enables focused analysis of individual dynamics within the framework and integrates the treatment access processes of different diseases as components of a cohesive whole.

These studies collectively emphasize the practical use of Levesque's conceptual framework in recognizing and mitigating obstacles to healthcare access and performance. Levesque's study, by examining multiple dimensions of healthcare delivery, provides a thorough understanding of the elements impacting healthcare accessibility and quality, from systemic levers of change to patient-specific issues. This perspective provides a comprehensive basis for formulating successful measures to improve healthcare systems and ensure equal access for all demographic groups. Using this model also offers a thorough method for examining the supply-side structures of healthcare systems alongside the demand-side capacities of individuals to interact with these systems.

In the following sections of this thesis, I will link the theoretical insights outlined here with the specific context of Syrian women UTP in Türkiye. In order to contextualize and deepen the understanding of their access to healthcare services, the general conditions of Syrians in Türkiye, legislative frameworks, reports, and healthcare system will be discussed. With this particular route, I aim to bridge abstract theoretical concepts with the tangible realities of healthcare access and to provide a cohesive narrative that connects systemic exclusion to practical implications in healthcare access.

CHAPTER 3

METHOD AND METHODOLOGY

3.1. Research Design

Since it focuses on the healthcare access landscape in Türkiye, the research design can be classified as a case study. This design was chosen due to its suitability for exploring complex, context-specific phenomena (Yin, 2014). Moreover, the study adopts triangulation as a policy evaluation tool and research strategy to explore the healthcare access experiences of Syrian women UTP in Türkiye. Triangulation refers to a strategy where the researcher uses multiple forms of methods, data sources, or theoretical frameworks to ensure the validity and reliability of the research (Denzin, 1978; Patton, 1999). With this strategy, I can verify and support the findings by cross-checking the information from different resources. Therefore, it serves as a strategy that strengthens the case study design.

I followed a three-step path to conduct my analysis and used different data sources. First, I explored how Syrian women in Türkiye can access sexual and reproductive health services by looking at national and international legal regulations. My goal in this stage was to understand the context of the topic by evaluating the current situation and creating a framework for my future discussions. Second, I read international and national reports on this subject. These reports included both new developments in healthcare for forcibly displaced populations in Türkiye and the data resulting from the surveys conducted with Syrians. Since the number of people participating in the surveys was high, I thought that the outputs of these reports would be strong in terms of generalizability. While some of these surveys provided information on the health status of individuals and the utilization rates of the services, the other sections looked at the problems encountered while accessing

healthcare, which was the most crucial section for my research. I connect the relevant data with the dimensions within Levesque et al.'s (2013) healthcare access framework that I used in my study as the primary analytical tool. While analyzing the legal documents, I strengthened my understanding of the supply side of healthcare access, and through international and project reports, I shaped my findings from a position that provides a more balanced perspective on both supply and demand.

In the last stage of my study, I conducted semi-structured interviews with twelve people from NGOs working on Syrian women's access to health. At this stage, I obtained my data from a position closer to the service recipient side. Again, as I did in the previous stage, I placed the results of these interviews in relevant dimensions within Levesque's framework of healthcare access and established connections. While analyzing that information, I also touched upon the laws and regulations and the results of the reports that I discussed in the first stages. I performed data triangulation by combining the information I obtained from different sources with Levesque et al.'s (2013) framework of access to health. In addition, I performed methodological triangulation by evaluating the results of different methods such as report review and interview together.

3.2. Research Setting

In the third stage, fieldwork was conducted through interviews held with various NGOs in Ankara. The choice of Ankara was influenced by its role as a central hub for migrant-related services and its concentration of organizations working with forcibly displaced populations. At the same time, Ankara is one of the top 10 provinces where Syrians reside the most. According to the Presidency of Migration Management (2024, November 28), 85.754 Syrians are living in Ankara, but it should be noted that this number presents the registered Syrians. Another reason for choosing Ankara is related to the limitations such as budget and time constraints, which necessitate a localized focus. Although the third stage was based in Ankara, the reports and literature analyzed encompass data and findings from across Türkiye. This combination allows us to form a nuanced understanding of local dynamics while also situating them within a broader national context.

3.3. Sampling Strategy

The snowball sampling strategy was employed in the third stage of my study, which is particularly suited for accessing those with specific expertise in a field (Biernacki & Waldorf, 1981). Having previously volunteered for NGOs in the field of forced migration gave me a starting point for finding interviewees. NGOs were selected due to their dual perspective on healthcare provision, as they interact with both service providers and recipients. The "in-between" position of Levesque et al.'s framework allows us to conduct a much more comprehensive examination of access in our study. Initially, contacts were established with key representatives in NGOs, and subsequent participants were identified through their recommendations. In total, 12 individuals participated in the interviews. These participants were selected based on their expertise and experience in projects and initiatives related to Syrians' access to healthcare. This approach ensured that the sample consisted of individuals who could provide insights into both service provision and user experiences.

3.4. Data Collection

As I have touched upon, three distinct yet interconnected data sources were utilized, which are legal documents, national and international healthcare reports, and semi-structured interviews with NGO representatives. The first phase involved a review of national and international legal frameworks, including the Temporary Protection Regulation and related health documents and policies. This provided a basic understanding of the structural context in which health services are provided to Syrian women. In the second stage, I collected survey data from the national and international reports, which serve as policy documents for my case. Particular attention was given to sections addressing healthcare access issues, as they were directly relevant to the study's objectives. In the final stage, semi-structured interviews are employed as the primary data collection method to gain in-depth insights into the healthcare access experiences of Syrian women UTP in Türkiye. Semi-structured interviews were chosen for their flexibility, allowing participants to share detailed narratives while ensuring the discussions remained aligned with the research objectives. An interview guide was developed based on Levesque et al.'s

(2013) healthcare access framework. The guide included open-ended questions designed to explore barriers and facilitators related to the dimensions. Examples of questions include: “What are the main challenges in accessing healthcare for Syrian women?” and “How do you perceive the role of Migrant Health Centers in addressing these challenges?” The interviews were conducted in a face-to-face setting, and audio recordings were made with participants' consent. On average, each interview lasted approximately 60 minutes.

3.5. Data Analysis

I conducted my data analysis through the thematic analysis method, which is guided by Levesque et al.’s (2013) healthcare access framework. In the first two stages, I analyzed two types of sources: national and international legal regulations and international and national health service reports. Official government websites, academic databases, and the archives of organizations such as the European Union, World Health Organization, and United Nations Refugee Agency have been examined to collect data in this stage. While analyzing the selected documents, I focused on certain thematic areas. In determining these areas, asking the following questions was effective: what laws are regulating access to health services, what obstacles or facilitators do the reports emphasize, and how are the scope and accessibility of health services defined? I identified key areas and concepts related to both the barriers and facilitators of healthcare access. For example, issues related to language barriers were examined, and causes were identified as codes. One among those causes was the limited presence of interpreters. This code is then grouped into a broader theme corresponding to the dimensions of the healthcare access framework adopted in this study. In this context, it was appropriateness. This stage helped me understand the core messages and dominant themes presented in the data.

In the last stage, where I conducted my interviews, the process began with the transcription of audio-recorded interviews, which were then reviewed alongside legal documents and healthcare reports. I applied the same coding process. Moreover, to ensure the validity and reliability of the information that is driven from interviews, I cross-checked them against findings in the first two stages. The next phase included

bringing together the themes developed in the previous stage into a thematic map that indicated how each of the graph components was related to other components of the dimension of access. This stage was founded on Levesque's framework of analysis, making sure that both the supply-side and the demand-side dimensions of access have been discussed.

Lastly, I went through the themes in light of the research questions as well as the general theoretical framework of the study. This included examining how structural and systemic barriers intersected with individual-level factors, which together shape healthcare access for Syrian women UTP.

3.6. Ethical Considerations

Before starting the interviews in the third stage of my study, I obtained ethical approval from the Middle East Technical University ethics committee. While reaching for potential interviewees, ethical approval was shown, and a prewritten information text was sent and explained, containing my and my supervisor's information and the subject of the thesis. During the interviews, participants were asked to read the consent form and sign it if they deemed it appropriate. They have also been told that they can omit questions if they do not want to answer and terminate the interview whenever they want. Participants were informed that their names and the names of their institutions would remain confidential and would not be included in the study. Audio recordings were deleted after the interviews were analyzed.

3.7. Limitations of the Methodology

Although the methods I used had many strengths for the study, there were also some drawbacks. First of all, using the triangulation strategy created difficulties in the process of integrating different data sources (Mathison, 1988). Conflicting information in the data sources increased the complexity of the analysis and made the processes time-consuming. Moreover, related to the third stage of data collection, the interviews with NGOs were conducted in Ankara, which may decrease the

generalizability of results. This was a result of time and budget constraints. In addition, the initial contacts with the representatives of NGOs were problematic since some were reluctant to get involved in the study due to the sensitivity of the subject and confidentiality concerns. Another problem related to interviews was the difficulty of reaching the right people inside the organizations with the most experience and knowledge about Syrian women's access to SRH services. This problem was related to the frequent staff turnover and rotation of the personnel in the organizations.

CHAPTER 4

GENERAL CONDITIONS OF SYRIANS IN TÜRKİYE

This chapter examines the current national and international legal regulations regarding the general situation of Syrians in Türkiye. Starting from fundamental international documents such as the 1951 Geneva Convention and its 1967 Protocol, Türkiye's national legal frameworks, such as the Law on Foreigners and International Protection and the Temporary Protection Regulation are examined.

Although these regulations aim to ensure that individuals under temporary protection have access to fundamental rights, they are limited by the difficulties encountered in practice, bureaucratic obstacles, and social inequalities. In addition, the importance of access to health services in the context of gender equality is stressed, and the regulations for accessing the right to health and reproductive health services are discussed in light of international laws and regulations. The chapter evaluates the opportunities and limitations that are provided by these regulations and sheds light on the challenges and facilitators that Syrians may face within this legal framework.

4.1. Key International and National Legislation on The Rights of Non-citizens

In this section, the 1951 Geneva Convention, which forms the basis of international refugee protection law, the Law on Foreigners and International Protection (LFIP), which has an important place in Türkiye's migration management, and the 2014 Temporary Protection Regulation will be discussed. Addressing how Türkiye's national and international legal regulations provide a framework for Syrians UTP to access basic rights and services is of critical importance in understanding the practical effects of this legal framework. In the context of this thesis, evaluating the opportunities and limitations contained in these legal regulations will provide a basis

for us to better understand the structural and individual dynamics behind the obstacles encountered in accessing health services. Moreover, this analysis aims to make sense of Syrian women's experiences of accessing the health system within the broader framework of social exclusion.

> The term "forcibly displaced" primarily corresponds to the concept of refugees, defined by the 1951 Geneva Convention as individuals unable or unwilling to return to their country of origin due to a well-founded fear of persecution based on race, religion, nationality, membership in a particular social group, or political opinion (Convention Relating to the Status of Refugees, 1951).

Refugees can seek refuge different countries and may apply for asylum, a legal protection granting them temporary or permanent residence. The Geneva Convention was established by the United Nations in response to the post-World War II refugee crisis and stands as a fundamental document in international refugee law. The combination of the 1951 Convention and its 1967 Protocol serves as the cornerstone of the international legal framework for refugee protection (Protocol Relating to the Status of Refugees, 1967). Moreover, Article 90 of the Turkish Constitution ensures that these international agreements hold supremacy over domestic law (Constitution of the Republic of Turkey, 1982).

Due to the geographical limitation Türkiye placed on the 1951 Geneva Convention, the term "asylum seeker" used for individuals coming to our country and seeking asylum due to events outside of Europe has been clarified. These individuals are referred to in Türkiye as "conditional refugees". Furthermore, foreigners who do not meet the criteria for being a refugee or conditional refugee but are at risk of death, torture, or personal threat in conflicts if returned to their country, are provided with "subsidiary protection" (Law on Foreigners and International Protection, 2013) in accordance with the non-refoulement principle required by the European Convention on Human Rights and other human rights treaties to which Türkiye is a party.

As of mid-2024, there are 37.9 million refugees worldwide, with 6.5 million being Syrian refugees (United Nations High Commissioner for Refugees, 2024, October 8), and Türkiye hosts 3.148.663 forcibly displaced people (UNHCR, 2024, October 8)

among them, 2.936.252 are from the Republic of Syria (Presidency of Migration Management, 2024, November 28). Refugees may qualify for diverse forms of support, such as housing, medical care, education, and financial assistance, depending on the policies and programs of the host country. Nevertheless, accessing these services can pose challenges for refugees, attributed to factors like legal and regulatory obstacles, language and cultural disparities, and a lack of proper documentation. To avail themselves of public services, refugees often need specific documents or permits, like a refugee or asylum seeker identification card or a work permit. These credentials can be issued by the host country's government or international bodies such as the United Nations Refugee Agency. In Türkiye, government organizations oversee the issuance of these documents. However, Türkiye, having accepted the 1951 Convention with a geographical restriction, is not obligated to give refugee status to individuals from outside Europe. Consequently, refugees from Syria in Türkiye hold a temporary protection status rather than a refugee status. Therefore, the population who had to migrate to Türkiye due to the war in Syria will be referred to in this study as Syrians with temporary protection status rather than as refugees. A problem related to using this status while referring to Syrians in Türkiye is that they might be irregular migrants who have not yet registered with authorities, and they might have lost this legal status due to the restrictions on registrations to defined areas.

In addition to the Geneva Convention and its Additional Protocol, Türkiye has involved itself in national legislation to manage the flow of non-citizens, especially refugees and asylum seekers. The 2013 Law on Foreigners and International Protection (LFIP) has functioned as the umbrella legislation in controlling migration into the country and in trying to safeguard the rights of foreigners who enter the country. It is a law providing procedures for international protection, stating the rights and obligations of asylum seekers and refugees, and appoints the Presidency of Migration Management (PMM) as the main authority responsible for applying such regulations. Furthermore, the Temporary Protection Regulation dated 2014 is a regulation that regularized the needs of Syrians who had fled the conflict and sought refuge in Türkiye. This regulation provides a legal ground for the temporary protection status for Syrians, defines access to basic rights and services such as

health care, education, and social aid, and outlines limitations for accessing these rights, including freedom of movement and requirements to reside in certain areas unless permission is granted for relocation. While temporary protection offers certain rights, it also imposes limits upon them.

The influence of international human rights conventions on policies about the rights of non-citizens can also be noted in the case of Türkiye. Türkiye, being a party to the European Convention on Human Rights (ECHR) and several other international treaties, is, as I have mentioned before, under the obligation not to return a person to his country of origin where he will be persecuted, tortured, or subjected to inhuman treatment. This principle is one of the very cores of the protection of refugees and asylum seekers and is explicitly realized in different international and national legislative initiatives. However, discussions about whether post-war regions are safe, where the conflict is ongoing, and how the situation will evolve, similar to current debates regarding safe zones in Syria, are likely to continue. Also, the fact that Syrians in Türkiye are not refugees because of the geographical restriction puts them in a distinctive position. Consequently, uncertainties related to the principle of non-refoulement may arise from time to time, particularly during periods of negotiation and transition.

Despite all this legislative infrastructure, challenges abound in practicing the rights of a non-citizen, more so those under temporary protection status. Auxiliary difficulties that stand in the way of implementing the laws are inefficiencies in bureaucracies, limited access to information, and socio-economic inequalities. In addition, the volatile nature of flows of migration - and the increasing population of irregular migrants - provides additional challenges to the Turkish government in maintaining a balance between concerns about national security and the protection of human rights.

To these, the contribution of international organizations and NGOs in supporting the rights of non-citizens in Türkiye goes beyond discussion. There are services provided through legal aid, psychosocial support, and integration programs for the use of UNHCR and other international organizations, such as the International Organization

for Migration (IOM) and several local NGOs. These works support the initiatives of the Turkish government to overcome the existing deficiencies in service delivery to non-citizens, especially in under-served locations and in areas affected by the February 6 earthquake that happened in 2023.

Two key laws regarding access to fundamental rights and freedoms are discussed. Now, I will delve deeper into who is eligible to benefit from these laws and explain the legal statuses of other communities living in Türkiye who have migrated from countries other than Syria since one needs to be aware of the different legal statuses these persons bear, as the legal regime in Türkiye varies depending on the origin of the migrants and their various situations.

4.2. Categories of Protection for Non-Citizens in Türkiye

The following information about the categorization of different legal statuses is taken from the Presidency of Migration Management's (n.d.) website.

4.2.1. Conditional Refugees

Since Türkiye applied a geographical limitation to the 1951 Geneva Convention, refugee status is granted only to those fleeing from European countries. Nevertheless, the nationals of the non-European states who apply for asylum in Türkiye are considered to be "conditional refugees." The latter are allowed to temporarily stay within the territory of Türkiye until their readmission to a third country. The LFIP forms a legal basis for conditional refugees who enjoy a scope of rights, ranging from access to basic services and the possibility of acquiring work permits to enjoying legal protection; this status, however, is accorded with the proviso that it be temporary.

4.2.2. Subsidiary Protection

The subsidiary protection status refers to those persons who are not recognized as refugees or conditional refugees but, if returned, would be exposed to serious harm in

their home country. This includes, for example, nationals from countries with widespread violence or conflict, such as Afghanistan and Iraq. In turn, subsidiary protection offers some sort of protection that is close to being a refugee, even though it is generally more limited in scope. Subsidiary protection persons enjoy rights associated with access to education, health care, and social assistance, according to the LFIP.

4.2.3. Temporary Protection

In 2014, the Temporary Protection Regulation was enacted to assist Syrian nationals who fled the conflict in their homeland and arrived in Türkiye. Those under temporary protection not only have a range of rights to health facilities and educational services but also to social services. While the conditional refugees and those under subsidiary protection are facing resettlement with priority, Syrians under temporary protection do not face immediate resettlement but are allowed to stay in Türkiye with access to many of the same services available to Turkish citizens. This status is exclusive to Syrians, something underlining the size of the Syrian crisis and the need for a comprehensive and immediate response.

4.2.4. Irregular Migrants

Irregular migrants include all those who enter or stay irregularly on Turkish territory. This includes entry, whereby a person may have been admitted into Türkiye legally but overstayed the validity date of their visa or crossed the border without proper documentation. Irregular migrants do not benefit from the same safeguards as those under-recognized statuses, such as conditional refugee or temporary protection. Nevertheless, international human rights law still entitles them to certain basic rights, which, inter alia, include very basic rights, such as emergency health care and protection from forced return to the country of origin where they may face danger.

There are many people in Türkiye from various countries, including Syria, Afghanistan, and Iraq, who have fled from war or conflict zones. Many of these individuals entered the country without registration, which makes the number of people in this category uncertain.

4.2.5. International Protection Applicants:

Third-country seekers who apply for international protection in Türkiye but have not received any status yet are treated as applicants for international protection. This status is a temporary classification while their applications are under process. It is during this period that applicants are entitled to basic services such as shelter, healthcare, and legal aid. The LFIP governs the rights of applicants for international protection and respective responsibilities, making sure that their basic needs are catered for while such cases are under review.

4.3. Applicability of the LFIP and Regulation on Temporary Protection

4.3.1. Law on Foreigners and International Protection:

The LFIP was designed to create a general legal regime that will cover all foreigners entering Türkiye or currently within its borders, including those seeking international protection. It deals with conditional refugees, subsidiary protection beneficiaries, and applicants for international protection in general. It regulates their access to basic services such as education, social aid, employment, and legal protection. It further provides the procedural rights of these categories: the right to appeal, to legal counsel, and to dwell in selected areas.

