GOVERNING IMMIGRANT HEALTHCARE:

PERSPECTIVE OF TURKISH HEALTHCARE SPECIALISTS IN ISTANBUL

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This is to certify that we have read this thesis and that in our opinion it is fully adequate, in scope and quality, as a thesis for the degree of Master of Arts in Cultural Studies.

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

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ABSTRACT

GOVERNING IMMIGRANT HEALTHCARE:
PERSPECTIVE OF TURKISH HEALTHCARE SPECIALISTS IN ISTANBUL

İdrisoğlu Dursun, Gizem.
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Istanbul has become one of the most immigrant-populated cities due to the recent migratory flows. In this thesis, I aim to explore understandings of Turkish healthcare specialists involving in public and mental healthcare delivery to immigrants in Istanbul. I analyze my ethnographic inquiry to search for how healthcare services are introduced, promoted and delivered to Syrian immigrant population residing in Istanbul. I examine the governing power of healthcare providers by focusing on the subjectivities constructed through technologies of governmentality such as regular medical examinations, healthcare training, immunization program, and therapy. In line with that, I argue the affirmative strategies developed to respond to immigrant patients and othering produced in immigrant healthcare delivery extends beyond the profession. Lastly, I focus EU-funds for health-related projects for immigrants conducted by local partners as a technology that facilitates "governing at a distance".

Keywords: healthcare specialists, immigrant healthcare, Syrian immigrants, technologies of governmentality, "governing at a distance"

ÖZ

GÖÇMEN SAĞLIĞI HİZMETLERİNİ YÖNETMEK:
TÜRKİYELİ SAĞLIK HİZMETİ UZMANLARININ ALGISI

İdrisoğlu Dursun, Gizem.
Kültürel Çalışmalar Yüksek Lisans Programı
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İstanbul, son zamanlardaki göçmen akımları sebebiyle en büyük göçmen nüfusuna sahip kentlerden birisi olmuştur. Bu tezde, İstanbul'da ikamet eden göçmenlere halk sağlığı ve ruhsal sağlık alanlarında hizmet veren Türkiyeli sağlık uzmanlarının anlayışlarını/kavrayış/ algı araştırmayı amaçlamaktayım. İstanbul'da ikamet eden Suriyeli göçmen nüfusa Sağlık hizmetlerinin nasıl takdim edildiğini, götürüldüğünü ve Suriyeli göçmen nüfusun sağlık hizmetleri için nasıl teşvik edildiğini araştırarak etnografik araştırmamı analiz etmekteyim. Düzenli tıbbi muayeneler, sağlık eğitimleri, bağışıklama programı ve terapi gibi yönetimsellik teknolojileri yoluyla inşa edilen öznelliklere odaklanarak, sağlık hizmeti sağlayıcılarının yönetici iktidarını incelemekteyim. Bu doğrultuda, göçmen hastalara cevap vermek üzere geliştirilen olumlu stratejilerin ve göçmen sağlığı hizmeti sağlamada üretilen ötekileştirmenin uzmanlığın ötesine geçmeye yol açtığını savunmaktayım. Son olarak, yerel paydaşlar tarafından yürütülen göçmen sağlığına ilişkin projelerdeki AB fonlarına, "uzaktan yöneten" bir teknoloji olarak odaklanmaktayım.

Anahtar Kelimeler: sağlık hizeti uzmanları, göçmen sağlığı hizmeti, Suriyeli göçmenler, yönetimsellik teknolojileri, "uzaktan yöneten"

Dedicated to my family

YÖK

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CHAPTER I

INTRODUCTION

1.1. Research Question

This thesis aims to explore understandings of Turkish healthcare specialists providing healthcare services to Syrian immigrants in Istanbul. Investigating expert conceptualizations about Syrians is an illuminating method to search for how healthcare services are introduced, promoted and delivered to Syrian population residing in Istanbul. By examining the narratives of specialists involving diverse realms of immigrant healthcare delivery such as primary healthcare and psychosocial support, I focus on how they interact with immigrants through regular medical examinations, healthcare training, immunization program, and therapy. I argue that providing healthcare services differentiate between the citizens and the immigrants.

I trace immigrant healthcare management based on the negotiations and challenges embedded in everyday encounters of immigrant healthcare providers with receivers in Istanbul. I make an effort to shape an analytical framework by seeking the influences of public health and migration politics adopted by Turkey on planning immigrant healthcare services and programs in Istanbul. In line with this, I also examine how Turkish healthcare specialists perceive their experience in healthcare access of Syrian immigrants residing in different neighborhoods in Istanbul.

1.2. Motivation and Background

Like many other countries all around the world, Syrian immigrants have occupied the agenda on mainstream and social media as I have come across over the past seven years, after the first group fled from their homes in Syria and crossed the border to Turkey on March 2011 (Çağaptay, 2014: 1). As the immigrant population increases, there have been various speculations about assistance for health- and education-related issues provided to Syrian migrants.

A local newspaper in Konya[1], with a Syrian population rate of 4, 83%; claimed that the Metropolitan Municipality provides financial support in a form of salary to Syrians residing in the city. A video used in their news showing Syrian migrants lining up to get that salary[2]. However, a voluntary organization working on false media claims searched this statement of the newspaper published the result that aforesaid video was taken in front of a Social Benefit Card Office at Selçuklu, a municipality of Konya. Their search proved that the video showing Syrians waiting to get a benefit card, only used in shopping, and limited to 150 TL, and delivered by Konya Metropolitan Municipality in several social benefit card offices[3]. Similar claims circulating on social media in 2016 that Syrians are lining up outside PTT (Post Bank) branches to get their salary from the Turkish government. However, according to the declaration of United Nations High Commissioner for Refugees (UNHCR) in 2017, it is not the salary but the winter aid for one-off assistance provided by UNHCR through PTT-debit cards[4].

In addition to these, several controversies associated with healthcare service for Syrian migrants are covered on local media and prime-time TV news bulletins, such as Syrian women benefitting free in-vitro fertilization services at state hospitals[5], or a Syrian migrant beating a female doctor[6] were all proved to be false later[7]. However, their circulation influenced negative and hostile comments on social media platforms. They are mainly resonated with accusations towards Turkish government,

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[1] http://www.goc.gov.tr/icerik3/gecici-koruma_363_378_4713.
Accessed 5 December 2018

[2] http://archive.ph/ULTZc. Accessed 21 December 2018

[3] https://teyit.org/konya-buyuksehir-belediyesi-suriyelilere-maas-bagladi-iddiasi/ Accessed 4 January 2019.

[4] https://teyit.org/en/allegations-on-syrians-lining-up-outside-ptt-branches-in-order-to-get-their-salary/ Accessed 4 January 2019.

[5] https://teyit.org/suriyelilerin-tup-bebek-tedavisinden-ucretsiz-yararlandigi-iddiasi/ Accessed 4 January 2019

[6] https://archive.ph/z6Yct Accessed 21 December 2018

[7] https://www.dogrulukpayi.com/bulten/suriyeli-siginmacilar-hakkinda-dogru-sanilan-yanlislar Accessed 4 January 2018. https://teyit.org/turkiyede-yasayan-suriyelilerle-ilgili-internette-yayilan-22-yanlis-bilgi/ Accessed 5 January 2019.

state institutions and ministries including. In some of the articles, authors directed their complaints about Syrians by comparing the services provided to Turkish citizens and Syrian migrants. The articles and news pieces mostly claimed the inadequacy of the former to the advantage of the latter[8] and relating this to the reasons for inequality in Turkey. Many articles were written to blame Syrians for causing high unemployment and profitable enrollment of Syrians in Turkish higher education institutions[9].

Contrary to all these speculations related to Syrian immigrants, I have primarily started to search for which services have been delivered for them. Specifically, healthcare service delivery has drawn my interest as I have met psychologists working at immigrant-assisting nongovernmental organizations such as Association for Solidarity with Asylum Seekers and Migrants (ASAM), Support to Life (STL) and Istanbul&I. Meanwhile, I have come across with doctors and nurses handling Syrians at emergency health units at state hospitals as well as community health doctors involving in vaccination campaigns for Syrian children conducted by the Ministry of Health.