For the non-European asylum seekers, most of them from countries like Afghanistan, Iraq, and Iran, the LFIP is the basic legal framework that regulates their stay in Türkiye. It gives them the relevant protection while they are waiting for resettlement or other long-term solutions. However, particularly in terms of long-term residency and integration, their rights under the LFIP are generally more limited compared to Turkish citizens. Article 91 of this law regulates temporary protection (LFIP, 2013).

4.3.2. Regulation on Temporary Protection:

The Temporary Protection Regulation thus serves the needs of the individuals who escaped the civil war in Syria. In line with this regulation, Temporary Protection

Identity Documents given to Syrians are issued. Each ID includes the foreign identity number of the person in question, as in the Turkish citizen's identity cards. This special status grants extensive rights and services compared to other nationals due to the vastness of Syrian refugee crisis. During the application of the regulation, the Syrians UTP (under temporary protection) will benefit from a wide array of services, such as health, educational services, social assistance, and the right to work. However, these services are conditioned by several restrictions, such as obtaining a work permit. Foreigners within the scope of this regulation are required to declare their address. Related to this obligation, they are provided with the right to access public services and other social assistance provided that they are in the provinces where they declared. Also, foreigners with a temporary protection identity document can apply to the Ministry of Labor and Social Security to obtain a work permit in the sectors, business lines, and geographical areas determined by the Presidential Cabinet.

The cancellation of Temporary Protection Identity Cards is carried out by the Presidency of Migration Management when necessary. For example, temporary protection records of individuals who are not at the declared address during address determination and who do not report current address information may be canceled. Actions that will disrupt public order, endanger national security, and certain crimes in the Turkish Penal Code are also among the reasons for the cancellation of identity cards. A person who cannot renew his/her identity will be deported from the country.

The Migration Board was established by a presidential decree; the procedures and principles regarding the services to be provided to foreigners are determined by this Migration Board. This board is established under the Presidency of Migration Management bodies, so the services provided by the relevant ministries and public institutions and organizations are carried out under the coordination of the Presidency of Migration Management. On the other hand, health services provided or commissioned are carried out under the control and responsibility of the Ministry of Health. A co-payment for basic and emergency health services, treatments, and medicines within this scope may be collected from individuals based on the amount or rate determined by the ministry.

Although designed essentially for Syrians, the Temporary Protection Regulation has established a precedent for how Türkiye may respond to large-scale influxes of either refugees or displaced persons in the near future. It should be noted, however, that this regulation is not applicable for non-Syrians but rather is placed under the LFIP. The differentiation underlines the different approach Türkiye has followed until now toward the various refugee and migration crises, providing a specific legal status to Syrians in light of the peculiar circumstances surrounding their displacement. However, as it is mentioned in the subsequent paragraphs, temporary protection status can be taken away from people just as it is granted. If it is deactivated, the person's identity used in Türkiye becomes invalid, they cannot benefit from public services, and they can be deported from the country.

> Regarding the termination of temporary protection in effect in the temporary protection regulation, the Presidential Cabinet may decide to limit or temporarily or indefinitely suspend temporary protection measures in the event of conditions that may threaten national security, public order, public safety, or public health (Temporary Protection Regulation, 2014).

The comparative analysis of national and international regulations that I conducted in this section of the thesis reveals both opportunities and limitations in Türkiye's practices towards forcibly displaced persons and individuals under temporary protection. The 2013 Law on Foreigners and International Protection (LFIP) and the 2014 Temporary Protection Regulation are compatible with Türkiye's international refugee protection regime; however, they also have a legal infrastructure shaped according to the national priorities. The provision of comprehensive rights by the temporary protection status, especially for Syrians, provides an important framework as a response to international humanitarian crises. However, the implementation of these regulations is overshadowed by practical difficulties such as restrictions related to residence address, settlement restrictions in certain regions, and bureaucratic obstacles to accessing services.

Although this legal framework has provided significant progress in accessing fundamental rights, the temporary nature of the statuses and the fact that access to services is subject to certain conditions limit the long-term integration and social participation of individuals. In particular, the article "Termination of Protection

Status" in the Temporary Protection Regulation shows how sensitive ground this status is.

As a result, Türkiye's national regulations and the practical implementation of these regulations present a complex picture in terms of access to rights for forcibly displaced individuals under temporary protection. Türkiye has developed different approaches and systems for different refugee and migrant groups. Within this system, special status and rights have been defined for Syrians. However, this system still has aspects that need improvement to ensure long-term integration and a sustainable solution.

The national and international regulations I have examined above provide an important framework for ensuring access to fundamental rights, especially for individuals under temporary protection status; however, it is difficult to understand the effectiveness of these regulations by using only a general legal and policy framework. Gender perspective should also be included to this discussion since inequalities in access to health services cannot be fully resolved without understanding the specific difficulties faced by women and other disadvantaged groups. Considering that this thesis also focuses specifically on women and sexual and reproductive health, it is necessary to mention international gender equality laws and principles on this issue. Therefore, considering the following section as a separate makes it possible to discuss in more depth the dimensions of the social exclusion in question and what needs to be done in this area in the following discussions.

4.4. International Legislation on Gender Equality in Healthcare

As part of the Gender Equality Monitoring Project, the health rights and norms related to gender equality in access to healthcare services are outlined as follows: gender equality, equality of differences, transformative equality, accessibility, and quality (Akın & Türkçelik, 2018). The fundamental standards for these include establishing primary healthcare services that are easily accessible, affordable, and of high quality. It is especially emphasized that marginalized and disadvantaged groups

should have unrestricted access to all types of health services related to sexual and reproductive health (Akın & Türkçelik, 2018). In 1948, the World Health Organization established in its constitution that health is a fundamental human right (Constitution of the World Health Organization, 1948). That same year, the Universal Declaration of Human Rights (1948) defined health as one of the most basic human rights.

Another significant step in recognizing this right was the World Health Organization's Alma Ata Conference. The focus of this conference was the concept of primary healthcare. According to this approach, priority in healthcare should be given to preventive services, and the protection of health is the responsibility of states (Alma-Ata, 1978). One of the most important documents related to women's access to healthcare is the "Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), " which was opened for signature in 1979 and signed by Türkiye in 1985. This document emphasized that women still do not have equal rights with men in health and there is a necessity for states to take the additional measures to achieve this equality (Convention on the Elimination of All Forms of Discrimination against Women, 1979). Moreover, article 12 of CEDAW (1979) states that women should be provided with free healthcare services when necessary, during pregnancy and the postpartum period.

> In relation to the norm of respect for human dignity, CEDAW (1979, pp. 2-6) has outlined several criteria, including “the right to access quality healthcare, the prohibition of ill-treatment, the prohibition of discrimination, respect for physical and mental integrity, respect for cultural and religious differences, the right to access information, and respect for private life”.

> In general comment number 14 adopted in 2000, The United Nations Economic, Social and Cultural Rights Committee (2000) has assigned the responsibility to states parties to the convention to ensure that "everyone, including prisoners, detainees, minorities, asylum seekers, and undocumented immigrants, has access to preventive, curative, and rehabilitative health services”. It also emphasized the responsibility of states to protect groups that may face disproportionate, multiple, and intersectional discrimination in accessing health services.

The integration of Sexual and Reproductive Health services into the general healthcare system is of great importance as well. This entails delivering services in a

way that ensures individuals receive comprehensive SRH (sexual and reproductive health) support across their lifespan. Services should be coordinated across various healthcare levels and locations, both within and outside the health sector, to provide effective care (WHO, 2018). The integration of SRH services holds significance as each aspect within these services is interconnected with others (WHO, 2023).

CHAPTER 5

SYRIAN'S ACCESS TO HEALTH SERVICES IN TÜRKİYE

5.1. Relevance of National Regulations to Healthcare Access

Since healthcare access is the main subject of the thesis, I will now examine in detail the development of access to healthcare services for Syrians in Türkiye over time, the relevant laws and regulations, the institutions providing these services, and the specific services offered.

Türkiye, before the adoption of the Law on Foreigners and International Protection in 2013, the legislation related to international migration management was fragmented, with no comprehensive regulation in the area of international protection (Işıkçı, 2017, p. 32). Therefore, policies in this area were implemented through narrow, short-term regulations and directives that were periodically created in response to specific migration events. The increasing population of Syrians outside the refugee camps called for the need to regulate health care services. An initial step in this direction occurred on January 18, 2013, with a circular issued by the Disaster and Emergency Management Authority (AFAD), facilitating Syrians' access to hospitals and healthcare centers at no cost. This circular was issued to set up more organized and regulated access to health care for Syrians living outside the camps. Before this circular was enacted, healthcare services for Syrians outside the camps were relatively disparate and depended largely on international and local resources and initiatives. To receive compensation for preventive and medical care expenses, out-of-camp Syrians were required to apply to healthcare institutions in ten cities where temporary accommodation centers were established. Consequently, Syrians with a temporary protection identity card and a valid application were granted the right to avail themselves of free healthcare services throughout Türkiye. The circular

coordinated AFAD with the Ministry of Health of Türkiye in making public health facilities accessible to Syrians. This development was one of the most significant steps taken at that time to enhance the approachability and availability dimensions of access in Levesque's healthcare access model. It made sure that state hospitals and health centers could provide any needed medical care to this population. Syrians had to provide a number of documents to access these services, which included a temporary protection identity card that would help the authorities keep track of service users, hence using resources efficiently. This circular covered all possible services connected with treatment: preventive, emergency, and routine treatment. This made it easier for Syrians to get medical aid for a myriad of health problems without the huge financial costs associated with such care.

This temporary provision was formalized into a permanent arrangement through the October 2014 Regulation on Temporary Protection. This regulation explicitly provided access to a comprehensive range of rights, encompassing health services and social assistance (Icduygu, 2016). However, an already overburdened and understaffed primary healthcare system found itself unable to cope with the sudden increase in demand. The constraints within the primary healthcare system also added to the strain on hospitals. Therefore, a more organized and cohesive healthcare system for Syrians was outlined in the "Administration Circular on Health Benefits for Temporary Protection Beneficiaries" released in November 2015. This circular played a crucial role in governing the operations of different entities involved in health services, including public institutions, NGOs, and charitable organizations, and identified the recipients of the health services. It is therefore served to standardize healthcare services to Syrians all over Türkiye. It looked at standardizing the services both in quality and scope, regardless of which part of the region the beneficiaries were. These efforts were related to the appropriateness dimension of Levesque's framework since it includes the desire to increase the general quality and adequacy of services. The circular gave elaborate instructions as to the kind of healthcare services that should be offered, protocols that healthcare providers are to follow, and so forth.

Among the objectives foreseen in the circular was the improvement of coordination relating to the various bodies involved in the delivery of healthcare services

(Administration Circular on Health Benefits for Temporary Protection Beneficiaries, 2015). This involves public institutions, including the Ministry of Health, NGOs, and international organizations. Also, it was circularly stipulated that a comprehensive package of health services had to be provided to the beneficiaries of temporary protection. This includes primary health care, preventive health, maternal and child health, vaccinations, follow-up for patients with chronic diseases, and, if necessary, also emergency care and specialized services.

The circular addressed the issue of funding for health care services extended to the Syrians. A stipulation was made where the treatment expenses would be met wholly by the government of Türkiye and, in certain cases, the international donors; the same was put together with this aid. The circular further provided for the regulation on the contributions or any costs that would have been paid by the healthcare institutions while offering services to temporary protection benefactors.

Moreover, the responsibility for coordinating health response and delivering medical care to those under temporary protection, as well as international protection applicants and status holders, transferred to the Ministry of Health (MoH) of Türkiye in November 2015. A subsequent directive, issued in September 2015, permitted the provision of primary healthcare services through Migrant Health Centers established as supplementary units within existing Community Health Centers in regions with a high concentration of Syrian population (Regulation on the Community Health Center and Related Units, 2015).

Afterward, those centers supported by a project which is the EU-funded health initiative known as ''Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities'' abbreviated as SIHHAT, which commenced in January 2016 and spans 36 months which is extended then and continuing still. The project is currently in its third phase.

The Ministry of Health aimed to close all NGO-operated clinics by the end of 2017, with primary healthcare services that were temporarily permitted no longer being allowed after January 2018. NGO centers meeting specified criteria were converted

into Migrant Health Centers. NGOs are now continuing to provide health services exclusively in two areas: mental health and psycho-social support and physical therapy and rehabilitation. According to the Regulation on Community Health Centers and Attached Units (2015) with its 2018 regulations to facilitate access to services and service delivery, as needed, a separate unit attached to the Community Health Center (CHC) and/or an additional unit may be opened in a different building. The opening, closure, and relocation of additional and attached units to community health centers are carried out upon the proposal of the relevant Directorate and approval from the Ministry of Health. It is still relevant according to the recent regulations that were made under the Regulation on the Cascading of Health Service Providers dated February 10, 2022. This regulation has a specific emphasis on Migrant Health Centers as well and an important role in ensuring that non-citizens and, specifically, Syrians UTP, have access to the appropriate level of care based on their health needs (Regulation on the Cascading of Health Service Providers, 2022). The cascading system lays down a progressive structure for the delivery of health care so that non-citizens do not unnecessarily burden facilities meant for specialized care when their requirements can be met at a lower level of care. It also ensures that services for non-citizens, particularly in high-need areas, are geographically and functionally appropriate to their situations. It assures access to Migrant Health Centers that constitute an integral part of the larger national health system.

Syrians UTP can access primary diagnosis, treatment, and rehabilitation services at primary healthcare facilities. These include migrant health centers, family health centers, community health centers, maternal and child health and family planning centers, and tuberculosis dispensaries. At these facilities, they can also receive necessary screening and vaccination services to protect against infectious diseases, as well as services provided for infants, children, and adolescents and those related to women's and reproductive health.

In addition to primary healthcare facilities, they can access secondary and tertiary healthcare facilities. State hospitals are considered secondary healthcare facilities, while training and research hospitals and university research hospitals are classified as tertiary healthcare institutions. However, except in exceptional cases, Syrians UTP

cannot directly seek care in the universities' Health Practice and Research Centers or private hospitals, a referral is needed. You can see in Table 1, the categorization of health institutions adapted from the Ministry of Health (Circular on the Categorization of Healthcare Providers, 2019).

Table 1. Classification of Health Institutions by Levels

Primary Health Institutions	Secondary Health Institutions	Tertiary Health Institutions
Family Health Centers	State hospitals and branch hospitals without training and research functions, and their affiliated outpatient clinics	Training and Research Hospitals
Community Health Centers	Integrated District Hospitals	University Hospitals
Family Physicians	Ministry-affiliated Dental Health Centers	Specialty Hospitals (e.g., Eye, Chest, Cardiac, Orthopedic)
Private Clinics	Private Hospitals	
Dispensaries	Private Medical and Branch Centers	
Migrant Health Centers	Dental Hospitals	
	Dialysis Centers, Assisted Reproductive Treatment Centers, Hyperbaric Oxygen Treatment Centers, Medical Laboratories, and similar licensed diagnostic and treatment centers	

Source: Adapted from Republic of Turkey Ministry of Health (2019), "Sağlık Hizmeti Sunucularının Basamaklandırılması Hakkında Genelge" (Circular on the Categorization of Healthcare Providers).

Briefly, individuals under Temporary Protection Status in Türkiye can directly access healthcare facilities affiliated with the Ministry of Health in their city of registration. They can receive all healthcare services in their place of residence free of charge. If necessary, they can be referred to university's health practice and research centers or private hospitals, where they also receive services free of charge. Medications prescribed according to the proper procedures can be obtained from pharmacies at no cost (additional costs may occur, as I mentioned in the previous sections). On the other hand, those who have not yet acquired Temporary Protection Status, irregular migrants, and undocumented migrants are only provided with essential services such as immunization and emergency healthcare free of charge. Healthcare services for

non-citizens who do not have General Health Insurance, or international or temporary protection status are not regulated by the Health Implementation Directive of Social Security Institution; instead, they are governed by the Regulation on International Health Tourism and Tourist Health. Moreover, in 2022, the government implemented a stricter policy by restricting the registration of new applicants for international protection, temporary protection, and residence permits in nearly 800 neighborhoods across various provinces (Presidency of Migration Management, 2022). As a result of these restrictions, along with stricter address verification and monitoring of the residences of Syrians under temporary protection, approximately 600,000 temporary protection statuses were deactivated in 2022 (Regional Refugee and Resilience Plan, 2023). Table 1 summarizes the key laws and regulations related to healthcare access for Syrians UTP in Türkiye that are discussed in this section.

Table 2. Laws and Regulations Related to General and Healthcare-Specific Legislation for Syrians UTP

Category	Date	Laws and Regulations
General Laws	**2011**	AFAD Regulation (AFAD Yönetmeliği)
	2013	Law on Foreigners and International Protection (6458 Sayılı Yabancılar ve Uluslararası Koruma Kanunu)
	2014	Regulation on Temporary Protection (Geçici Koruma Yönetmeliği)
Laws Related Specifically to Healthcare Access	**2013**	AFAD Circular: Facilitating Syrians' Access to Healthcare Services (Suriyeli Misafirlerin Sağlık ve Diğer Hizmetleri Hakkında Genelge)
	2015	Administration Circular on Health Benefits for Temporary Protection Beneficiaries (Geçici Koruma Altına Alınanlara Verilecek Sağlık Hizmetlerine Dair Esaslar)
	2015	Directive on Migrant Health Centers/Units (Göçmen Sağlığı Merkezleri/Birimlerine Dair Yönetmelik)
	2015	Regulation on Community Health Centers and Attached Units (Toplum Sağlığı Merkezi ve Bağlı Birimler Yönetmeliği)
	2018	Amendment to the Regulation on Community Health Centers (Toplum Sağlığı Merkezi ve Bağlı Birimler Yönetmeliğinde Değişiklik)
	2022	Regulation on the Provision of Distance Health Services and the Cascading of Health Service Providers (Uzaktan Sağlık Hizmetlerinin Sunumu Hakkında Yönetmelik)

Source: Created by the author

5.2. The Composition of Migrant Health Centers

To provide protective healthcare services and basic healthcare more effectively and efficiently to Syrians in Türkiye, to overcome problems arising from language and

cultural barriers, and to increase access to healthcare services, Migrant Health Centers (MHC) are being established in areas where these individuals predominantly reside, as a unit attached to the district's community health center. These centers are established as "Community Health Center (CHC) Affiliated Units" in line with the "Community Health Center and Attached Units Regulation". MHCs consist of Migrant Health Units (MHUs) composed of a physician and auxiliary healthcare personnel, similar to the family medicine practice in Türkiye, and one serving approximately every 4,000 individuals. There are 192 MHCs all over Türkiye, composed of 800 MHC units. Fifty-one of those MHCs are extended centers. In Ankara, there are 8 MHCs composed of 35 units inside them. In addition to Syrian healthcare personnel, MHCs employ patient referral agents proficient in two languages (Arabic-Turkish) and support services personnel. These units comply with the physical and technical standards defined for family medicine.

In areas with relatively high populations and a considerable distance from a fully equipped state hospital, Extended Migrant Health Centers are established in temporary shelters and settlements with over 20,000 Syrian residents. Extended MHCs provide additional services beyond primary healthcare, including internal medicine, pediatrics, obstetrics and gynecology, dental care, and psychosocial support, supported by imaging units and basic service laboratories. Primary health care data are recorded using the "Examination Information Management System".