I also searched for the Internet specifically about health conditions of Syrian immigrants in Turkey, especially the vaccination campaigns of Syrian immigrants. Most of the news and articles published in Turkish newspapers and reactions on social media consisted of anxiety and negative discourse about Syrians. Many arguments show that many transmittable diseases such as polio, measles, and foot-and-mouth disease are spreading from Syrian refugees. Moreover, some users refer foot-and-mouth disease as Syrian skin disease in online forums. Most of the

[8] https://www.sozcu.com.tr/2016/yazarlar/pinar-turan/musluman-shakespeare-1308133/ Accessed 5 January 2019. https://www.sozcu.com.tr/2016/ekonomi/issize-vermedikleri-maasla-suriyeliye-is-ogretecekler-1213628/ Accessed 5 January 2018. https://www.cnnturk.com/2012/guncel/09/22/suriyeli.multeciye.sinavsiz.universite/677698.0/index.html Accessed 23 September 2018

[9] https://www.sozcu.com.tr/2016/ekonomi/10-suriyeli-6-turk-vatandasini-issiz-birakiyor-1099162/ Accessed 5 January 2019

commentators on social forums were Turkish parents consistently blaming Syrian peers of their children and complaining about their children's long-lasting recovery[10].

Milliyet.com.tr » Gündem » Haber » Suriyelilerden yayılan bu hastalık Türkiye'yi sarıyor

24.09.2013 - 09:25 | Son Güncelleme: 24.09.2013-13:01

Suriyelilerden yayılan bu hastalık Türkiye'yi sarıyor

Türkiye'de geçen yıl 349 kızamık vakası görüldü. Bu sayı, Suriyeli mültecilerin akını sonrası 20'ye katlandı. Türkiye Halk Sağlığı Kurumu Başkan Yardımcısı Mehmet Ali Torunoğlu ise, Türkiye'deki kızamık vakalarının kaynağına ilişkin yaptığı açıklamada virüs Suriye değil Avrupa kaynaklı olduğunu söyledi

Paylaş Tweet G+ Sitene Ekle

Önceki yıllarda salgınlar şeklinde görülen kızamık, aşılama çalışmaları sayesinde sıfıra yaklaşırken yurt dışı kaynaklı vakalar yüzünden yeniden hortladı. Vakalardaki artışın özellikle Güneydoğu ve Akdeniz illerinde yaşanması gözleri bu illerde yoğunlaşan Suriyeli mülteci kamplarına çevirdi.

Figure 1.1."This disease spreading from Syrians takes hold of all over Turkey."

Suriyeli sığınmacılarla hastalıklar da geldi!

Ana Sayfa » 14.08.2015 00:01

Figure 1.2."Syrian children brought diseases"

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[10] http://www.mynet.com/haber/dunya/turkiyede-suriye-kaynakli-salgin-hastalik-endisesi-1971698-1 Accessed 23 September 2018. https://odatv.com/suriyeli-gocmenler-hangi-hastaliklari-getiriyor-1009141200.html Accessed 23 September 2018. https://eksisozluk.com/suriyelilerden-yayilan-deri-hastaligi--5246325 Accessed 23 September 2018. https://www.sozcu.com.tr/2017/yazarlar/pinar-turan/suriyelilerin-getirdigi-salgin-1756271/ Accessed 23 September 2018. http://www.haberturk.com/gundem/haber/996274-bilinmeyen-virus Accessed 23 September 2018 https://sorcev.com/suriyeli-hastaligi-ve-belirtileri-nelerdir Accessed 23 September 2018.

As shown in pictures above, headlines highlight the speculations that Syrian children caused an increase in epidemics rate. Although the head of Turkey Public Health Institution declared that the virus leading to measles and the increase in the epidemics rate connected to Europe, the headline and the content of the news still relates the measles rates to Syrian immigrant population on camps near the border of Turkey.