Migrant Health Centers are one of the biggest steps taken to improve the acceptability dimension in accessing health for Syrians in Türkiye. The aim of establishing these health centers is to ensure that the services provided are culturally and socially compatible with the population that will receive the service. The fact that the centers only provide services to Syrians under temporary protection and those Syrian doctors and nurses are employed are indicators of this compatibility. Also, here, as in state hospitals, the services are provided free of charge, indicating these services are aligned with the affordability dimension.

While Migrant Health Centers provide important healthcare access to Syrians UTP, there were still unmet requirements, notably for women and girls who require

specialized sexual and reproductive healthcare as well as protection from gender-based violence. To address these gaps, a project undertaken by Hacettepe University Women's Research and Implementation Center demonstrates how existing services can be expanded and adapted. This project was a good example of non-state activities to improve access and knowledge of Syrian and other forcibly displaced women in Ankara, which was held between March 2015 and October 2019.

The "Strengthening Access to Sexual and Reproductive Health and Sexual and Gender-Based Violence Services for Syrian and Other Refugees through Women and Girl Safe Spaces (WGSS)/Women Health Counselling Units" project in Ankara has made great strides in addressing the health needs of not only Syrians but also other communities fleeing the war and came to Türkiye. The initiative was a joint effort by the Hacettepe University Women's Research and Implementation Center (HUWRIC) and the Ankara Health Directorate, with support from the United Nations Population Fund (UNFPA) and funding from the European Civil Protection and Humanitarian Aid Operations (ECHO). This project brought together local and international resources at the points where health services were needed most to ensure that displaced women and girls in Ankara received safe, gender-sensitive health services.

This initiative included the establishment of Women and Girls Safe Spaces (WGSS) in three Migrant Health Centers in Ankara. The safe spaces established within the Migrant Health Centers targeted sexual and reproductive health and gender-based violence. Thanks to the approaches to managing these two basic components together, women were able to receive various health services while meeting their psychosocial needs that were important for their overall health. The project activities include SRH counselling for women and girls, psychosocial support on gender-based violence, empowerment activities for women and girls, information training sessions on institutions/organizations providing services and referring individuals to relevant institutions when necessary, legal counselling, training for service providers and beneficiaries, and various other social and cultural activities.

In addition to direct barriers to healthcare, the project also addressed other barriers that make it difficult for immigrant and refugee women to receive adequate

healthcare, such as language barriers and cultural differences. Outreach programs were conducted to raise awareness of these resources and to help build trust with communities. The project also stressed training healthcare personnel who work in these safe places, ensuring that they are equipped to meet the special needs of survivors of violence and trauma. Staff training includes trauma-informed treatment and gender-sensitive techniques, which were critical for understanding the issues that refugee and migrant women confront.

In short, the WGSS project in Ankara represented a comprehensive approach to supporting women who came through forced migration. Through safe spaces designed for women and girls, the initiative offered a supportive environment where they could access healthcare, safety, and empowerment practices. The project's commitment to addressing SRH and SGBV needs highlights the importance of accessible, inclusive healthcare for all, ensuring that women and girls can find the care, respect, and support they deserve. This initiative served as an example of how to create a healthcare framework that adapts to meet the needs of diverse and vulnerable communities, especially in humanitarian contexts.

The project's activities presented initiatives that contributed to almost all of the dimensions examined in Levesque et al.'s (2013) framework of access to health care. However, such projects contributed most to the areas where the aim is to improve acceptability, ability to seek, and ability to perceive dimensions.

The dimensions mentioned correspond to the stage in the access to health care process when individuals recognize their own needs and decide to seek health care.

5.3. International and SIHHAT Project Reports

In this section, the texts I will examine will be considered as policy documents. Policy documents are documents created by a government, institution or organization to address a specific policy issue. They identify challenges in different public services and prioritize intervention areas. Examining such documents is important for this thesis because they provide details and evidence-based information on the

implementation of policies related to access to health, which is the subject of the thesis.

This section will provide a comprehensive review of the health services provided to Syrians living in Türkiye. The aim of this section is to provide a detailed assessment of the achievements and challenges in the field of health. The steps taken to improve health services and the barriers that continue to affect access to services will be explained. To do this, we will examine the Facility for Refugees (FRIT) reports of the European Commission, which contributes to the refugee crisis with its funds and process monitoring together with Türkiye. Therefore, I will first briefly touch on the importance and characteristics of FRIT.

5.3.1. Facility for Refugees Türkiye (FRIT) and SIHHAT Project

The European Union (EU) established FRIT to meet the needs of refugees in Türkiye and support Türkiye's efforts in this area. A total of €6 billion, managed in two phases, was allocated specifically to various projects in Türkiye (European Commission, 2023). The various areas where the funds were allocated were humanitarian aid, education, health, municipal infrastructure and protection.

The SIHHAT project is a key component of FRIT, which was established to meet the health needs of the Syrian population under temporary protection in Türkiye. Funded by the EU, SIHHAT continues to coordinate financial assistance to support refugees and host communities. As part of SIHHAT I-II-III, the facility supported the operation of 192 Migrant Health Centers and trained and employed approximately 4,000 healthcare personnel. As of December 2023, approximately 33.4 million primary healthcare consultations had been carried out and approximately 8.7 million vaccine doses had been provided to refugee children (European Commission, 2023).

European Commission's reports in the scope of FRIT present an assessment of health services over a certain period, considering both quantitative and qualitative improvement while at the same time pinpointing areas where there are still problems. Based on this sector-specific analysis of assessments carried out over different

periods, this study tries to explain the trends of healthcare service provision, identify the areas in which improvement has been sustained, and find out if there are any deficiencies or setbacks that have emerged as demands have evolved. I will then turn to the reports of the SIHHAT Project.

The SIHHAT Project represents one of the largest and most comprehensive health programs for refugees in Türkiye, targeting a wide range of health needs. By analyzing reports data from 2018, 2020, and 2022, I aim to assess how the project's interventions have specifically impacted SRH services for Syrian women. This temporal analysis will allow us to both measure the project's effectiveness over time and understand its potential to create sustainable improvements in access to healthcare.

This analysis will be important in one respect: to show where the SIHHAT Project has been successful in expanding access to SRH and where further improvements may be necessary in order to fully meet the needs of this population. Our step-by-step, time-focused approach will follow the way in which healthcare accessibility for Syrians has changed and developed over the years. This will allow us to evaluate how the health sector and the SIHHAT Project have responded to new and emerging challenges, as well as how they have adapted to shifting needs. Ultimately, this method will help us construct a well-rounded perspective on the project's trajectory, assessing its long-term impact on SRH services and the broader health outcomes for Syrian women in Türkiye.

Additionally, it is important to note a terminological choice in this chapter: in line with the common language used in many of these reports, I may use the term "refugee" when discussing the Syrian population in Türkiye, despite the fact that Syrians are officially classified as individuals under temporary protection, rather than refugees, due to Türkiye's geographical limitation under the 1951 Refugee Convention. In this context, the term "refugee" refers to all displaced communities seeking refuge in Türkiye as a result of war and conflict, regardless of their specific legal status. This inclusive use of the term was chosen to be consistent with the terminology found in many reports.

5.3.2. Analysis of the European Commission Reports

The first three annual reports of the European Commission on Facility for Refugees do not give us crucial outputs related to the health service provision to Syrians in Türkiye since there is not enough information to compare data and interpret the feedback coming from the service users. Starting with the fourth one, the Commission's annual reports on the EU Facility for Refugees indicate a progressive but cautious approach towards enhancing healthcare services for the Syrian population in Türkiye. Initially, we can observe a transition from emergency to development-oriented programming, with an emphasis on integrating specialized health services.

The fourth annual report, which was written in 2020, highlighted the beginning of the shift toward development programming, where restricted mobile services would meet urgent primary healthcare needs (European Commission, 2020). This report also puts special emphasis on the need to increase specialized services, including reproductive health, mental health, and physical rehabilitation. It also brings up the question of continued access to health services for refugees who are outside their zones of initial registration or are in transit, although the services available are mainly limited to emergency services and vaccination provisions. Therefore, it can be concluded that such limitations have adverse implications for mobile refugees, seasonal workers, and those who have moved to other provinces.

Ability to Reach: This report shows the limitations of healthcare services, which are primarily restricted to emergency and vaccination services for Syrians UTP outside their zones of registration. Their inability to access healthcare institutions from their current locations due to registration-related issues causes problems within the "ability to reach" dimension that is related to a person’s mobility and the alignment of service locations with patient’s needs. This situation is linked to the requirement for individuals to migrate to the cities where their addresses are registered to receive healthcare services. It stems from policies regarding address registration updates and the closure of neighborhoods, as observed in the laws and regulations section.

> According to the fifth annual report dated 2021, as of December 2020, specialized health services, including mental health and psychosocial support (MHPSS), were incorporated into the SIHHAT I program, and additionally, most activities related to sexual and reproductive health and sexual and gender-based violence had been integrated into SIHHAT I earlier, in October 2019. However, stationary and mobile services to urgent and unmet healthcare needs are still limited, according to this report, particularly in the areas of physiotherapy and physical rehabilitation. Furthermore, registration problems mentioned in the fourth report persist (European Commission, 2021).

Availability and Accommodation: The fifth annual report underlines the limitation of stationary and mobile healthcare services, particularly in specialized areas such as physiotherapy and physical rehabilitation, and highlights gaps in service provision. It also shows healthcare services are not physically and functionally accessible to meet patient needs with the impact of ongoing registration problems, which means it still undermines the ability to reach.

The sixth and seventh annual reports emphasized the Commission's monitoring of policy changes and efforts to reach affected refugee populations through mobile healthcare activities, but the same access issues persisted (European Commission, 2022, 2023). However, in the seventh annual report, tangible results from SIHHAT-II and preparations for SIHHAT-III can be seen, which shows the desire to continue healthcare services beyond 2024. Also, the last report highlighted a planned focus on vulnerable groups and specialized services for them (European Commission, 2023).

The project's actions appear to address issues of availability and accommodation. This is a notable development when compared to the challenges identified in previous reports. The project simultaneously tries to enhance the dimension of the availability and accommodation, enabling better physical and logistical access to healthcare services for those in need, but these developments have not fully achieved their goal due to ongoing problems with registration-related issues and restrictions on intercity travel for Syrians. Therefore, these problems are not related to healthcare institutions but to the demand side, specifically the service recipients. Resolving these issues requires changes in policies and legal regulations concerning address registration updates and the closure of neighborhoods.

Throughout the Commission's Annual Reports, a consistent challenge remains: ensuring equitable access to healthcare for refugees outside their original province of registration or those on the move. Although there has been development and strategic planning for upcoming initiatives, this challenge has remained, meaning the need for adjustment and focused interventions on registration-related issues.

5.3.3. A More Detailed Review Based on The Strategic Mid-Term Evaluation Report

Even though these reports give valuable information about the annual processes in the health sector, they are not detailed enough to see the whole picture. The Strategic Mid-Term Evaluation Report and its sector report on health are much more detailed and comprehensive which are looking at the 2016-2019/2020 period. According to this report, generally, Syrians UTP are able to access suitable health services, particularly when they are registered and located within the province, and even unregistered and out-of-province refugees could obtain essential services through hospital emergency units (European Commission, 2021). However, the utilization of health services does not give us the full picture of access since "access" is viewed as a process in this study (Levesque et al., 2013). Upon a more thorough examination of the report, it mentions several issues related to E/MHCs. These issues include a shortage of personnel to operate the technical equipment, insufficient numbers of specialist doctors in certain areas, costs of some medicines, prolonged waiting times, limited opening hours, and legal barriers that prevent the adequate employment of Syrian doctors. Additionally, it highlights from the health personnel's side that there is still no clarity on whether doctors working in E/MHCs can be employed elsewhere, and it points out complaints regarding annual leave, transportation, childcare during working hours, and physical infrastructure (European Commission, 2021). Related to the services at state hospitals, 27% of respondents in an online survey conducted under this report claimed that there were services they wanted to access but were unable to do so because of a lack of available interpreters and uncovered medicines (European Commission, 2021). Two other mentioned access barriers in state hospitals are transportation challenges and the costs of some uncovered treatments (European Commission, 2021). The fees for medications and

treatments not covered by the Social Security Institution are also related to an individual's capacity to pay. This issue is connected to the "ability to pay" dimension on the demand side of Levesque et al.'s healthcare access framework. It is tied to the poverty experienced by Syrians, which is identified in reports as one of the barriers to accessing healthcare.

5.3.3.1. Women's Health and Wellbeing

Related to women's health and wellbeing, negative aspects presented in this report are insufficient numbers in breast and cervical cancer screenings, discrimination, pregnancy risks, limited access to family planning leading to high birth rates, lack of education, insufficient control over personal resources, restricted access to sexual and reproductive health services, and gender-based violence (European Commission, 2021). Moreover, although Syrians UTP are now entitled to the same health access rights as the host population at primary and secondary levels, disparities continue in reproductive health, maternal, newborn, and child health. Additionally, there are differences between Turkish citizens and Syrian women in social health determinants, such as higher fertility rates, higher incidences of child, early, and forced marriages, higher under-five mortality and malnutrition rates among Syrian children, and low levels of antenatal care visits (European Commission, 2021).

The reports of the European Commission indicate that registration-related issues are the main barriers for Syrians', under temporary protection while applying to healthcare services. However, applying to healthcare services is just the beginning. For the population under temporary protection registered in their respective cities, legal and capacity barriers seem to have been almost removed through legislative regulations, new health centers, and the employment of additional doctors. Nevertheless, as I proceed, I encounter the aforementioned issues following the initial contact with the health center. To provide a more comprehensive presentation related to these problems, I will refer to the last two reports of the SIHHAT Project. Firstly, I would like to evaluate the health service application to and satisfaction of E/MHCs and state hospital rates by comparing the 2020 and 2022 project reports. The 2020 report presents the data from both 2018 and 2020; on the other hand, the

2022 report sets forth the 2022 data. Afterward, I'll move on to analyzing data on sexual and reproductive healthcare services, starting with giving information on the applications and satisfaction.

5.3.4. SIHHAT Project Reports

In 2020, a significant majority (80.8%) of Syrians UTP applied to State Hospitals for healthcare services. (Republic of Turkey Ministry of Health Directorate General of Public Health, 2020). However, by 2022, the utilization rate of state hospitals decreased to 51.6%. This notable reduction suggests a shift in healthcare-seeking behavior among Syrians, potentially due to increased availability and trust in alternative healthcare facilities such as E/MHCs. On the other hand, the 2020 data shows that 40.9% of Syrians UTP applied to E/MHCs, and the application rate to E/MHCs had increased significantly from 2018, indicating an improvement in the accessibility and perhaps the perceived quality of these centers. In 2022, the share of applications to E/MHCs, or mobile health services, increased slightly to 41.4%. This relatively stable utilization rate highlights the continued importance of E/MHCs within the healthcare system for the Syrian population residing in Türkiye. The marginal increase also reflects continued trust and reliance on those services, which might have strengthened over the years (Republic of Turkey Ministry of Health Directorate General of Public Health, 2020; 2022).

My conclusions from comparing the data from the 2020 and 2022 reports on healthcare utilization among Syrians under temporary protection in Türkiye:

- As mentioned, the number of visitors to state hospitals has decreased, while the number of applications to E/MHCs has remained stable. This trend can be inferred from the targeted integration of Syrian healthcare personnel into E/MHCs, meeting the unique care needs of the population, and eliminating language barriers, facilitating access to services. Therefore, I can say that trust in migrant healthcare centers has increased over the years.
- The expansion of mobile healthcare services reported in the 2022 data, although there is insufficient information on their utilization, has reflected an adaptation in healthcare delivery to better serve the Syrian population.

When looking at the satisfaction rates of the three mostly used health facilities, E/MHCs showed an improvement in satisfaction levels from 72.2% in 2018 to 78.1% in 2020, and state hospitals experienced a significant improvement in satisfaction levels from 72.4% in 2018 to 82.4% in 2020 (Republic of Turkey Ministry of Health, Directorate General of Public Health, 2020; 2022). The 2022 report primarily focuses on E/MHCs, so similar data for state hospitals is not available.

5.3.4.1. Sexual and Reproductive Health Data

Although there is no similar data in the 2022 report, regarding reproductive health, when the 2020 SIHHAT report asked 758 Syrian women who gave birth in Türkiye and whether their newborns had undergone newborn screening, the vast majority of women (92.1%) said that newborn screening tests were applied to their newborns (Republic of Turkey Ministry of Health, General Directorate of Public Health, 2020; 2022). The rate reported in 2018 was 78.9%. In light of this data, we can say that there has been a positive trend in Syrian women following newborn health protocols over the years.

While 38.8 percent of the 758 women who participated in the surveys in 2018 stated that they had undergone postpartum check-ups, this rate increased significantly to 58.4 percent in the 2020 surveys. Unfortunately, the 2022 report does not provide data that follows this positive trend. Of the 3,478 women who participated in the survey, 79.2 percent said they did not receive any postpartum health follow-up, and of the minority who did, only 8.3 percent received internal or additional follow-up (Republic of Turkey Ministry of Health, General Directorate of Public Health, 2020; 2022). This significant decline in postpartum follow-up rates suggests that there are significant gaps in postpartum care that require urgent attention. Table 3 presents the neonatal screening and postpartum follow-up rates among Syrian LTP women compiled from data provided by the Republic of Turkey Ministry of Health (2020, 2022).

The findings of the 2020 report related to the utilization of pregnancy examinations show that 48.1% applied to State Hospitals, 18.2% to (E)Migrant Healthcare Centers

(E/MHCs), 13.9% to Private Polyclinics, 6.4% to Family Health Centers, and 3.7% to Private Hospitals.

Table 3. Neonatal Screening and Postpartum Follow-Up Rates Among Syrian Women UTP

Neonatal Screening Rates

Year	Neonatal Screening (%)
2018	78.9
2020	92.1

Postpartum Follow-Up Rates

Year	No Postpartum Follow-Up (%)	Three or More Follow-Ups (%)
2018	61.2	-
2020	41.6	-
2022	79.2	8.3

Source: Compiled by the author based on data from the Republic of Turkey Ministry of Health, Directorate General of Public Health, 2020, 2022)

According to the results of the 2022 report, based on data from 2022, 61% of the 3,530 respondents surveyed had not obtained any prenatal follow-up care, while 31.4% stated that they had received three or more follow-up visits. Despite these shortcomings, there was a significant improvement in the utilization of E/MHCs for routine prenatal care, with 52.6%. Additionally, 67.2% of the respondents utilized prenatal care at state hospitals. (Republic of Turkey Ministry of Health, Directorate General of Public Health, 2020; 2022). You can see the comparison of the above-mentioned data corresponding to the utilization of health facilities below.