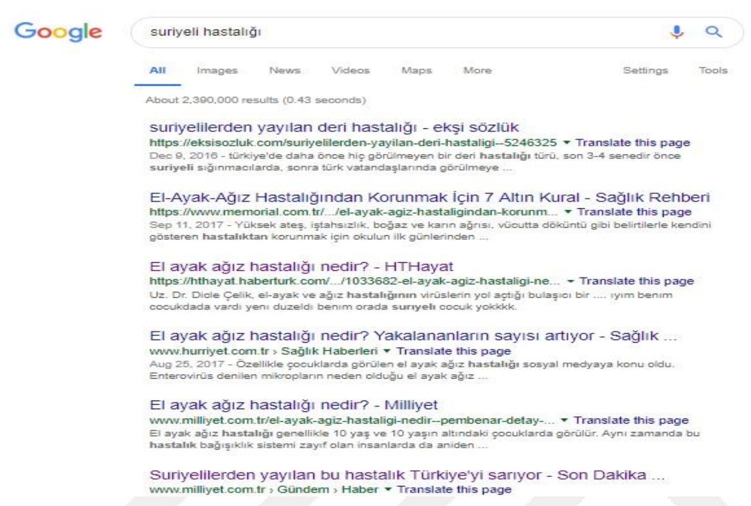

Figure 1.3.When you do a Google search for “Syrian disease” in Turkish; it lists the results of a disease called as foot-and-mouth disease. Retrieved 4 December 2018.

State Community Health Centers (CHC)[11] has organized a Vaccine Campaign for Syrian children on May 2017. Meanwhile, I decided to meet some of the medical staff who would be later become as main informants of my research.

I made contact with one doctor, involved in the campaign, who explained that the ongoing campaign was about to finish, and he shortly informed me about the campaign: "We are gathered with practitioners of CHC and visit neighborhoods where Syrian population is high. We find children who are playing on the streets and they are guiding us to find Syrian households. In that sense, we solved the translation problem because Syrian kids may speak Turkish fluently. They translate our words to the families that we, as the medical team, has come to vaccinate little children". One

[11] Türkiye Cumhuriyeti Sağlık Bakanlığı Toplum Sağlığı Merkezleri.

of these doctors who was leading the medical team in vaccination campaigns quit the job due to the private reasons and therefore, the process of organization for the following campaign took longer than expected. For that reason, I had to wait to start the interviews with CHC medical staff that I planned earlier.

All these information have challenged me to start the fieldwork, so I seek different sources and informants. I also had the information that UN is one of the partners in vaccination projects; hence, I made contact with a friend who works as a social worker for United Nation High Commissioner for Refugees (UNHCR). As part of my preliminary research in September 2017, she informed me about the campaign, locations of the campaign and the districts highly populated with Syrian refugees such as Küçükçekmece, Fatih, Zeytinburnu, and Sultanbeyli where CHCs were organizing their two-years-long-vaccination campaigns with the support of UNICEF. She acknowledged that the first period of the project had started in 2016; however, it could not achieve the objectives due to some logistics and political problems, and eventually, it failed. She also pointed out the requirement of legal permission for conducting fieldwork and suggested the experts suggested who would be respondents for my thesis research. Based on this insider perspective, I determined the sites of my fieldwork. Then, I made contact with community health centers providing healthcare services to Syrian immigrants. Most of them rejected to talk except two.

In the meantime, I also made contact with four psychologists and a social worker actively involving in campaigns and projects conducted by immigrant-assisting NGOs. In order to meet and get permission from the supervisor of one of the NGOs, I made the first visit in November 2017.

The association is located at a neighborhood highly-populated with Syrians and seeks solutions to the problems of all the immigrants in the district who are in need of international protection. There is a clinic providing healthcare services on several branches of medicine such as gynecology, ear-nose-throat clinics, physiotherapy and

rehabilitation center, community healthcare unit as well as a psychosocial support center.

Before I met the supervisor, I had a chance to make an observation and meet a nurse working for the ongoing vaccination campaign held on 1st – 17th November. She introduced herself as a delivery nurse at CHC and we talked about the difficulties in the vaccination campaign due to the missing vaccination information of refugees:

> We are trying to complete the missing cases of Syrian children within the scope of 'Campaign on Completing Vaccination of Guest Children Under 5-year-old. That would be third or fourth times this year, I guess. We have heard that they are vaccinated one at a time for the diseases of diphtheria, whooping cough, tetanus, polio, and meningitis when they were in Syria. We have several difficulties because most of them lack the certificate of immunization, so we will never know which vaccines are missing. We are trying to ask them, but unfortunately, we cannot collect true data because we mostly cannot understand each other. So we vaccinate who are not sure about their immunization story. Sometimes we vaccinate them, in any case, to prevent them from infecting other people (Fatma, 42, nurse).

Her narrative demonstrated that although it was not the first time, they still had difficulties in vaccination due to a series of problems such as unreliable data due to the lack of vaccination card and vaccination history, because of a language barrier.

After that, I had a meeting with the supervisor and informed her about the fieldwork. She stated that she could accept my consent if I get the approval from the ethics committee. Meanwhile, I continued to search for public health doctors and nurses in the other districts all of whom refused the interview due to the lack of legal permission. After I took the approval of the ethics committee, I explicitly started the fieldwork with conducting interviews first with psychologists at the NGOs working at Anatolian Side of Istanbul in December 2017. I have deliberately preferred to make the first interviews with them due to many reasons. As far as I experienced, directors at immigrant-assisting NGOs were more welcoming to health-related research topics since they expressed that they took most of the responsibility on health issues of Syrian immigrants since the first migration flow to Turkey. They also stressed many

fieldworks undertook by several scholars in their associations. Therefore I have felt more motivated for beginning the research with healthcare providers involving in those NGOs.

In addition to these, I made an effort to find informants working at public healthcare centers. As my key contacts also emphasized, due to their tight schedule with both Turkish and Syrian patients, they refused my inquiry despite the approval of the ethics committee.

On April 2018, I have met with a doctor specialized in family healthcare working at a community health center which conducted several vaccination campaigns for Syrian children. She noted that there would not be a campaign planned for the near future, however, that I could conduct an interview with her, and two nurses worked for the campaigns.

During the interviews with the campaign team, I often heard that the Ministry of Health was establishing migrant healthcare centers under Public Healthcare Directorate and planning to employ Syrian specialists. These centers were still few in numbers when the circular was enacted on May 2018[12]. Therefore, I could make interview with only one Turkish doctor who works at Migrant Healthcare Center.

1.3. Methodology of the Research

I conducted six-months of fieldwork from December 2017 until May 2018 to explore the perspective of healthcare specialists on healthcare services delivery to Syrian immigrants.

I used qualitative research methods to explore the process in which immigrant healthcare is understood, produced and experienced by medical professionals. According to Mason, qualitative research is mainly interpretivist and contextual, by

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[12] http://istanbulism.saglik.gov.tr/TR,54032/gocmen-sagligi-merkezleri.html, Accessed 4 November 2018. http://www.resmigazete.gov.tr/eskiler/2018/05/20180525-1.htm Accessed 4 November 2018.

focusing on practices, discourses or constructions based on the methods of analysis and explanation rather than claims (Mason, 2002: 3-7). Considering consistently changing statistics and controversies on the post-migration in Turkey, I suggest that qualitative research on healthcare providers would provide the first-hand experience of the field research setting which is considered as the best way of generating knowledge (Mason, 2002: 55; cf. Atkinson et. al., 2001: 4-5).

Using semi-structured qualitative research questions, I conducted 10 in-depth interviews in total with specialists working in the field of healthcare delivery for Syrian immigrants in Istanbul. Five of the informants were professionals working at different immigrant-assisting NGOs. Three of the informants were psychologists whereas two of them were social workers. Other five informants were specialized in medicine. One doctor worked at migrant healthcare center whereas one doctor and two nurses worked at public healthcare center. I will give brief information about the respondents of my research.