Table 4. Prenatal Follow-Up and Healthcare Facility Usage Among Syrian Women UTP in Türkiye

Year	No Prenatal Follow-Up (%)	Three or More Follow-Ups (%)	E/MHC Usage for Prenatal Care (%)	State Hospital Usage (%)
2018	-	-	-	-
2020	-	-	18.2	48.1
2022	61.0	31.4	52.6	67.2

Source: Compiled by the author based on data from the Republic of Turkey Ministry of Health, Directorate General of Public Health (2020, 2022)

Comparative analysis of the 2020 and 2022 SIHHAT reports revealed conflicting results on maternal and infant health service utilization among Syrian UTP women in

Türkiye. There is an improvement in newborn screening and postpartum check-up rates from 2018 to 2020, but this leads to a worrying result in the 2022 report with a decrease in postnatal follow-up rates. The last report showed that most women did not receive any follow-up care for postpartum even though the reliance on E/MHCs for antenatal care has increased, rates remain inadequate. As seen in the section of my study on the impact of migration and gender on access to health care, receiving prenatal care is a major problem for migrant women (Darj & Lindmark, 2002; Gushulak et al., 2009; Knudsen et al., 1990). Furthermore, as mentioned before, the results of studies conducted outside of Türkiye show that migrant women are less likely to participate in prenatal care than non-migrant women (Darj & Lindmark, 2002; Knudsen et al., 1990).

The implication here is, therefore, that access to and quality of maternal and infant health services, including prenatal and postnatal care, must be strengthened (Republic of Turkey Ministry of Health, Directorate General of Public Health, 2020; 2022). In addition, the findings of reports in this field indicate the need to increase awareness-raising activities on pregnancy checkups. This will potentially respond to problems related to the ability to perceive in Levesque et al.'s (2013) healthcare access framework.

In the 2020 SIHHAT survey, 83.4% of Syrian women reported no issues with genital discharge, while 16.6% did. The most common place for seeking treatment for genital discharge was state hospitals (39.2%), though 26.9% did not seek any medical help. The number of women going to State Hospitals for this issue dropped from 51.9% in 2018 to 39.2% in 2020, while visits to Family Health Centers increased from 7.9% to 15.1%. Regarding women's health screenings, the survey revealed low awareness and participation among Syrian women. In 2020, about 78.1% were unaware of how to perform a breast self-exam, and 73.4% did not have annual gynecological exams. A vast majority had not undergone breast cancer screening (92.4%) or cervical screening (86.6%) in Türkiye. While discussing the impact of gender and migration on healthcare, it is seen that immigrant women engage in cervical screening at lower rates compared to non-migrant women (Taylor et al., 2001; Webb et al., 2004). Furthermore, another research also indicated that

breast cancer screenings occur significantly less often among immigrant women compared to non-immigrants (Holk et al., 2002; Visser et al., 2005).

Family planning is one of the major components of SRH services. Demand for family planning among Syrian women UTP in Türkiye has depicted fluctuating trends over the past few years. In 2018, nearly 25.5 percent of women reported that they did not have access to family planning services, which manifests a large gap in reproductive health services. By 2020, this proportion had dropped to 13.2%, indicating an improvement in both access to and utilization of such programs. However, by 2022, unmet needs had increased to 17.4%, showing ongoing challenges and the need for further emphasis on family planning support (Republic of Turkey Ministry of Health, Directorate General of Public Health, 2020; 2022). The above-mentioned data can be seen in the Table 5.

Table 5. Trends in Family Planning Unmet Needs Among Syrian Women UTP in Türkiye (2018-2022)

Year	Unmet Needs (%)
2018	25.5
2020	13.2
2022	17.4

Source: Compiled by the author based on data from the Republic of Turkey Ministry of Health, Directorate General of Public Health (2020, 2022)

The analysis of general and sexual and reproductive health care available to Syrian women UTP in Türkiye demonstrates progress while stressing the challenges that remain. Healthcare reports from the European Commission and the SIHHAT Project show changing trends in healthcare delivery. There has been a shift from the emergency response model to one that is more constructive and development-oriented within the healthcare sector during this period. This development has broadened the scope of certain specialized services, such as reproductive and mental health services; nevertheless, some deficiencies still exist, especially concerning those who live outside their registered cities or those who are on the move.

E/MHCs have played a critical role in meeting the health requirements of Syrian women. One of the most significant changes in care-seeking behavior over time is the increased preference for E/MHCs over state hospitals, which demonstrates growing trust in these centers.

Despite such developments, there remain formidable challenges: specialized services are hard to access, registration challenges have not been entirely resolved, and maternal and child health outcome disparities between Syrian and Turkish women continue to be concerning. Further, low health screening utilization, insufficient family planning resources, and high birth rates will explain the nature of SRH for the Syrian community. Commitment to more equitable, holistic, and tailor-made healthcare services that are attuned to the peculiar needs of this population must, therefore, be drafted.

I prepared a figure in which I map the barriers to sexual and reproductive health access, as identified in the reports causing the aforementioned negative health outcomes, onto Levesque et al.'s (2013) healthcare access framework. In this figure, it is clearly seen whether the barriers are related to the supply or demand side of healthcare access, which dimension of the framework they correspond to, and at which stage of the healthcare access process they occur. Additionally, to provide a comparative analysis, I will illustrate which barriers are encountered specifically at E/Migrant Health Centers, which ones occur in state hospitals, and which ones are common to both.

As seen in the figure, all barriers encountered on the demand side, that is the service recipient side, seem to be common to both state hospitals and E/MHCs. Therefore, any intervention targeting this side of the healthcare access process would definitely increase the access to both E/MHCs and state hospitals. Furthermore, related to the availability and accommodation, E/MHCs which are very close proximity to high concentrated Syrian neighborhoods, makes access to these institutions easier. In contrast, the more distant locations of state hospitals resulted in transportation-related barriers. Unfortunately, despite their advantageous proximity, the limited working hours and long waiting times at E/MHCs create challenges that negatively affect this dimension.

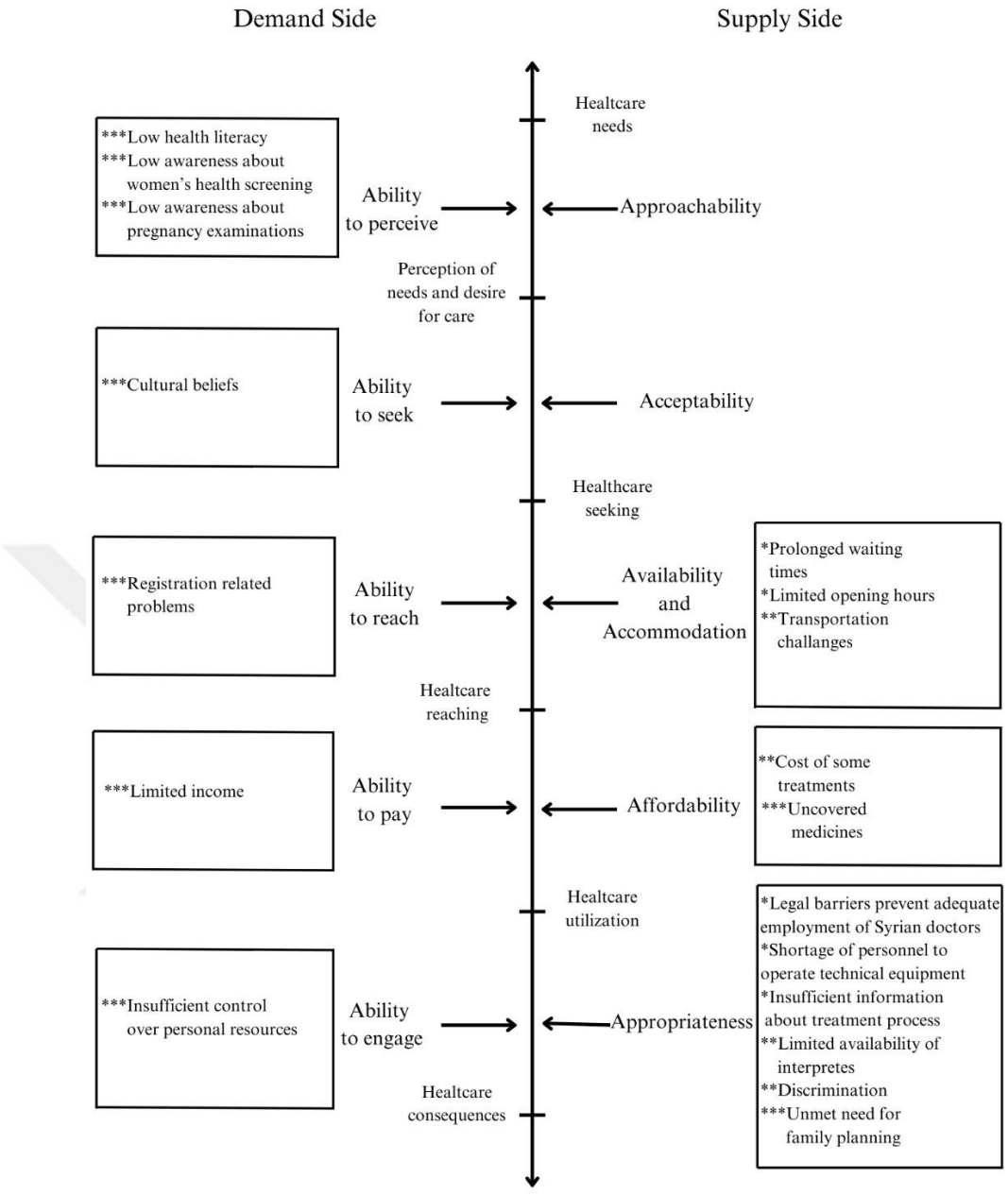

Figure 2. Barriers to Access SRH services in the E/MHCs and State Hospitals According to the Reports

*Refers to the barriers encountered in E/MHCs

**Refers to the barriers encountered in state hospitals

***Refers to the barriers encountered in both

Source: Figure adapted by the author from Levesque et al. (2013), with additional data from the Republic of Turkey Ministry of Health (2020, 2022)."

Concerning the affordability dimension, the issues related to treatment costs arise only in state hospitals but not in E/MHCs. This can be attributed to the fact that state

hospitals are secondary healthcare providers, offering more complex services that may incur higher fees.

Among the problems observed in the final dimension on the supply side, only the inadequacy of family planning services is common to both state hospitals and migrant health centers. At this stage, the problems seen in E/MHCs are linked to staff shortages and legal regulations. Meanwhile, issues such as discrimination and a lack of interpreters are specific to hospitals.

The following section consists of the final stage of my analysis, which presents the results of the interviews conducted with NGO representatives. While discussing the findings obtained from these interviews, I will refer to the healthcare access framework I have employed and the discussions within my theoretical framework. Finally, as I did at the end of the previous section, I will create a figure using the healthcare access framework to present the findings in a clear and comprehensible manner.

CHAPTER 6

WHEN SUPPLY MEETS DEMAND

Semi-structured interviews with the respondents from different non-governmental organizations were conducted. Those organizations were specifically focusing on healthcare provision to Syrian women and so are believed to give insights into some of the recurrent problems regarding healthcare service access, which can also be compared with the report's findings. This section will provide us with a better look from the side of service recipients. Therefore, regarding the healthcare access framework used in this study, Our knowledge of both the service provider, their intersection, and the service recipient's perspective will be complete.

6.1. Experiences with E/Migrant Health Centers

In the interviews, respondents expressed a considerable satisfaction level among Syrian women about the services offered at the Migrant Health Centers (E/MHC). One of the most important reasons, as told by interviewees (I_2, I_3, I_5, I_7, I_8, I_9, I_{10}, I_{11}, I_{12}) about why Syrian women are satisfied is that they can be treated in their first language and these facilities are located near their homes. It is added that such accessibility is driving comfort and confidence, and following this, E/MHCs become natural go-to places for most primary care services.

Two critical aspects of Levesque's healthcare access model, acceptability and availability and accommodation, can help explain this positive feedback. One major factor contributing to their satisfaction is the opportunity to communicate with healthcare providers in their native language. Using the same language has a big impact on their trust in the institutions which is related to the acceptability dimension of the healthcare access process.

Additionally, the convenient location of E/MHCs near their homes significantly increases their utilization. The centers' physical proximity eliminates barriers such as long travel times and transportation costs, which refers to the availability and accommodation dimension of Levesque and his colleagues' model. From these responses, it can be said that E/Migrant Health Centers are solidifying their role by offering language accessibility and geographic convenience. These all together offer a practical and welcoming option.

On the other hand, the participants of the interviews pointed out some issues that are not as positive as the above-mentioned ones. Interviewees (I_5, I_6, I_8, I_9, I_{10}) mentioned the unpleasant behavior of some medical professionals working at E/MHCs as a common complaint. They also add that those negative behaviors are mostly coming from the doctors themselves. This included instances of being impolite, failing to show understanding, and not providing the necessary respect during the course of the medical appointment. Additionally, the short duration of medical examinations (I_5, I_6, I_7, I_9, I_{10}) and the insufficient information provided about the treatment process and necessary precautions (I_5, I_6, I_9, I_{10}) are among the highlighted issues regarding this issue.

Further, restrictions on the availability of services to those lacking a proper identity card and those who are registered in other provinces are mentioned among the important barriers to accessing E/MHCs (I_1, I_2, I_5, I_7, I_9, I_{11}, I_{12}). As told in the interviews, there were times when such people could seek healthcare based on the initiatives of the staff, but this seems to no longer be an option for two to three years with the government’s stricter policy on registration and identification. These registration-related problems, which are also seen in the reports, are related to the dimension of ability to reach and a reason that obstructs the healthcare access process right in the middle of its course.

While E/Migrant Health Centers have been largely appreciated for their accessibility, several concerns emerged during the interviews, which can be linked to the dimensions of ability to reach and appropriateness in Levesque et al.’s (2013) healthcare access framework. Participants express restrictive eligibility criteria for

accessing services, particularly for individuals lacking valid identification cards or those registered in other provinces. These registration-related challenges are the result of problems related to the ability to reach dimension since the lack of an individual's identification due to its cancellation or residing in a location different from the province where they are registered in the system prevents utilization of the services by hindering people's ability to reach them. The focus of this thesis is not on all Syrians in Türkiye but specifically on those UTP, examining their access processes. Therefore, the registration-related issues I refer to involve problems experienced by Syrians with temporary protection status. These include cases where temporary protection status is canceled due to address registration updates, those who hold temporary protection status but reside in a different city and cannot access public services, and those who are in transit. Groups such as seasonal agricultural workers are also among those that may be affected by this situation, even if they live in the provinces where they are normally registered. When discussing these problems, I am not referring to Syrians who arrived through irregular migration and have never obtained temporary protection status. These are the issues related to the exclusion of those already integrated into the healthcare system.

Additionally, the appropriateness of care was called into question due to the reported negative attitudes of some doctors at E/MHCs. Participants frequently described experiences where medical staff, particularly doctors, displayed dismissive or impolite behavior, failed to demonstrate understanding, and showed a lack of respect, especially during SRH consultations. The fact that these problems are experienced in SRH examinations makes this already sensitive area even more sensitive for Syrian women. Such attitudes undermine the quality of care and deter patients from seeking or engaging with healthcare services. Appropriateness, in this context, highlights not only the technical adequacy of care but also the relational and interpersonal aspects that significantly influence patients' experiences. Table 6. highlights how Levesque et al.'s (2013) dimensions are reflected in the interview findings, showcasing both positive and negative aspects of healthcare access for Syrian women under temporary protection (UTP) in Türkiye.

When interviewees who mentioned problems within the appropriateness dimension were asked about the impacts of these issues, it became evident that the challenges

experienced at this stage also negatively influenced the ability to engage and the ability to seek dimensions, which highlighted an interrelated connection. It was noted that Syrian women are unable to integrate into decisions and processes concerning their health due to negative attitudes, which also reduces their adherence to the healthcare services they receive and the subsequent treatment or follow-up process. Furthermore, it was highlighted that in similar situations requiring healthcare in the future, they sometimes do not seek services at all or look for them in other types of institutions and other E/MHCs.

Table 6. Analysis of Healthcare Access Dimensions in Relation to Healthcare Access for Syrian Women UTP Based on Interview Data

Levesque's Dimension	Connection to Interview Information	Positive/Negative
Acceptability	Language alignment fosters trust and comfort, making services culturally and socially aligned.	Positive
Availability & Accommodation	Proximity of centers to homes eliminates travel and transportation barriers.	Positive
Ability to Reach	Restrictions on service eligibility due to lack of valid ID cards or registration in other provinces limit access.	Negative
Appropriateness	Negative attitudes of doctors, short duration of medical consultations, insufficient information given about treatment process.	Negative

Source: Adapted from Levesque et al. (2013)

These findings parallel the results of Sutherland et al. (2017), who examined problems in hospital care experiences between Aboriginal and non-Aboriginal patients in Australia. Similar to the issues raised by our respondents, their study was highlighting how ineffective communication, insufficient patient education, and perceived disrespect during care can aggrandize inequalities in healthcare delivery. As Sutherland and his colleagues (2017) emphasize, precise communication and respectful interactions with clinicians are crucial for meeting patients' expectations and have a significant effect on clinical results. This emphasizes how crucial it is to solve the interpersonal elements of care in order to increase the outcomes of and involvement in healthcare for underprivileged populations such as Syrian women UTP.

Furthermore, some interviewees (I_1, I_2, I_4, I_6, I_7, I_8, I_{10}) mentioned that previously conducted informational training sessions and seminars on women's health and

sexual and gender-based violence were perceived as highly beneficial by Syrian women. They noted that Syrian women expressed disappointment in the decline of such initiatives in recent years. Some others (I_1, I_2, I_4) emphasized the importance of conducting these projects in collaboration with government institutions. They state two primary reasons for preferring state partnership, which are increased participation rates among women in Syrian families and the facilitation of securing international funding.

When asked about the reasons behind higher participation rates, respondents explained that collaboration with government institutions made it easier for women to obtain permission from their spouses to attend such programs. Feedback that participants of the interviews received from Syrian women who participated in these trainings shows that they learned how to navigate in healthcare settings. Last but not least, it is reported to the interviewees that these programs provide a supportive environment where they can socialize with other women.

The demand-side dimensions of Levesque et al.'s (2013) framework are particularly relevant here, especially the ability to perceive and the ability to engage. Informational training sessions seemed to empower Syrian women to better understand their health needs, particularly in sensitive areas like gender-based violence and reproductive health and increase their commitment to their treatments and follow-up controls. This directly ties to their ability to recognize when and why to seek healthcare. However, as noted during the interviews, although those who attended the training sessions now have a better understanding of their SRH needs, certain cultural beliefs and patriarchal dynamics within the family still act as barriers to seeking some healthcare services (I_1, I_2, I_3, I_{11}, I_{12}) corresponding to the ability to seek dimension.

As Bowleg (2012) and Krieger (1999) have argued, the idea of intersectionality emphasizes how overlapping identities, gender, immigrant status, and socioeconomic level compound the vulnerabilities and obstacles people are experiencing in trying to access resources. Since these projects directly address the interconnected types of

marginalization experienced by Syrian women, the training courses and seminars offered for them aim to jointly remove different intersectional barriers.

For Syrian women UTP, gender intersects with their temporary legal status and socio-political position as individuals who have fled the war. These positions also combined with the more patriarchal nature of Syrian society, which in the end creates unique challenges such as restricted autonomy, limited access to resources, and cultural stigma. These training programs acted as a tool and aimed to empower women by providing them with the knowledge and skills to navigate healthcare services and raise awareness about gender-based violence. In this sense, the programs went beyond training Syrian and other forcibly displaced women; they have actively removed some of the cultural and social barriers that exclude Syrian women from both healthcare and public life.