Meltem (22, psychologist) youngest informant of the research, is one of the founders of the association where she undertakes voluntary psychosocial support sessions for Syrian children. She grew up and lived in the neighborhood, where the association is located until she moved to another district in Istanbul close to the university she was registered. She stated that she has been involved in many volunteer projects throughout her university education.

Buse (28, translator and social worker) is an NGO professional for three years, gives counseling to Syrian immigrants on health-related issues through healthcare training and translation of the treatment and medication. She expressed that she mostly accompanies them to visit health facilities to facilitate communication with healthcare specialists.

Nurhan (56, doctor) is specialized in family healthcare and has been pursuing her profession for almost 30 years. She has been involved in several immunization programs with the experience of planning various vaccination campaigns and leading

the medical teams on the field. She stressed that she suddenly found herself on the streets vaccinating children, as it is used to be.

Ece (34, nurse) holds an undergraduate degree in nursing and now she studies public health in MSc program. She works at public healthcare centers for almost ten years.

Demet (27, nurse) has been practicing medicine for five years. She noted that her assignment vaccination unit has coincided with the mass migration of Syrians to Istanbul. The center initiated the first phase of the vaccine campaign for Syrian children after she started to work at the center. As she highlighted a couple of times during the interview that she had no field experience beforehand.

Murat (27, psychologist) is involved in several volunteer projects such as humanitarian aid for the victims of Van Earthquake in October 2011. Now, he has a full-time job at one of the immigrant-assisting NGOs.

Hakan (53, doctor) is specialized in family healthcare and works at one of the migrant healthcare centers.

Emel (24, psychologist) was involved in psychosocial support project conducted by the Ministry of Family and Social Policies for Syrian children in her neighborhood before working as NGO-professional. She overtakes therapy sessions with Syrian children and adults.

Aylan (25, social worker) had volunteer experience at Hatay, a border city, after fleeing from Aleppo, her hometown, and cross the border with her family in 2012. She taught English at temporary education centers for Syrian children after she came to Istanbul. Now, she works as a translator at one of the NGOs.

Ayşe (36, delivery nurse) is specialized on obstetrician (midwife) and assigned to the vaccination unit of public healthcare center four years ago.

I left the decision of the location of the interviews to the informants. Some interviews were conducted in their offices whereas some in the cafes. I got the consent and then recorded the interviews via my mobile phone. I put it somewhere accessible to her/him in case of the withdrawal from participation in the study. Interviews lasted for forty minutes to two hours. I have replaced the real names of the interviewees with pseudonyms.

1.4. Outline of the Thesis

This thesis consists of six chapters. After this introduction chapter, the second chapter explores the emergence of public healthcare approach based on the institutionalization of liberal health systems. This chapter is divided into six subsections. In the first subsection, I focus on the construction of public healthcare discourse based on public measures consisted of health promotion and hygiene programs. By tracing the historical framework that shapes public health politics, I examine the shifting discourse from treatment to prevention of the disease as well as the shift in the focus on population health to individual well-being. In this sense, I seek out the regulative power of public healthcare approach conducted through the medical domination over the patients. Specifically, I carry out a discussion on the adoption of health as a service rather than relief in the making of immigrant-subjects. In the following three subsections, I make an effort to draw a historical framework of Turkey's experience with the welfare state. After I briefly evaluate how global transformation on health systems entails reforms on health politics in every country in the second subsection; in the next subsections, I study socialization of healthcare services in Turkey and reforms on Turkey's health policies respectively. Last two subsections consist of anthropological analysis on migration literature. The fifth subsection is shaped by healthcare delivery to immigrants in the world whereas the last one focuses on Syrian immigrants in Turkey.

Chapter Three deals with the migration and migrant healthcare politics by looking at legal and administrative regulations and anthropological research on Syrian immigrants. I mainly focus on the contradictory EU- Turkey relationship shaped around Turkey's Accession Partnership Period during the 2000s and its revival after

Turkey becomes transit space of border crossing process to EU countries for Syrian immigrants. I also evaluate temporary protection that regulates health services provided for Syrians by focusing on its influences on resettlement in Istanbul.

Next two chapters discuss everyday experiences of healthcare providers on the encounters with Syrian immigrants in Istanbul through new technologies of governmentality such as immunization and therapy. I analyze governing power exerted from healthcare providers by focusing on the subjectivities produced under temporary protection. In the fourth chapter, I explore strategies adopted by healthcare providers, extending beyond their profession, to respond to Syrian patients and negative and positive discourses embedded into hygiene perspectives of the experts'.

Chapter five examines the adjustments migrant healthcare providers introduce to public health care approach based on the challenges they experience with language barrier, professionalism, and bureaucracy. I discuss the relationship between medical experts and beneficiaries in relation to the multiplication of new actors such as translators. By exploring perspectives of healthcare provider and translator, I analyze access to Syrian immigrants as well as a new form of relationship constructed between healthcare specialist, translator and Syrian patients. Chapter Six, the conclusion, deliberates the results of the study and highlights a variety of fields of further research and policy.

CHAPTER II

ANALYTICAL FRAMEWORK: PUBLIC HEALTHCARE APPROACH

In this chapter, I will begin with the search of the literature and discussions shaped around the expertise of public health care. Based on my examination of the global and political processes drawing upon transformation of health policies, public health intersects with the historical framework weaving the concepts of liberal thought, welfare states and the expertise of medicine in modern states. Exploring the conceptualizations of public healthcare approach by following the historical and political framework, I will trace public health measures first emerged in European countries that are considered to be the first form of health policy (Yılmaz, 2017: 24).

As part of their health politics, most governments have carried out several reforms within the processes of institutionalizing modern health systems. Correspondingly, the Turkish Republic has also undergone reforming attempts through the health sector unceasingly. History of health reforms in Turkey corresponds to the liberal construction of public health services and institutions, inasmuch as it refers to the redefinition of citizenship and social rights. Endeavors of socializing health programs in the 1960s and the pursuit of health reforms since the beginning of the 1980s have significant influences on describing who the citizen is and which rights of them are recognized by Turkish law.

In addition to the initiation of universal healthcare services based on citizenship rights, the years of 1980s also refer to the process of immigration. Turkey has become the center of migration at the periphery of Europe since the 80s since transit migrants from East to the West have drastically increased. Therefore, the concepts of asylum and *refugeeness* stand out as an issue of law, as public health approach has been introduced to healthcare policy of Turkish Republic in order to deal predominantly with the accessibility of healthcare services in the outbreak of epidemics. Legislations on health services entailed a series of transformation in social and economic

configurations that lead to ill-health with respect to both citizens and migrants awaiting to move on to the destination country.

Based on the association among above-mentioned concepts and predicaments, analytical framework of this chapter relies on the idea that the history of transformation in Turkish health politics will provide an illuminating ground for discussing migration/policy/anthropology nexus[13].

2.1. Public Healthcare Discourse

According to many scholars, the state has been the dominant actor in the provision of healthcare services. Intervention and the interference of the state to the realm of health have been much discussed with its association to the field of public health (Ağartan 2012; Günal 2008; Leys 2010; Navarro 1976; Lupton 1994; Üstündağ and Yoltar 2007 and Yılmaz 2017). These studies point out public health measures as "the first form of health policy" (Yılmaz, 2017: 24) and stress state domination on healthcare services. Social sciences literature based on political dynamics in the development of public healthcare approach includes a diversified explanation on the relationship among public health, modern state and the emergence of capitalism.

Navarro claims that it is capitalism that fostered the emergence of public health measures since the sustainability of capitalist production entails well-being of laborers (Vicente, 1976: 176). On the other hand, according to Leys, autonomy and political opposition of organized labor class in England achieved to get the beneficiaries of healthcare in the 1930s and socially provided healthcare for all was provided after 1945 by reference to capitalism as not only the cause of the regulation of public health policies and as much as in spite of it at the same time (Leys, 2010: 2).