6.2. Experiences with State Hospitals

Based on our interactions with respondents, state hospitals, which are secondary healthcare facilities, are characterized among some Syrian women by dissatisfaction due to organizational and operational deficiencies. As told (I_5, I_8), even though Syrian women recognized the standards of care provided, especially with regard to gynecology and obstetrics medical services, for many households, the geographical location of hospitals further complicates the matter because it usually results in transport challenges. Another important problem is the lack of available interpreters (I_1, I_2, I_3, I_4, I_6, I_7, I_{10}, I_{11}, I_{12}) in state hospitals and how this makes interaction and movement in the hospitals more difficult. Both barriers were also observed in the reports as well. To solve language problems, it is mostly added that Syrian women often bring their children with them to overcome language barriers since their children know Turkish better. While transportation challenges are related to the availability and accommodation dimension, the absence of interpreters corresponds to the appropriateness dimension which is related to competence, quality, and effectiveness.

Furthermore, interviewees frequently mentioned the difficulty of finding their way within hospital premises (I_3, I_4, I_5, I_6, I_7, I_9, I_{10}) and Syrian women's hesitation to

visit hospitals due to issues related registration (I_1, I_2, I_4, I_8, I_9, I_{11}). The second mentioned barrier was also present while accessing E/MHCs. It is common in both since this is a barrier that obstructs the access process to healthcare in general. Some interviewees (I_4, I_5, I_6, I_8, I_{10}) also said Syrians told them about experiencing prejudice at the hands of hospital staff, mostly from nurses and cleaning staff. These negative attitudes generally manifest in the form of racial slurs and hostile interactions and discourage them from seeking treatment altogether which are problems related to appropriateness. Discriminatory and hostile attitudes were stressed even in instances of childbirth. There were also comments (I_5, I_6, I_8) about how these prejudiced attitudes directly affect the quality and experience of care, especially during childbirth. The above-mentioned challenges reflect the ability to engage dimension as well. Negative interpersonal interactions undermine their confidence in utilizing healthcare services. Moreover, they even create a sense of alienation both from the health system and from society. These barriers show that both structural and interpersonal improvements are needed to provide better health services to Syrian women.

The above discussions align with Krieger's (1999) intersectionality framework, which highlights the compounded impact of gender and ethnic discrimination on marginalized groups. Furthermore, as I mentioned before, related to experiences during examinations in E/MHCs, Sutherland, Hindmarsh, Moran, and Levesque (2017) emphasized that prejudicial attitudes among healthcare providers not only affect patient satisfaction but also have tangible consequences on the quality of care and in consequence on the clinical outcomes. Additionally, Reimer's (2004) perspective on social exclusion as a relational process emphasizes how such interactions perpetuate cycles of exclusion and in this study's context reinforces Syrian women's withdrawal from essential healthcare services.

Unlike E/MHCs, treatments, and diagnoses in state hospitals can be more complex, which means that the healthcare costs defined by laws and regulations may exceed the upper limit set by the Social Security Institution or fall outside its coverage. As a result, the dimensions of affordability and ability to pay create problems on both ends. However, the primary issue mentioned in the interviews is that Syrian women

often become aware of the costs only after receiving healthcare services (I_5, I_6, I_7, I_{10}, I_{12}). Due to communication-related problems in hospital settings, patients often lack adequate information about the services they receive. This not only impacts the dimensions of affordability and ability to pay but additionally negatively affects the ability to engage, as service recipients are not fully aware of the decisions being made about their own health. Moreover, when a health need arises again, individuals hesitate to seek healthcare because they are unaware of which services are paid, resulting from a lack of information reaching activities about the costs of services. This brings us back to the beginning of the healthcare access process, which is mostly related to the information-reaching activities: approachability.

Same cost-related barriers are also seen while accessing medications and treatments for chronic diseases, which show critical interactions between affordability and the ability to pay. Many women mistakenly believe that certain medications or services are free, and after the treatment process, they discover that it is required to pay some contribution costs. As the treatment process becomes more complicated, the amount to be paid for them may increase in relation to the scope of the law. This lack of clarity reflects a systemic issue in approachability, where the healthcare system fails to effectively communicate which services and medications are subsidized or free. Experiencing these financial shocks even once can lead women to delay or avoid seeking healthcare altogether, as they fear encountering similar costs in the future treatments. Unexpected contribution costs discourage individuals from seeking care, as seen in the study of Callander, Corscadden, and Levesque (2016) regarding cost-related avoidance of care.

The above-mentioned issues reveal how supply-side failures in the appropriateness and affordability dimensions amplify demand-side vulnerabilities in perception and financial capacity. For example, poor communication from the healthcare system directly influences individuals' perception of care options, while unaffordable costs negatively impact their ability to pay. This interplay between structural failures and individual vulnerabilities creates a cycle of delayed or forgone care, further undermining equality in healthcare.

6.3. Comparison of Migrant Health Centers and State Hospitals

Based on the comparison of E/Migrant Health Centers and state hospitals, some key distinctions and shared challenges emerge. E/MHCs excel in acceptability and availability due to their proximity to communities, language accessibility, cultural alignment, and targeted educational programs. These features increase trust and confidence, making E/MHCs a preferred choice for primary care. However, there are several concerns shared with state hospitals related to the ability to reach dimension due to registration problems, which necessitates a comprehensive policy rather than only formulating focused interventions on this specific dimension. Moreover, appropriateness is another issue in E/MHCs because of the negative attitudes of some doctors, but this problem may be solved with a focused intervention, like making complaint mechanisms more active. Related to the same dimension, the short duration of medical examinations and insufficient information given are other problems.

On the other hand, related to availability and accommodation, state hospitals face barriers in the areas regarding navigating hospital premises and accessing clear information about services. Those problems are the result of language problems and so lack of interpreters in the hospitals. Furthermore, in state hospitals as well, there are important problems related to appropriateness, which are a result of prejudicial attitudes and racism. The difference in this dimension between E/MHCs and state hospitals is related to the reasons behind negative attitudes. It has been reported that the negative behaviors encountered in E/MHCs were predominantly exhibited by doctors. On the other hand, in state hospitals, these behaviors were more often displayed by nurses, caregivers, and non-medical hospital staff and were expressed in an explicitly racist manner.

E/MHCs benefit from a culturally harmonious environment, but this harmony is not seen in the state hospitals where discriminatory attitudes and unprofessional behavior are exercised, especially during childbirth. While the SIHHAT project aims to address these gaps by educating healthcare professionals on issues like dealing with vulnerable groups, the persistence of such problems highlights systemic deficiencies.

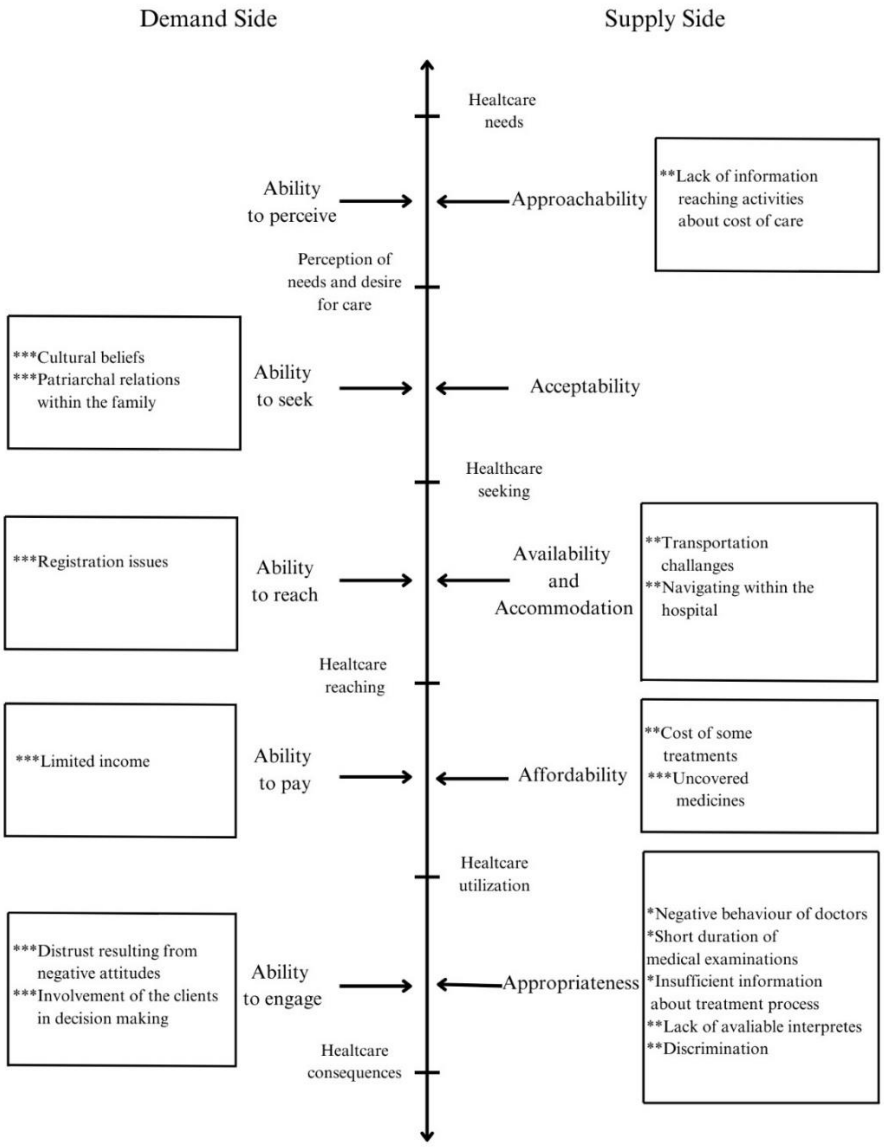

Figure 3. Barriers to Access SRH services in the E/MHCs and State Hospitals According to the Interviews

*Refers to the barriers encountered in E/MHCs

**Refers to the barriers encountered in State Hospitals

***Refers to the barriers encountered in both

Source: Figure adapted by the author from Levesque et al. (2013).

However, both settings share challenges related to appropriateness, as negative staff attitudes undermine patient trust and engagement which is seen in E/MHCs as well. Healthcare services are free in both hospitals and migrant health centers, but contributions for certain treatments and medications often create problems during payment, particularly in hospital settings, where patients may not have prior

information about associated costs. This is partly because hospitals are secondary healthcare facilities, where the required treatment methods are generally more complex compared to services provided at the primary care level and may fall outside the scope of free treatment options. Another reason is that even if a copayment is charged for a medication prescribed to a patient at an E/MHC, this is communicated to the patient in their native language. Now, by placing it within the healthcare access framework I am using, I will comparatively show which stage of the healthcare access process the barriers discussed belong to.

In the interviews, it is observed that the barriers on the demand side of healthcare access are common in both state hospitals and E/MHCs. Therefore, any policy intervention targeting the demand side would improve access to both types of institutions. However, the barriers identified before reaching the stage of applying to a healthcare institution require inclusive and long-term policies. The barriers encountered under the "ability to seek" dimension show how gender-based discrimination and culture in households and communities impact healthcare access. Meanwhile, the registration problems frequently emphasized throughout our study, observed under the "ability to reach" dimension, indicate the necessity for systemic changes.

New policies aimed at preventing the clustering of the Syrian population under temporary protection in certain cities and neighborhoods, as well as keeping their records updated, have been security-oriented steps. However, they have created new obstacles to accessing any kind of public services, including healthcare. To prevent the complete exclusion from public service systems caused by issues such as address registration renewal, neighborhood and city changes, and travel restrictions, the personnel capacity of units handling these matters in public institutions can be increased. Additionally, the conditions leading to the cancellation or invalidation of identity cards, which arise from the aforementioned reasons, can be softened.

The barriers encountered at the final stage of the demand side are a result of problems on the supply side. Therefore, their solutions also depend on addressing the issues under the supply-side "appropriateness" dimension. These barriers are related

to the quality of the services provided. However, if the inadequacy of interpreters in state hospitals is excluded, the barriers reflect the interpersonal manifestations of societal discomfort toward Syrians. On the other hand, the situation in E/MHCs is independent of the societal atmosphere and related to interpersonal negative behaviors and the quality of healthcare services provided. However, they both affect the ability to seek dimension since such barriers undermine an individual's autonomy and confidence to express the intention to access care, particularly among vulnerable or marginalized groups.

Another barrier, which is the lack of available interpreters, contributes to patients not fully understanding their diagnoses, treatments, and associated costs. Therefore, due to communication-related problems in state hospital, patients often lack adequate information about the services they receive. This not only impacts the dimensions of "affordability" and "ability to pay" but also negatively affects the "ability to engage" dimension because service recipients are not fully aware of the decisions being made about their own health. Also, difficulty in navigating hospital systems that is covered under the availability and accommodation dimension is a result of the lack of available interpreters as well. Although it does not directly stem from the same issue, another problem related to the same barrier arises at the very beginning of the supply side. Unexpected costs encountered due to communication problems deter individuals from seeking healthcare in similar future health needs. This highlights that, in terms of approachability, information-sharing activities about which healthcare services are free or paid in state hospitals are insufficient.

6.4. Causes That Affects Seeking Healthcare Services on A Wide Range

While specifically looking at the general barriers that hinder people from seeking healthcare services, respondents pointed out a number of key issues. Some of the interviewees (I_2, I_4, I_5, I_8, I_{10}, I_{11}) mentioned racism and the experience of social exclusion, which creates a feeling of being pushed to the periphery as the most worrying issue. What I am describing is not limited to incidents occurring within healthcare institutions that were mentioned in the former discussions. Negative and racist remarks directed at Syrian women also take place in daily life and social

settings even before they visit a health center. This creates additional barriers, making it difficult for them to leave their homes or neighborhoods to access any kind of service. Other major impediments are issues of temporary protection identification cards, including their withdrawal.

6.5. Concluding Remarks on the Case

In the above observations, one of the outputs is that the barriers to healthcare access among Syrian women are not only confined to the interactions with the healthcare system. These issues can be derived from the factors across a wider context. The experience of social exclusion, feelings of insecurity associated with a temporary legal status, and the threat of deportation mostly affect how they perceive healthcare services.

Furthermore, discriminatory features show themselves in the form of verbal abuse, making the Syrian women victims even more. The above factors are combined with each other and lead to a scenario around which, despite the fact that health care is available, a large number of women are fearful or unwilling to take examination and treatment. This fear and unwillingness are not only the consequences of structural concerns; rather, they are connected to the psycho-emotional impact of their everyday experiences, which are rife with exclusion and discrimination.

The findings further indicate that in order to offer solutions to the problem of access to healthcare by Syrian women UTP, the effective intervention should be complex and cover issues that are beyond the health system. The efforts also need to consider Syrian women's inclusion and participation in issues of society and structural discrimination so that they feel protected and accepted and, most importantly, enabled to seek their essential needs.

The integration of the concept of social exclusion in the frameworks is important in understanding the structural factors that impede Syrian women’s access to health services. Those challenges do not only result from institutional weaknesses but are complexities situated in the way society views and treats this group of people.

Looking at health care provision and its accessibility through social exclusion, it is clear that the issues that are experienced by Syrian women are not only the issues solely of the providing and management of the services. There are other greater issues that are present in the background. Those issues, when coupled with the logistical aspects of providing care, prevent Syrian women from seeking treatment even when the healthcare system is fully functional.

Social exclusion as an analytical tool links Syrian women's experiences of victimization to the overarching social picture. For instance, a woman's reluctance to seek care from a center because she dreads being verbally assaulted or racially abused does not occur in isolation; these are everyday forms of social exclusion. Social exclusion as a concept facilitates this study with an intersectional perspective by recognizing that Syrian women encounter multiple layers of discrimination related to their gender, migration status, ethnicity, and socioeconomic condition. This intersectionality exacerbates their vulnerability and increases barriers to healthcare access.

At this point, I would like to turn to the social exclusion domains presented by Reimer (2004). It can be observed that all four of these domains are related to the challenges Syrian women face in accessing healthcare. If I were to explain this one by one, for example, a Syrian woman excluded from market relations may be unable to benefit from a healthcare service due to additional fees, which illustrates how the economic domain, in the context of our study, influences access to healthcare. In the bureaucratic domain, which pertains to relationships with formal institutions, factors such as lack of information, registration problems, and negative experiences within institutions emerge as reasons for exclusion in this area and may result in limited access to healthcare services. The findings of this thesis particularly highlight negative outcomes related to these three reasons.

The relational domain, as the third area, is connected to social networks and participation in society at a social level. The bonds established within this domain can enhance access to public services, while their absence can lead to problems in access. As a result of my fieldwork, I observed that Syrian women have weak social

networks and even lack sufficient solidarity mechanisms among themselves. Consequently, it is seen that exclusion from this domain also results in difficulties in accessing healthcare services.

Lastly, the communal domain brings to the forefront elements such as collective experiences, shared identities, and common culture. Unfortunately, this appears to be the area where Syrian women face the most exclusion. The reason I make this claim is the clear evidence of discrimination, racism, and negative attitudes and discourses that emerged in the findings of my fieldwork. This situation not only manifests itself in social life but is also seen in healthcare settings, negatively impacting access to healthcare services.

CHAPTER 7

CONCLUSION

7.1. Revisiting Key Arguments and Theoretical Framework

This thesis aimed to examine access to sexual and reproductive health for women under temporary protection through Migrant Health Centers in Türkiye. In developing the analytical framework for this examination, I was aided by the social exclusion literature and theoretical discussions on how exclusion, combined with elements such as gender and migration, can affect health. However, the main framework for my study was Levesque et al.'s (2013) framework of access to health. The main reason for using this framework is that it looks at both the service provider side and the service recipient side of the access to health process, which will enable me to see the relationship between these two clearly.

I adopted the triangulation method as a policy analysis tool and conducted my analysis in three stages accordingly. I started my analysis by examining national and international regulations, which would show me more about the situation on the supply side of access to health and provide a general framework for my further discussions. In the following section, I looked at international and national reports that examined the access to E/MHCs and of Syrians to the health system in general. I placed the problems that appeared in these reports in the healthcare access framework I used. My aim in doing this was to ensure that the reports were equidistant from supply and demand and that they would give the barriers specific to both sides of supply and demand in the process of access to health. Finally, I went out into the field and interviewed NGOs working in the field of Syrians' access to health, and these interviews gave me more of the problems seen from the demand side. In light of the information I obtained in the last two stages of my analysis, I will

gather the barriers in both E/MHCs and state hospitals to access sexual and reproductive health for Syrian women into a single figure and present my conclusions. Before discussing the theoretical and empirical findings, I would like to quickly touch upon the differences and complementary features between reports and interviews.

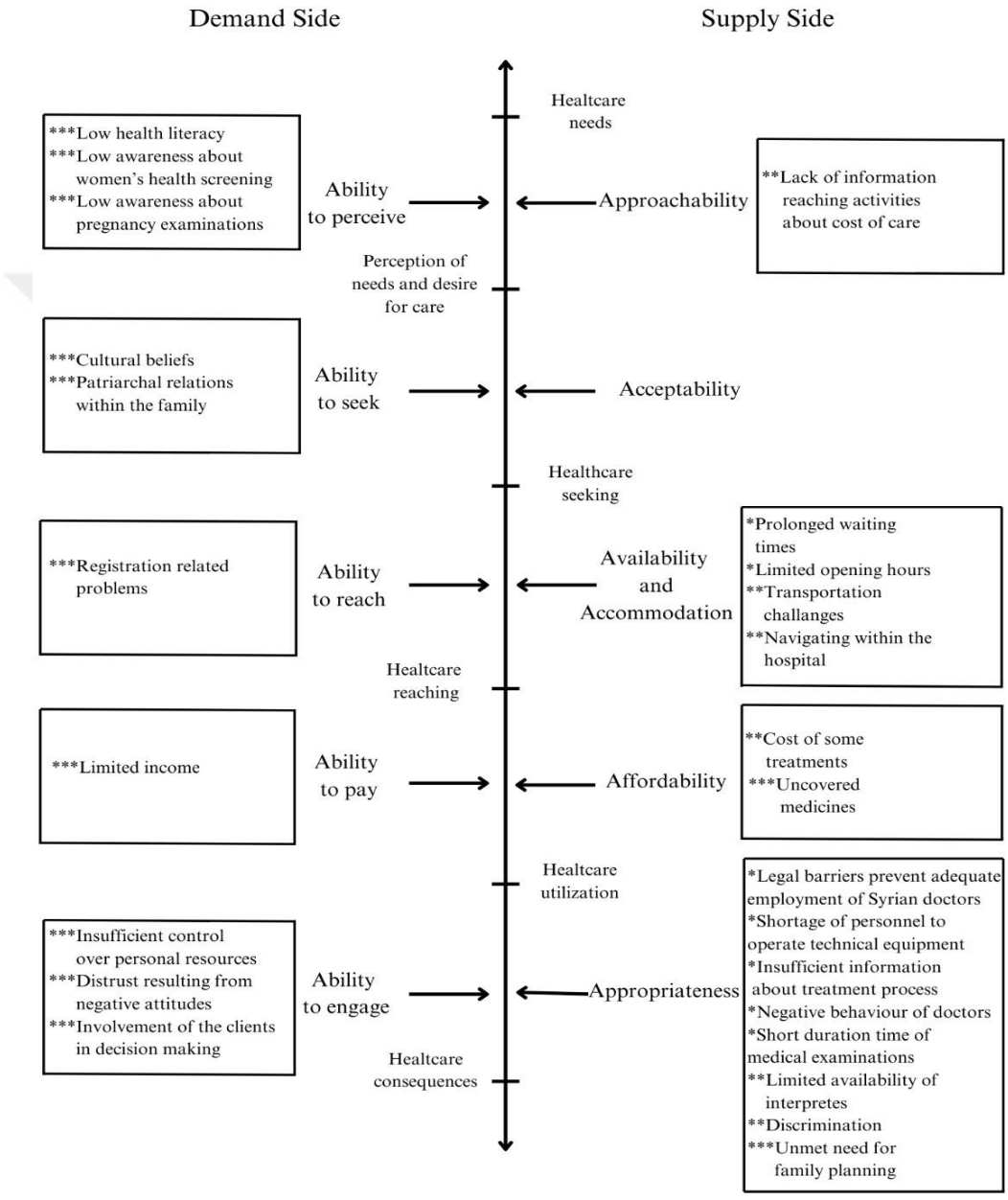

Figure 4. Barriers to Access SRH services in the E/MHCs and State Hospitals According to the Reports and Interviews

*Refers to the barriers encountered in E/MHCs

**Refers to the barriers encountered in State Hospitals

***Refers to the barriers encountered in both

Source: Adapted from Levesque et al., 2013, and Republic of Turkey Ministry of Health, 2020, 2022).

7.1.1. Comparison of Reports and Interviews

The information I gathered from the reports and interviews did not contradict each other, but there were some additional and missing data. I would like to talk a little about these differences and their potential reasons. In the "ability to perceive" step, which is the first step of healthcare access, I did not see the barriers that were seen in the reports in the interviews. The reason for this might be that the NGOs I interviewed have already implemented projects to strengthen this step, so the problems they see from the perspective of Syrians may no longer be a problem for them. Again, the reason why the long waiting times and limited working hours that I see in the reports about E/MHCs did not appear in the interviews may be that the number of E/Migrant Health Centers has increased since the dates of the reports. Therefore, there seems to be not an intense accumulation of patients in a single center anymore. Another issue that I see in the reports but did not come across in the interviews is the supply-side barriers at the last stage of healthcare access, such as the difficulty in finding personnel to use technical equipment and specialized doctors. These barriers may have appeared in the reports as they are more visible from the service provider's point of view.

The problems that are encountered at the last stage of healthcare access, which I do not see clearly in the reports and only appear under the heading of discrimination, are revealed through the interviews. The reason might be that the interviews I conducted used the semi-structured interview method, not the survey method. Therefore, after a barrier was mentioned by the interviewees, additional questions were asked to understand the underlying reasons for that barrier more clearly. Consequently, I came across results that affect both other stages and other dimensions of the healthcare access process related to that barrier. For example, it has been seen how the lack of adequate translators in state hospitals can negatively affect the affordability of health services, Syrian women's perception of the quality of the health services they receive,

their impact, and how unexpected fees can negatively affect the seek for services in the event of a new health need.

Furthermore, I have seen in the interviews how the outcomes related to the negative attitudes of the doctors and the quality of the examinations in the E/MHCs affect the other stages and dimensions. Although the affordability problems seen in the state hospitals caused by language barriers due to the lack of translators are not apparent here, I have seen how the "ability to engage" and the "ability to seek" dimensions can be negatively affected.

These results show that the contribution of the triangulation technique was that it enabled me to see the aspects of the subject that might have been missing in a single-stage analysis and that the outputs in the reports and interviews complemented each other.

7.2. Key Empirical Findings

The empirical results of this thesis show that the strict conditions of the address registration renewal policy, which I grouped under the heading of registration-related problems, are among the main factors that negatively affect Syrian women's access to SRH services. Therefore, these problems directly exclude some Syrian women UTP from the system. In such cases, exclusion from the bureaucratic domain completely blocks access to healthcare.

In E/MHCs, Syrian women UTP face indifferent and negative attitudes from doctors, especially in the SRH examinations, which prevents them from actively participating in the treatment and follow-up process and leads them to either not seek health services altogether or to prefer state hospitals when a new health need arises.

Discriminatory attitudes and discourses against Syrian women in state hospitals are perpetrated by hospital staff rather than doctors. Although the reasons and forms of negative attitudes are different from E/MHCs, this situation prevents Syrian women from actively participating in the healthcare process and decisions regarding their

own health and even prevents them from seeking services in case of a new healthcare need, just as it has been seen in E/MHCs. This issue is deeply connected to social exclusion, as the negative attitudes experienced by Syrian women in healthcare institutions are not merely interpersonal but reflective of broader systemic barriers. These negative interactions erode trust and reinforce feelings of marginalization, making Syrian women feel unwelcome or unvalued within the healthcare system.

With their strength in the dimensions of "acceptability" and "availability and accommodation", E/Migrant Health Centers offer an alternative service to solve the problems of communication, cultural adaptation, transportation, and navigation within state hospitals. However, if policies increase the institutional capacity of E/MHCs but ignore the barriers on the demand side of the health access process and fail to address the problems at the final stage of the supply side, these institutions will remain far from providing a better alternative to state hospitals for SRH services. This highlights the necessity of aligning supply-side policies with solutions that tackle demand-side challenges to ensure their effectiveness in improving healthcare access.

The findings that do not fit neatly into the framework of access to health services are related to negative attitudes stemming from the widespread anti-Syrian hostility in Turkish society. This hostility makes it increasingly difficult for Syrian women to leave their neighborhoods, thus negatively affecting every step of their access to healthcare.

7.3. Key Theoretical Contributions

The fact that I have created a theoretical framework by incorporating the social exclusion literature into my study, along with a specific model of healthcare access, has illuminated both the social and systemic aspects of the barriers faced by Syrian women UTP in Türkiye.

Levesque et al.'s (2013) access to health framework provides an effective model for simultaneously understanding and linking supply-side and demand-side barriers to

accessing health services, and my research adds a new layer to their framework of healthcare access, focusing on the experiences of Syrian women under temporary protection. This filled a gap in the literature by looking at how different barriers jointly affect healthcare access instead of treating them separately. Therefore, this thesis provides an examination of how systemic, interpersonal, and institutional factors intersect at different points of healthcare provision, thereby offering targeted insights for addressing these challenges effectively.

7.4. Policy Recommendations

Based on these findings, I am proposing the following recommendations:

The number of translators in state hospitals should be increased, and complaint mechanisms in E/Migrant Health Centers should be made more active.

Awareness-raising training and seminars for Syrian women should continue, especially in sexual and reproductive health.

Registration problems in accessing health facilities resulting from address verification issues and traveling should be addressed by increasing the number of staff managing these processes and/or by integrating further conditions for related identity revocations.

New policies in the health sector should adopt a holistic approach that recognizes access to health services as part of a broader framework to address social exclusion and integrate health interventions with efforts to combat racism, xenophobia, and systemic discrimination in society.

7.5. Final Remarks

This thesis demonstrates that access to sexual and reproductive health for Syrian women UTP in Türkiye is affected by a combination of systemic, interpersonal, and societal factors. Although Migrant Health Centers were established with the mission

to increase the inclusion of Syrians in the health system, there is room for improvement in terms of the amount of care taken to assess health problems and determine the right treatment and the technical and interpersonal quality of the services provided. In addition, the discrimination experienced in state hospitals as a reflection of the exclusion they experience in public life is an obstacle to Syrians' access to secondary healthcare services.

7.6. Limitations of the Study and Recommendation for Future Research:

Two of the limitations are about my third stage analysis, where I conducted my interviews. Firstly, I was unable to interview individuals directly providing or receiving healthcare services, which limited the primary perspectives in my work. Secondly, the number of interviews was limited to twelve, which is a reason that reduces the generalizability of the data. Moreover, as this study is a three-stage health policy analysis, it has covered the access process quite broadly, so there may be factors that have been overlooked. Therefore, more focused studies using a similar framework are needed. Those studies might consider looking at only one stage of Levesque et al.'s healthcare access framework while analyzing a similar subject. This would allow for a more detailed examination of the challenges associated with that particular stage.

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APPENDICES

A. ORIGINAL RESEARCH PROTOCOL AND QUESTIONS

GÖRÜŞME FORMU

Görüşme No: _____ Tarih: _____

Öncelikle çalışmaya katılmayı kabul ettiğiniz için teşekkür ederim. Ben ODTÜ Siyaset Bilimi ve Kamu Yönetimi Yüksek Lisans Programı öğrencisi Melike Kaya. Prof. Dr. Mustafa Kemal Bayırbağ danışmanlığında yüksek lisans tezim için, sizlerle görüşerek veri toplamam gerekmektedir. Yüksek lisans tezim kapsamında Ankara'da yaşayan Geçici Koruma Statüsü altındaki Suriyeli kadınların cinsel sağlık ve üreme sağlığına erişimleri ile alakalı bilgi topluyoruz. Bu tezi yazabilmek için sizin duygu, düşünce ve deneyimlerinizi bizimle paylaşmanızın çok önemli olduğunu düşünüyoruz.

Görüşmeye başlamadan önce, verdiğiniz cevapların sadece araştırmacı tarafından bu çalışma için kullanılacağını, hiç kimse ile paylaşılmayacağını belirtmek isterim. Sorulara içtenlikle cevap vermeniz çalışmanın amacına hizmet etmesi bakımından önemlidir. Çalışma ile ilgili olarak bilgi edinmek isterseniz, araştırmacı Melike Kaya ya da tez danışmanı Prof. Dr. Mustafa Kemal Bayırbağ ile iletişime geçebilirsiniz.

Görüşmeyi izninizle hem veri kaybını önlemek hem de analizi kolaylaştırmak adına kayıt altına almak istiyorum.

Herhangi bir sorunuz ya da söylemek istediğiniz bir şey yoksa izninizle görüşmeyi başlatmak istiyorum.

Melike Kaya

ODTÜ Siyaset Bilimi ve Kamu Yönetimi
Yüksek Lisans Öğrencisi
İletişim:

1. Çalıştığınız kurumun ismi nedir?
2. Çalıştığınız kurumun türü nedir?
3. Söz konusu kurumdaki mesleğiniz ve görevleriniz nelerdir?
4. Suriyelilere cinsel sağlık ve üreme sağlığı hizmetleri sunumunda, gözlemleriniz doğrultusunda en başarılı bulduğunuz hizmet nedir? Bu hizmetin öne çıkmasının nedenleri nelerdir?
5. Suriyeli kadınlara cinsel sağlık ve üreme sağlığı hizmetleri sunulurken karşılaşılan başlıca zorluklar nelerdir? Bu sorunların çözümü için önerileriniz nelerdir?
6. Cinsel sağlık ve üreme sağlığı hizmeti alan Suriyeli kadınların en memnun kaldığı hizmet sizce nedir? Gözlemleriniz doğrultusunda bu memnuniyeti sağlayan faktörler nelerdir?
7. Suriyeli kadınların cinsel sağlık ve üreme sağlığı ile alakalı hizmetlerden faydalanabilmek için başvurmayı özellikle tercih ettikleri bir kurum tipi var mıdır, varsa hangisidir ve bunun nedenleri neler olabilir?
8. Cinsel sağlık ve üreme sağlığı hizmetlerinin Suriyeli hizmet alıcı kadınlar tarafından etkin kullanılabildiğini düşünüyor musunuz? Evet ise; bunu sağlamak için alınan önlemler nelerdir? Hayır ise; bunun sebepleri nelerdir ve çözüm önerileriniz nelerdir?
9. Suriyeli kadınların, cinsel sağlık ve üreme sağlığı hizmetlerinden yeterince haberdar olduklarını düşünüyor musunuz? Hayır ise bunun nedenleri nelerdir?
10. Suriyeli kadınlara verilen cinsel sağlık ve üreme sağlığı hizmetleri ile Türk vatandaşlarına verilen hizmetler arasında farklar var mı? Bu alanda, Suriyeli kadınların Türk vatandaşlarından farklı özel ihtiyaçları oluyor mu? Oluyorsa bunlar nelerdir?
11. Cinsel sağlık ve üreme sağlığı hizmeti almak için hastanelere ya da göçmen sağlık merkezlerine başvuran Suriyeli kadınlarla güçlü bir iletişim için gerekli kanalların yeterli olduğunu düşünüyor musunuz?
12. Kurumlardaki cinsel sağlık ve üreme sağlığı ile ilgili teknik ekipman ve bu ekipmanları kullanabilecek personel sayısını yeterli buluyor musunuz? Bu konuda varsa iyileştirme önerileriniz nelerdir?
13. Kaydı olmayan veya hizmet almak istedikleri ilde kayıtlı olmayan Suriyeli kadınlar cinsel sağlık ve üreme sağlığı hizmeti almak için başvurduklarında süreç

nasıl işliyor? Bu konuyla alakalı varsa atılan ve atılması gereken adımlar nelerdir?

14. Göçmen Sağlık Merkezlerinin, cinsel sağlık ve üreme sağlığı alanında hastanelerin yükünü hafiflettiğini düşünüyor musunuz?

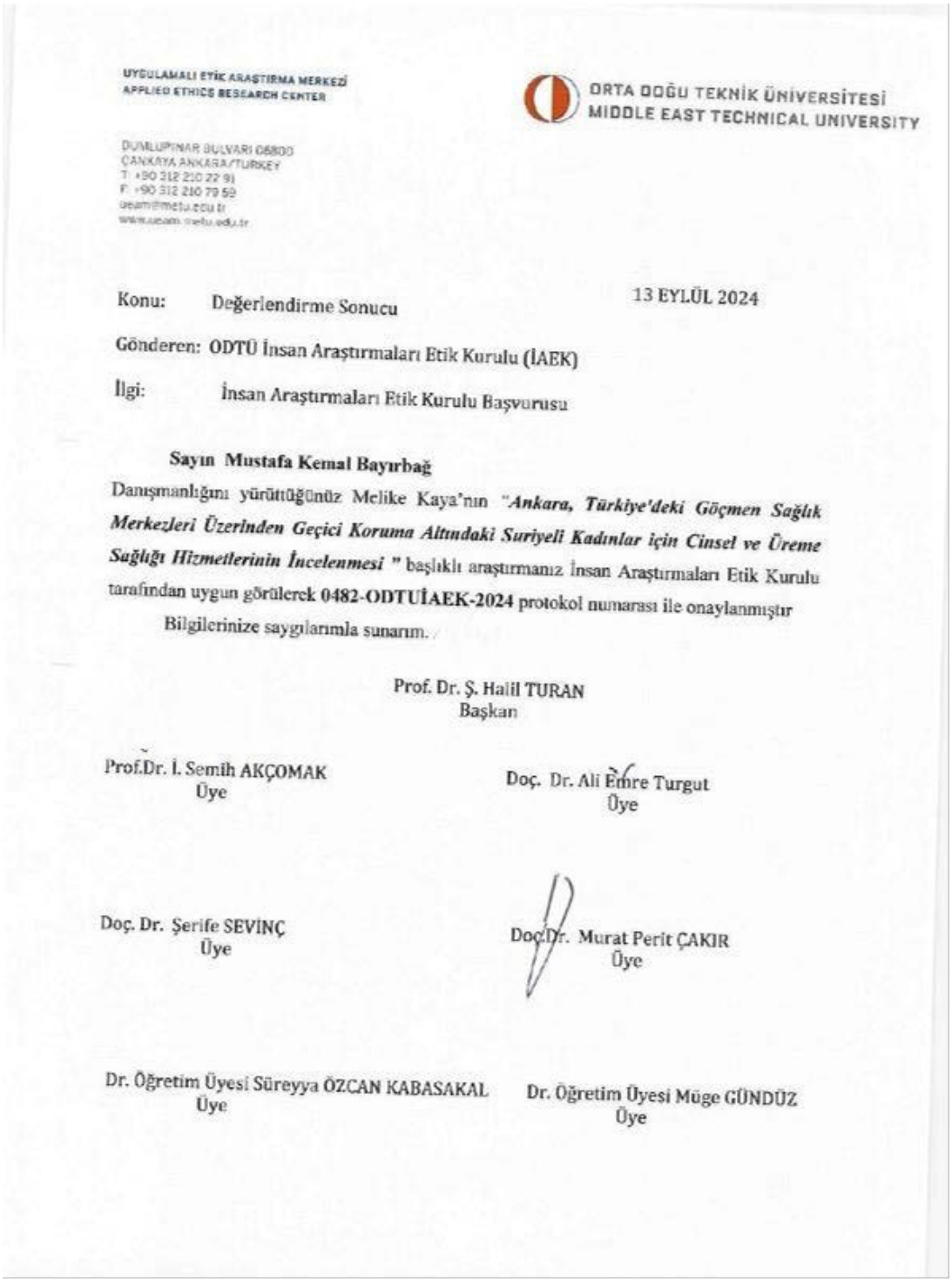
15. Göçmen Sağlık Merkezlerini diğer kamu/özel hastanelerinden ve aile hekimliklerinden hizmet sunum şekli olarak farklı kılan ve başvuru oranlarını artıran özellikler sizce nelerdir?

16. Göçmen Sağlık Merkezlerinin iyileştirilmesi ile alakalı en fazla gelen öneriler nelerdir? Öneri ve görüşlerden haberdar olmak için hangi kanalları kullanıyorsunuz?

17. Zorunlu göç ile ülkemize gelen toplumlara sağlık hizmeti sağlayan STK'lar tarafından işletilen kliniklerin kapatılması hakkında ne düşünüyorsunuz, sizce bu adımın faydaları ve zararları ne oldu?

18. Suriyeli kadınlara yönelik sağlık hizmetleri hakkında paylaşmak istediğiniz ek yorumlar veya öneriler var mı?

B. APPROVAL OF THE METU HUMAN SUBJECTS ETHICS COMMITTEE



UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

ORTA DOĞU TEKNİK ÜNİVERSİTESİ
MIDDLE EAST TECHNICAL UNIVERSITY

DUMLUPINAR BULVARI 06800
ÇANKAYA ANKARA/TURKEY
T: +90 312 210 22 91
F: +90 312 210 79 59
uygulametu.edu.tr
www.uygulametu.edu.tr

Konu: Değerlendirme Sonucu

13 EYLÜL 2024

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Mustafa Kemal Bayırbağ

Danışmanlığını yürüttüğünüz Melike Kaya'nın ***"Ankara, Türkiye'deki Göçmen Sağlık Merkezleri Üzerinden Geçici Koruma Altındaki Suriyeli Kadınlar için Cinsel ve Üreme Sağlığı Hizmetlerinin İncelenmesi "*** başlıklı araştırmanız İnsan Araştırmaları Etik Kurulu tarafından uygun görülerek **0482-ODTUİAEK-2024** protokol numarası ile onaylanmıştır

Bilgilerinize saygılarımla sunarım.

Prof. Dr. Ş. Halil TURAN
Başkan

Prof.Dr. İ. Semih AKÇOMAK
Üye

Doç. Dr. Ali Emre Turgut
Üye

Doç. Dr. Şerife SEVİNÇ
Üye

Doç.Dr. Murat Perit ÇAKIR
Üye

Dr. Öğretim Üyesi Süreyya ÖZCAN KABASAKAL
Üye

Dr. Öğretim Üyesi Müge GÜNDÜZ
Üye

C. TURKISH SUMMARY / TÜRKÇE ÖZET

Giriş

Göç, özellikle de zorunlu göç, Dünya genelinde toplumları yeniden şekillendirmeye devam etmektedir. 2024 yılı ortası itibariyle, zulüm, çatışma, şiddet, insan hakları ihlalleri ve kamu düzenindeki önemli bozulmalar nedeniyle Dünya genelinde 122,6 milyon kişi zorla yerinden edilmiştir (Birleşmiş Milletler Mülteciler Yüksek Komiserliği, 2024). Bunların 37.9 milyonu mülteci, 8 milyonu sığınmacı ve 5.8 milyonu uluslararası koruma beklemektedir (BMMYK, 2024). Zorla yerinden edilen nüfusların 6,3 milyonu Suriye Arap Cumhuriyeti'ndendir ve Türkiye 3.148.663 zorla yerinden edilmiş kişiye ev sahipliği yapmaktadır (BMMYK, 2024). Göç İdaresi Başkanlığı'nın Kasım 2024 tarihli son verilerine göre, Türkiye'deki zorla yerinden edilen kişilerin 2.936.252'si Suriye Arap Cumhuriyeti'ndendir (Göç İdaresi Başkanlığı, 2024). Yerinden edilen ve göç etmek zorunda kalan toplumlar, ev sahibi ülkelerde sağlık hizmetlerine erişim gibi kamu hizmetleriyle ilgili benzersiz zorluklarla karşılaşmaktadır. Göç etmeye zorlanmış Suriyeli toplumdaki kadınlar için zorluklar, kültürel engeller ve toplumsal cinsiyete dayalı eşitsizlikler de dâhil olmak üzere, genellikle kesişen kırılganlıklarla daha da artmaktadır. Türkiye bağlamında, Suriye'den gelen büyük göç dalgaları endişeleri artırmış ve yerinden edilmiş nüfusların sağlık sistemlerinde nasıl yollarını buldukları ve sisteme entegre olduklarına odaklanan çalışmaları gerekli kılmıştır.

Sağlık hizmetleri, diğer kamu hizmetleri arasında en erişilebilir hizmetlerden biri olarak gösterilse de (Erdoğan, 2020) sağlık hizmetlerine erişim düzeyini belirleyen birçok bariyer bulunmaktadır. İlgili literatüre göre, Türkiye'deki Suriyelilerin sağlık sektöründe en çok karşılaştığı sorunlar; dil engeli (Abohalaka ve Yeşil, 2021; Assi vd., 2019), operasyonel verimlilik ve ölçek verimliliği (Achiri ve Ibrahim, 2022), kayıt prosedürü düzenlemeleri (Alawa vd., 2019) ve maliyetlerdir (Karasapan, 2018).

Türkiye'deki Suriyeli kadınlar gibi, ülkelerini terk etmek zorunda kalmış kadınlar sıklıkla cinsel ve toplumsal cinsiyete dayalı şiddete yönelik koruma ve müdahale hizmetlerine erişim, düşük sağlık okuryazarlığı seviyeleri, sağlık çalışanları arasında yetersiz kültürel yeterlilik, damgalanma (Dünya Sağlık Örgütü, 2024), sosyal izolasyon, iş ve aile görevleri, sistemik ayrımcılık (Vissandjée vd., 2001) gibi ek engellerle karşılaşmakta ve bunların tümü, gerekli sağlık bakımı alma becerilerini engellemektedir.

Sağlık hizmet sunumundaki problemleri gidermek ve sağlık sisteminin kapasitesini artırmak için, 18 Mart Avrupa Birliği - Türkiye Anlaşmasını takiben SIHHAT (Geçici Koruma Altındaki Suriyelilerin Sağlık Statüsünün ve Türkiye Cumhuriyeti Tarafından Sunulan İlgili Hizmetlerin Geliştirilmesi Projesi) gibi büyük projeler finanse edilmiştir. SIHHAT Projesi, özellikle bu proje öncesi 2015'te kurulmuş olan Göçmen Sağlık Merkezlerini (GSM) birinci basamak sağlık tesisleri olarak finanse ederek devlet hastaneleri üzerindeki yükü hafifletmeyi amaçlamaktadır.

Bu tezin odak noktası olan Göçmen Sağlık Merkezleri, Toplum Sağlığı Merkezlerine bağlı birinci basamak sağlık hizmeti sağlayıcıları olarak öncelikle Suriyelilerin yoğunlukta yaşadığı bölgelerde daha sonra da tüm Türkiye'de sadece Geçici Koruma Altındaki Suriyelilere hizmet vermek için açılmıştır. Bu merkezler, Geçici Koruma Altındaki Suriyelilere kendi ana dillerinde, Suriyeli doktor ve personel aracılığı ile hizmet vermektedir. Proje aracılığı ile kurulan veya desteklenen GSM'lerin bir kısmı "Güçlendirilmiş" Göçmen Sağlığı Merkezleridir (GGSM). Güçlendirilmiş merkezlerde dahiliye, kadın hastalıkları ve doğum, pediatri, ağız ve diş sağlığı hizmetleri, psiko-sosyal destek hizmetleri, laboratuvar ve röntgen hizmetleri de verilmektedir.

Göçmen Sağlık Merkezlerinin Bu Tez Bağlamında Önemi

Türkiye'deki Geçici Koruma Altındaki Suriyelilerin sağlık hizmetlerine birincil erişim noktası olarak işlev gören Göçmen Sağlık Merkezleri, araştırmam için büyük öneme sahiptir. Öncelikle, genel sağlık sisteminin dışında tasarlanmış ve daha sonra sisteme entegre edilmiş olduklarından sağlık hizmeti sağlama modelleri açısından

benzersiz bir örnek oluştururlar. İkinci olarak, bu tesisler özellikle Suriyeli nüfusunun gereksinimlerini karşılamak için oluşturulmuştur ve bu da dil ve diğer kültürel sorunlar da dahil olmak üzere karşılaştıkları onlara özel zorlukları hafifleten bir atmosfer sağlar. Türkiye'deki Suriyeli nüfusa kendi dillerinde ve benzer göç deneyimlerini paylaşan Suriyeli doktor ve personel tarafından hizmet sağlarlar, bu da onları Suriyeli kadınların ihtiyaçlarına daha duyarlı hale getirir. Dahası, Suriyeli kadınların sağlığa erişimi için hem coğrafi hem de sosyal erişilebilirliğini sağlamak amacıyla, kasıtlı olarak yüksek Suriyeli nüfus yoğunluğuna sahip bölgelerde hizmet vermektedirler. Burada bahsettiğim G/GSM'lerin özellikleri, ilerleyen bölümlerde detaylıca açıklayacağım bu tezde kullanılan sağlık hizmetlerine erişim çerçevesindeki kabul edilebilirlik, mevcudiyet ve uyum boyutlarıyla ilgilidir. G/GSM'ler nispeten kapsayıcı ve hasta merkezli bir modeli temsil etse de hem birinci hem de ikinci basamak sağlık hizmeti ortamlarında önemli engellerin devam ettiği açıktır. Dolayısıyla bu tez, G/GSM'lerin Türkiye'deki Geçici Koruma Altındaki Suriyeli kadınlar için sağlığa erişimin bahsettiğimiz boyutlarında başarılı birer örnek teşkil etmeleri nedeniyle süregelen problemleri çözmek için alternatif bir yol sağladığı ve Cinsel Sağlık ve Üreme Sağlığı (CSÜS) hizmetlerine erişimi kolaylaştırdığını varsaymaktadır.

Bu çalışmayla, Türkiye'de Geçici Koruma Altındaki Suriyeli kadınlara sunulan Cinsel Sağlık ve Üreme Sağlığı hizmetlerinin, G/GSM'ler aracılığı ile erişilebilirliğini ve kalitesini araştırmayı amaçlıyorum. Ancak, CSÜS hizmetleri, bu hizmetlerin parçası olduğu genel sağlık sistemi tartışılmadan ve incelenmeden tek başına analiz edilemez. Bu nedenle, G/GSM'ler dışındaki genel sağlık sistemine ve özellikle devlet hastaneleri olmak üzere kurumlara bakmaktan ve karşılaştırmalı bir analiz sunmaktan kaçınmayacağım.

Temel Kavramlar ve Çerçeveler

Sağlık hizmetlerine erişim sürecini incelediğimden "erişim" bu tezin en temel kavramları arasındadır. Penchansky ve Thomas (1981, s.127) tarafından tanımlandığı üzere, erişim, hasta ile sağlık sistemi arasındaki uyumu tanımlayan spesifik boyutların bir kümesini özetlerler ve "hizmetlerin kullanımı" anlamının ötesine

geçer. Ayrıca, amacım sağlık hizmetlerine erişimi etkileyen karmaşık dinamikleri analiz etmek olduğundan, sosyal dışlanma kavramı toplumsal cinsiyetin etkisi de göz önünde bulundurularak analitik bir araç olarak kullanılmıştır. Ancak çalışmamın temelini oluşturan analitik çerçeve Levesque, Harriss ve Russell (2013) tarafından geliştirilen sağlık hizmetlerine erişim modelidir. Bu çerçeve, sağlık hizmetlerinin arz ve talep tarafındaki engelleri ve kolaylaştırıcıları analiz etmek için kapsamlı bir metodoloji sunmaktadır. Bulgular, hem sağlık sisteminin yapısal sorunlarının hem de özel olarak bireylerin sağlık arayışındaki deneyimlerinin anlaşılmasına katkıda bulunmayı amaçlamaktadır.

Sağlık Hizmetlerine Erişim Çerçevesi

Kullandığım sağlık hizmetlerine erişim çerçevesi, sağlık sistemlerinin farklı toplumların ihtiyaçlarını ne kadar iyi karşıladığını değerlendirmek için kapsamlı bir araç sunmaktadır ve erişimi etkileyen faktörlere hem arz hem de talep yönünden bakmakta ve farklı aşamalardaki boyutları listelemektedir. Dolayısıyla benzer faktörleri, sağlık sisteminin arz ve talep tarafında belirledikleri beş boyuta yerleştirerek, sorunların neyle ilgili olduğunu net bir şekilde gösterme imkanı sağlamaktadır. Ek olarak, bu sorunların, erişim sürecinin hangi aşamasında ve hangi boyutla ilgili olarak ortaya çıktığı görülecektir. Bu çerçeveyi uygulayarak, Türkiye'deki Suriyeli kadınların CSÜS hizmetlerine ne ölçüde erişebildiğini, bunları ne ölçüde kullanabildiğini, hizmetlerin ne kadar yararlı olduğunu ve G/GSM'lerin bu hizmetlerin erişimine etkisini sistematik olarak değerlendirebiliriz. Bu konunun Göçmen Sağlık Merkezleri merceğinden incelenmesi, yerinden edilmiş kişilere ve toplumdaki en kırılgan gruplara yönelik hizmet sunum modellerinin değerlendirilmesi açısından son derece değerlidir. Kullandığım sağlığa erişim çerçevesinin boyutlarını kısaca açıkladıktan sonra, araştırmamı nasıl bir yol ve yöntem izleyerek yaptığımı anlatacağım.

Sağlık Hizmetlerine Erişim Boyutları (Levesque, Harris, Russell, 2013)

Yaklaşılabilirlik (Approachability): Bilgi bulunabilirliği, erişim çabaları ve şeffaflık gibi yönler de dahil olmak üzere sağlık hizmetlerinin erişilebilirliğini ifade eder.

Algılama Yetisi (Ability to Perceive): Çoğunlukla bireylerin sağlık hizmeti aramanın önemini anlama kapasitesini ifade eder ve büyük ölçüde sağlık okuryazarlık seviyelerinden etkilenir.

Kabul edilebilirlik (Acceptability): Hizmetlerin, bir bireyin kültürel geçmişi ve sosyal koşullarıyla ne kadar iyi uyumlu olduğunu, adil ve uygun hizmet sunumunu garanti altına almayı ifade eder.

Arama Yetisi (Ability to Seek): Bir bireyin sağlık hizmeti arama konusundaki kişisel eğilimini yansıtır; özerklik ve sağlık hizmeti hakkında bilgi sahibi olma gibi faktörler de dahil olmak üzere bireyin ait olduğu grup veya grupların kültürel koşullarıyla da ilgilidir.

Mevcudiyet ve Uyum (Availability and Accommodation): Bu boyut, hizmetlerin ve sağlayıcılarının fiziksel ve zamanında erişilebilirliği ve hizmet sunma kapasiteleriyle ilgilidir.

Ulaşma Yetisi (Ability to Reach): Mevcudiyet ve uyumun talep tarafındaki izdüşümünü ifade eder ve bir bireyin hareketliliğinden ve seyahat edebilme yeteneğinden etkilenir.

Karşılanabilirlik (Affordability): Ödeme yöntemleri ve mevcut kaynaklar dahil olmak üzere hizmetlere erişimle ilişkili hem doğrudan hem de dolaylı maliyetleri ifade eder.

Ödeme Yetisi (Ability to Pay): Bireyin finansal sıkıntı yaşamadan hizmet maliyetlerini karşılayabilme yeteneği ile ilgili etmenleri gösterir.

Uygunluk (Appropriateness): Yeterlilik, kalite ve etkinlik gibi faktörleri göz önünde bulundurarak uygunluk, hizmetlerin hasta ihtiyaçlarını ne kadar iyi karşıladığıyla ilgilidir; sağlık sorunlarını değerlendirmede ve doğru tedaviyi belirlemede harcanan özen miktarını ve sağlanan hizmetlerin teknik ve kişilerarası kalitesini ifade eder.

Katılım Yetisi (Ability to Engage): Kişisel iletişimi ve bir bireyin sağlık hizmetleriyle ilgili olarak aktif olarak katılma ve bilinçli kararlar alma kapasitesini içerir.

Yöntem, Metodoloji ve Araştırma Tasarımı

Bu tez, Türkiye'deki sağlık hizmetlerine erişim ekosistemini analiz etmek için bir vaka çalışması tasarımı benimseyerek özel olarak Geçici Koruma altındaki Suriyeli kadınların CSÜS hizmetlerine erişimine odaklanmıştır. Bu tasarım, karmaşık ve bağlama özgü olguları keşfetme becerisi nedeniyle seçilmiştir (Yin, 2014). Ek olarak, çalışmanın geçerlilik ve güvenilirliğini güçlendirmek için hem bir politika değerlendirme aracı hem de bir araştırma stratejisi olarak, birden fazla yöntem, veri kaynağı ve/veya teorik çerçeve kullanabilmeyi sağlayan, bulguları çapraz kontrol eden ve araştırma tasarımını güçlendiren üçgenleme yöntemi kullanılmıştır (Denzin, 1978; Patton, 1999).

Analiz, farklı veri kaynakları kullanılarak üç aşamada gerçekleştirilmiştir:

1) Hukuki Metinlerin İncelemesi: Çalışmanın ilk aşaması, Suriyeli kadınların CSÜS hizmetlerine erişiminin daha geniş bağlamını anlamak için ulusal ve uluslararası yasal düzenlemeleri inceleyerek başlamıştır. Bu aşamadaki amacım, mevcut durumu değerlendirecek bir çerçeve oluşturmak ve ileriki analizlerim için bir temel oluşturmaktır. Aynı zamanda yasal belgelerin kurum ve sistemleri düzenleyen bir doğada olmasının bana başlangıçta sağlığa erişim sürecinin arz tarafına dair daha çok çıktı vereceğini düşünmüş olmam etkili olmuştur.
2) Politika Doküman İncelemesi: İkinci aşama, Türkiye'ye zorunlu göçle gelmiş toplumların ve bu topluluklar arasında özel olarak Suriye'den gelenlerin sağlık hizmetlerine erişimiyle ilgili uluslararası ve ulusal raporları incelemeyi içeriyordu. Bu raporlar, Göçmen Sağlık Merkezlerinin kurulması ve desteklenmesi ile ilgili Suriyelilerin sağlık hizmeti kullanımına ve karşılaştığı zorluklara ilişkin nicel veriler de sağladı. Buradan edindiğim bilgiler hem arz hem de talep perspektiflerinden görülen bariyer ve kolaylaştırıcıların dengeli bir şekilde sunulmasını sağladı ve konumuzla alakalı çıktılar Levesque ve

diğerlerinin (2013) sağlık hizmetlerine erişim çerçevesine yerleştirilerek analiz edildi.

3) Yarı Yapılandırılmış Görüşmeler: Son aşamada, Suriyeli kadınların sağlık hizmetlerine erişimi üzerine çalışan on iki STK temsilcisiyle yarı yapılandırılmış görüşmeler yapıldı. Bu adım, çıktılarımı hizmet alıcının perspektifine daha yakınlaştırdı. Görüşmelerin sonuçları Levesque'in ve diğerlerinin (2013) çerçevesine entegre edildi ve daha önceki yasal düzenlemeler ve rapor verileriyle çapraz referanslandı.

Çalışma boyunca, Levesque ve diğerlerinin çerçevesi içinde, yasal belgelerden, raporlardan ve görüşmelerden gelen bilgiler birleştirerek veri üçgenlemesi elde edildi. Ayrıca belge analizi ve görüşmeler gibi farklı yöntemlerden elde edilen bulgular da entegre edildiği için metodolojik üçgenleme gerçekleştirilmiş oldu.

İlk Aşama Analizin Sonuçları: Mevzuat

Suriyeliler için kamu sağlık hizmetleri ücretsizdir ancak belirli koşullara bağlıdır;

1) Adres beyanı zorunludur ancak bazı mahallelerde ve şehirlerde coğrafi kısıtlamalar vardır.
2) Geçici Koruma Altındaki Suriyeliler, kayıtlı oldukları illerin dışındayken acil sağlık hizmetleri dışında bir sağlık hizmeti alamazlar (seyahat edenler, mevsimlik işçiler vb.).
3) Kamu düzenini bozan eylemler kimlik kartlarının iptal edilmesine neden olur.
4) Bazı tedavilerden ve ilaçlardan katkı payı alınabilir.

Adreslerini beyan etmemiş Geçici Koruma altındaki Suriyeliler, yeni kısıtlamalarla kapatılan il veya mahallelerde yaşıyorlarsa adreslerini güncelleyemezler. Bu, sağlık hizmetleri de dahil olmak üzere kamu hizmetlerine asıl ikamet ettikleri şehirlerde erişmelerini engeller. Bu nedenle, ulaşma yetisiyle ilgili olarak; erişim süreci "sağlık hizmetine ulaşma" aşamasında kesintiye uğrar ve bireyin doğrudan herhangi bir sağlık hizmetine erişmesi engellenir. Geçici Koruma kimlik kartının başka bir nedenle iptal edilmesi durumunda da aynı süreç geçerlidir. Ek olarak, katkı payı ödemeleri ve bazı tıbbi hizmetlerin ücretleri, tedaviler veya teşhisler yasanın

kapsamının dışına çıktığında veya tanımlanmış ücret sınırlarını aştığında tahsil edilir. Dolayısıyla ücretsiz olduğu düşünülen sağlık hizmetleri belirli durumlarda ücretli hizmetlere dönüştürür ve bu, sağlık hizmetlerine erişim sürecinin hem arz hem de talep tarafındaki temel dinamiklerinden ikisi olan karşılanabilirlik ve ödeme yetisinde zorluklar yaratır.

Tezin bu bölümünde gerçekleştirdiğim ulusal ve uluslararası düzenlemelerin karşılaştırmalı analizi, Türkiye'nin zorla yerinden edilmiş kişilere ve Geçici Koruma Altındaki bireylere yönelik uygulamalarındaki fırsatları ve sınırlamaları ortaya koymaktadır. 2013 Yabancılar ve Uluslararası Koruma Kanunu ve 2014 Geçici Koruma Yönetmeliği, Türkiye'nin uluslararası mülteci koruma rejimiyle uyumlu; ancak, kendi ulusal önceliklerine göre şekillendirilmiş bir yasal altyapıya da sahiptirler. Özellikle Suriyeliler için Geçici Koruma Statüsünün kapsamlı haklar sağlaması, uluslararası insani krizlere yanıt olarak önemli bir çerçeve sunmaktadır. Ancak, bu düzenlemelerin uygulanması, ikamet adresiyle ilgili kısıtlamalar, hizmetlerin sadece sisteme kayıtlı olunan yerde alınabilmesi gibi hizmetlere erişimdeki bürokratik engellerin yarattığı pratikteki zorluklar tarafından gölgede bırakılmaktadır.

İkinci Aşama Analiz Sonuçları: Raporlar

Türkiye'deki Geçici Koruma Altındaki Suriyeli kadınlara sunulan genel sağlık ve CSÜS hizmetlerinin analizi, devam eden zorlukları vurgulasa da kararlı bir ilerleme profili çizmektedir. Avrupa Komisyonu ve SIHHAT Projesinin sağlık raporları, sağlık hizmeti sunumunda acil müdahale modelinden daha yapıcı ve gelişim odaklı bir modele doğru geçişi göstermiştir. Bu gelişme, üreme ve ruh sağlığı hizmetleri gibi Geçici Koruma Altındaki Suriyelilere sunulan belirli uzmanlaşmış hizmetlerin kapsamını genişletmiş; ancak, özellikle kayıtlı şehirlerinin dışında yaşayanlar veya hareket halinde olanlar açısından bazı eksiklikleri gideremeyiştir.

G/GSM'ler, Suriyeli kadınların sağlık gereksinimlerini karşılamada kritik bir rol oynayarak zaman içinde sağlık hizmeti arama eğilimlerinde değişikliklere neden olmuştur. En önemli değişimlerden biri, zaman içerisinde bu merkezlere olan

güvenin arttığını gösteren devlet hastaneleri yerine G/GSM'lere olan tercihin artmasıdır. Ancak, buna rağmen sağlık hizmeti erişim çerçevesinin talep tarafında görülen bariyerler her ikisinde de ortaktır; dolayısıyla sağlık hizmetlerinin talep tarafına yapılacak herhangi bir politika sadece Göçmen Sağlık Merkezlerine olan erişimi değil aynı zamanda Suriyeli kadınların sağlık ihtiyacında hala en çok kullanmayı tercih ettiği kurumlar olan devlet hastanelerine erişimi de arttıracaktır. G/GSM'lerin konumları sayesinde güçlendirdikleri mevcudiyet ve uyum boyutu, merkezlerin çalışma saatlerinin kısıtlılığı ve bekleme sürelerinin uzunluğu gibi sebepler yüzünden zayıflamaktadır. Devlet Hastanelerinde tedavi ve takip eden süreçlerin daha karmaşıklaşmasından kaynaklı Sosyal Güvenlik Kurumunun kapsamı dışında ek ücretler tahsil edilebilmekte bu da Suriyelilerin sağlığa erişim süreçleri içerisinde olumsuz olarak tanımladıkları bir etkene dönüşmektedir. Sağlığa erişim sürecinin son aşamasında yer alan arz tarafı boyutlarından uygunluk her iki kurum tipinde de bariyerlerin belirgin olduğu bir yerdir. Devlet hastanelerinde ayrımcılık ve yıllardır devam etmekte olan çevirmen yetersizliği öne çıkarken; G/GSM'lerde teknik eleman ve uzman doktor eksikliği ve muayene sürelerinin kısıtlılığı gibi kapasite ve kalite sorunları öne çıkmaktadır.

Üçüncü Aşama Analiz Sonuçları: Arz ve Talebin Karşılaştığı Nokta

Raporların sonuçlarında görüldüğü gibi, görüşmelerde de sağlık hizmetlerine erişimin talep tarafındaki engellerin hem devlet hastanelerinde hem de G/GSM'lerde aynı olduğu gözlemlenmiştir; dolayısıyla talep tarafını hedefleyen herhangi bir politika müdahalesi, her iki tür kuruma erişimi iyileştirecektir. Ancak, bir sağlık kuruluşuna başvuru aşamasına gelmeden önce karşılaşılan engeller, kapsayıcı ve uzun vadeli politikalar gerektirmektedir. "Arama yetisi" boyutu altında karşılaşılan bariyerler, hanelerde ve toplum içinde cinsiyete dayalı ayrımcılığın ve kültürün sağlık hizmetlerine erişimi nasıl etkilediğini vurgulamaktadır. Ayrıca eklemek gerekir ki, çalışmamız boyunca sıklıkla vurgulanan, "ulaşma yetisi" boyutu altında gözlemlenen kayıt sorunları, sistemsel değişikliklerin gerekliliğini göstermektedir.

Geçici Koruma altındaki Suriyeli nüfusun belirli şehir ve mahallelerde kümelenmesini önlemeyi ve kayıtlarının güncel tutulmasını amaçlayan yeni

politikalar, güvenlik odaklı adımlardır ama aynı zamanda sağlık hizmetleri de dahil olmak üzere tüm kamu hizmetlerine erişimde yeni engeller yaratmıştır. Adres kaydı yenileme, mahalle ve şehir değişiklikleri ve seyahat kısıtlamaları gibi sorunların neden olduğu kamu hizmeti sistemlerinden tamamen dışlanmayı önlemek için, kamu kurumlarında bu konuları ele alan birimlerin personel kapasitesi artırılabilir ve/veya belirtilen sebeplerden dolayı kimlik kartlarının iptaline veya geçersiz kılınmasına yol açan şartlar yumuşatılabilir.

Sağlığa erişim sürecinin talep tarafının son aşamasında karşılaşılan engeller, arz tarafındaki sorunların bir sonucudur; bu nedenle, çözümleri de arz tarafı "uygunluk" boyutu altındaki sorunların ele alınmasına bağlıdır. Bu engeller, sağlanan hizmetlerin kalitesiyle ilgilidir; ancak devlet hastanelerindeki tercümanların yetersizliğinin yanı sıra, engeller Suriyelilere yönelik toplumsal rahatsızlığın kişilerarası tezahürlerini yansıtır. Öte yandan, G/GSM'lerdeki durum toplumsal atmosferden bağımsızdır ve kişilerarası olumsuz davranışlar ve sağlanan sağlık hizmetlerinin kalitesiyle ilgilidir. Ancak, görüşmelerde görülmüştür ki her ikisi de sağlığa erişim sürecinin talep tarafından son aşamasındaki arama yetisi boyutunu oldukça olumsuz yönde etkileyen bir pozisyondadır; çünkü bu tür engeller, özellikle savunmasız ve marjinal gruplar arasında, bireyin bakıma erişim niyetini ifade etme özerkliğini, isteğini ve güvenini zayıflatmaktadır.

Devlet hastanelerinde görünen bir engel olan tercüman yetersizliği, hastaların teşhislerini, tedavilerini ve ilişkili maliyetleri tam olarak anlamamalarına sebep olmaktadır. Bu nedenle, devlet hastaneleri ortamlarındaki iletişimle ilgili sorunlar nedeniyle, hastalar genellikle aldıkları hizmetler hakkında yeterli bilgiye sahip değildir. Bu problem, yalnızca "uygunluk" ve "ödeme yetisi" boyutlarını etkilemekle kalmaz, aynı zamanda hizmet alıcıları kendi sağlıkları hakkında verilen kararların tam olarak farkında olmadıkları için sağlığa erişim sürecinin son aşaması olan "katılım yetisi" boyutunu da olumsuz etkiler.

Devlet hastanelerinde bahsedilen çıktılara ek olarak, mevcudiyet ve uyum boyutunda hastane sistemlerinde gezinme zorluğu da mevcut tercüman eksikliğinin bir sonucudur. Doğrudan aynı sorundan kaynaklanmasa da aynı engelle ilgili başka bir

sorun, arz tarafının en başında ortaya çıkar. İletişim sorunları nedeniyle karşılaşılan beklenmedik maliyetler, Suriyeli kadınları, gelecekte benzer sağlık ihtiyaçları ortaya çıktığında sağlık hizmeti aramaktan caydırır. Bu birbiri ile bağlantılı bariyerler aynı zamanda "yaklaşılabilirlik" açısından, devlet hastanelerinde hangi sağlık hizmetlerinin ücretsiz veya ücretli olduğuna ilişkin bilgi paylaşım faaliyetlerinin yetersiz olduğunu vurgular.

Sağlık Hizmetlerine Erişim ve Yönelimi Geniş Ölçekte Şekillendiren Nedenler

Yaptığım görüşmeler ışığında sağlık hizmetlerine erişimin sadece sağlık sistemi içindeki engellerle sınırlı olmadığını görmüş oldum. Suriyeli kadınlara yönelik olumsuz ve ırkçı tutumlar, Göçmen Sağlık Merkezleri de dahil olmak üzere, bir sağlık merkezine gitmeden önce günlük yaşamda ve sosyal ortamlarda kendini göstermeye başlıyor. Bu durum cinsiyet temelli ayrımcılık sonucu oluşan diğer bariyerlerle birleşerek Geçici Koruma altındaki Suriyeli kadınların herhangi bir kamu hizmetine erişmek için evlerini veya mahallelerini terk etmelerini çok büyük derecede zorlaştırmaktadır. Öte yanda sosyal dışlanma deneyimleri, geçici yasal statüyle ilişkili güvensizlik duyguları ve sınır dışı edilme tehdidi ile birleşince sağlık ihtiyaçlarını nasıl algıladıklarını bile etkileyen bir pozisyona gelmektedir.

Dahası, kurumsal engeller ve sıklıkla sözlü tacizlerle birlikte gelen ayrımcı deneyimler, mağdurları daha da fazla fail haline getirir. Yukarıda bahsettiğim faktörler bir araya gelerek, sağlık hizmetinin çok yakınlarında ve anadillerinde mevcut olmasına rağmen, çok sayıda Suriyeli kadının tedavi görmekten korktuğu veya isteksiz olduğu bir senaryoya yol açmıştır. Bu korku ve isteksizlik, tamamen yapısal kaygıların sonuçları değildir; bunun yerine, dışlanma ve ayrımcılıkla dolu günlük deneyimlerinin psiko-duygusal etkisiyle de bağlantılıdır.

Sonuç

Rapor ve Görüşmelerin Karşılaştırması

Raporlar ve görüşmelerin sonuçları birbiri ile çelişmese de bazı birbirini tamamlayıcı çıktılar sunmuşlardır. Sağlık hizmetlerine erişimin ilk adımı olan "algılama yetisi"

boyutunda, raporlarda görülen engelleri görüşmelerde görmeme sebebim; görüştüğüm STK'ların bu adımı güçlendirmek için halihazırda projeler uygulamış olmaları olabilir, dolayısıyla Suriyeliler açısından gördükleri bu aşamadaki bariyerler artık onlar için bariyer olmaktan çıkmış olabilir. Yine G/GSM'ler hakkında raporlarda gördüğüm uzun bekleme süreleri ve sınırlı çalışma saatlerinin görüşmelerde karşıma çıkmama nedeni, raporların tarihlerinden bu yana G/GSM'lerin sayısının büyük ölçüde artmış olması olabilir. Dolayısıyla artık tek bir G/GSM'de yoğun bir hasta birikimi yok gibi görünüyor. Raporlarda gördüğüm ancak görüşmelerde karşılaşmadığım bir diğer konu ise sağlık hizmetlerine erişimin son aşamasında teknik ekipmanları kullanacak personel ve uzman doktor bulma zorluğu gibi arz yönlü engeller. Bu engellerin, hizmet sağlayıcının bakış açısından daha görünür olması nedeniyle raporlarda ortaya çıkmış olması mümkün olabilir.

Raporlarda açıkça göremediğim ve sadece ayrımcılık başlığı altında görünen sağlık hizmetlerine erişimin son aşamasında karşılaşılan sorunlar, görüşmeler aracılığıyla daha net ortaya çıkmıştır. Bunun nedeni, gerçekleştirdiğim görüşmelerde anket yöntemi değil, yarı yapılandırılmış görüşme yönteminin kullanılmış olması olabilir; görüşülen kişilerin belirttiği bir engelden sonra, bu engelin altında yatan nedenleri daha net anlamak için ek sorular soruldu ve sonuç olarak, bu engele ilişkin sağlık hizmetlerine erişim sürecinin hem diğer aşamalarını hem de diğer boyutlarını etkileyen sonuçlarla karşılaşmış oldum. Örneğin; devlet hastanelerinde yeterli tercüman bulunmamasının sağlık hizmetlerinin karşılanabilirliğini, Suriyeli kadınların aldıkları sağlık hizmetleri hakkındaki kalite algılarını, olası bir tedavinin etkilerini ve beklenmedik ücretlerin yeni bir sağlık ihtiyacı durumunda hizmet arayışını nasıl olumsuz etkileyebileceğini gördüm. Ayrıca, görüşmelerde, G/GSM'lerdeki doktorların olumsuz tutumları ve muayenelerin kalitesiyle ilgili bariyerlerin diğer aşamaları ve boyutları nasıl etkilediğini gözlemlenmiş oldum.

Başlıca Ampirik Bulgular

"Kabul edilebilirlik" ve "mevcudiyet ve uyum" boyutlarındaki güçleriyle G/GSM'ler devlet hastaneleri içindeki iletişim, kültürel uyum, ulaşım ve navigasyon sorunlarını çözmek için alternatif bir hizmet sunmaktadır; ancak, politikalar G/GSM'lerin

kurumsal kapasitesini artırırken sağlık erişim sürecinin talep tarafındaki engelleri görmezden gelir ve arz tarafının son aşamasındaki (uygunluk) sorunları ele almazsa, bu kurumlar CSÜS hizmetleri için devlet hastanelerine daha iyi bir alternatif sunmaktan uzak kalacaktır. Bu, sağlık hizmetlerine erişimi iyileştirmedeki etkinliklerini sağlamak için arz tarafı politikalarını, talep tarafı zorluklarını ele alan çözümlerle uyumlu hale getirmenin gerekliliğini vurgulamaktadır.

Başlıca Teorik Bulgular

Levesque ve diğerlerinin (2013) sağlık hizmetlerine erişim çerçevesi, sağlık hizmetlerine erişimde arz ve talep tarafındaki engelleri aynı anda anlamak ve ilişkilendirmek için etkili bir model sunar ve benim araştırmam, Türkiye'deki Geçici Koruma altındaki Suriyeli kadınların deneyimlerine odaklanarak sağlık hizmetlerine erişim çerçevelerine yeni bir katman ekler. Farklı engellerin sağlık hizmetlerine erişime etkilerini ayrı ayrı ele almak yerine, birlikte nasıl sonuçlar doğurduğuna bakarak literatürdeki bir boşluğu doldurmak amaçlanmıştır.

Politika Önerileri

1. Kamu hastanelerindeki tercüman sayısı artırılmalı ve G/GSM'lerdeki şikayet mekanizmaları daha aktif hale getirilmelidir.
2. Suriyeli kadınlara yönelik özellikle CSÜS alanındaki farkındalık eğitimleri ve seminerleri devam etmelidir.
3. Adres doğrulama sorunları ve seyahatlerden kaynaklanan sağlık tesislerine erişimde yaşanan kayıt sorunları, bu süreçleri yöneten personel sayısının artırılması ve/veya ilgili kimlik iptalleri için daha fazla koşul eklenmesi yoluyla ele alınmalıdır.
4. Sağlık sektöründeki yeni politikalar, sağlık hizmetlerine erişimi, sosyal dışlanmayı ele almak ve sağlık müdahalelerini toplumdaki ırkçılık, yabancı düşmanlığı ve sistemik ayrımcılıkla mücadele çabalarıyla bütünleştirmek için daha geniş bir çerçevenin parçası olarak kabul eden bütüncül bir yaklaşım benimsemelidir.

Çalışmanın Sınırlılıkları ve Gelecek Araştırmalar İçin Öneriler

Araştırmamın sınırlamalardan ikisi, görüşmelerimi gerçekleştirdiğim üçüncü aşama analizimle ilgilidir. Birincisi, doğrudan sağlık hizmeti sunan veya alan kişilerle görüşme yapamamış olmam ve bununla birlikte birincil bakış açılarına erişimimin kısıtlanmış olması. İkincisi, görüşmelerin sayısının on ikiyle sınırlı olması ve bunun verilerin genelleştirilebilirliğini azaltması. Ek bir kısıtlılık olarak, çalışmamın üç aşamalı bir sağlık politikası analizi olmasından dolayı, erişim sürecini oldukça geniş bir şekilde ele almam ve bunun gözden kaçan faktörlere sebep olabilecek olmasıdır. Bu nedenle, benzer bir çerçeve kullanan daha odaklı çalışmalara ihtiyaç vardır. Bu çalışmalar, benzer bir konuyu analiz ederken Levesque ve diğerlerinin (2013) sağlık hizmeti erişim çerçevesinin yalnızca bir aşamasına bakmayı düşünebilir. Bu, belirli aşamalarla ilişkili zorlukların daha ayrıntılı bir şekilde incelenmesine olanak tanır.

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YAZARIN / AUTHOR

Soyadı / Surname : Kaya
Adı / Name : Melike
Bölümü / Department : Siyaset Bilimi ve Kamu Yönetimi / Political Science and Public Administration

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