2.1.1. Medical Technologies of Governmentality

As Günal (2008 :75) points, it is evident that with the emergence of public health approach in the western societies, the state has a central role on carrying out

[13] It is a phrase used by David Haines, editor of Migration Policy Volume of International Migration Journal, for describing the volume. (Volume 51, Issue 2, April 2013, Pages: 1-208)

preventive health activities and focusing on the aim of creating a healthy society rather than individual well-being. She also examines the perspective of the state that centers on public health by indicating local, provincial or national levels (Günal 2008: 76). I suggest that the fragmented characteristics of preventive health programs render the understanding of everyday encounters with healthcare regarding the dissemination and embeddedness of power that enhances health promotion through social or collective and voluntary actions.

As the literature focuses, the discussions on preventive medicine mainly shape around the transformation of state's role and its varied strategies from public health measures through the goal of healthy society to well-being of the individuals through the emergence of health promotion. Health promotional rhetoric is described as specific activities strongly focused on the 'rational' management of populations' health, in order to accomplish specific goals: "fostering 'positive health', preventing illness and disease rather than treatment, developing performance indicators based on specified objectives, the use of mass media to 'market' health-enhancing behaviors and attitudes, and a focus on working with 'communities' to develop health enhancing environments" (Lupton, 2003: 51). As Lupton cited, more radical scholars conceive the term as a form of interpellation of individuals to take responsibility for their own health status and stress how that serves in reducing the financial burden on health care services and avoiding institutionalized medical forms of care for a focus on public policy (Lupton, 2003: 52).

Lupton (1995) explores how the knowledge and practices of public health and health promotion are embedded into broader historical, socio-cultural and political settings rather than its direct relationship among state and its citizens. In other words, she seeks to present an analysis within the nexus that is more complex among the state, family, commodity culture, education instead of the dualism that affirm or condemn public health and health promotion as oppressive of citizens' rights in the state's quest for power" (Lupton, 1995, 4-5). In fact, public health measures which are identified with the perspective of the state proved their efficiency in the improvements to accomplish elimination of communicable diseases and longer life

expectancy during the nineteenth and twentieth centuries by the reduction in risky behaviors, vaccination against communicable diseases and prevention of disease transmission (Yılmaz, 2017 p: 24).

However, as Ong (2003: 6) notes, what is at stakes for liberal societies is that regulative power of the technologies of government based on public health paradigm such as policies, programs, codes and practices in the making of citizen-subjects. By following Foucault's work on technologies of governmentality, she points out to the transition from discipline to regulation which is embedded in the self-making process of subjects (Ong, 2003: 7). Therefore, we need to explore how medical authorities read and understand immigrant bodies through preventive medicine and how health policies produce self-motivated medical-, citizen- and immigrant-subjects through everyday techniques and practices of healthcare delivery.

In order to prevent reconstruction of the dualism of state and citizens, we need to tackle reconstruction of modern medicine with the introduction of public health approach which alters oppressive implementations of state such as exclusion and quarantine before the eighteenth century (Foucault, 2008: 10) with a utilitarian imperative based on public's good in the name of universal right. According to Lupton, public health regards the body of individuals as threatening to pose the danger of diseases to the rest of population, however, public health discourse hinders power relations by creating subjects that voluntarily and accordingly behave for the sake of their and the society's health:

> Disciplinary power is maintained through the mass screening procedure, the health risk appraisal, the fitness test, the health education campaign invoking guilt and anxiety if the advocated behavior is not taken up. The rhetoric of public health discourse is such that the individual is unaware that the discourse is disciplinary; health is deemed a universal right, a fundamental good, and therefore measures taken to protect one's health must necessarily be the concern and goal of each individual (Lupton, 1995; Petersen and Lupton, 1997). Thus, in being aware of the public gaze, the individual unconsciously him- or herself exerts disciplinary power, both over others and over the self through self-regulation. In this process, power

> relations are rendered invisible, and are dispersed, being voluntarily perpetuated by subjects upon themselves as well as upon others: 'subjects thus produced are not simply the imposed results of alien, coercive forces; the body is internally lived, experienced and acted upon by the subject and the social collectivity' (Grosz 1990, 65) (Lupton, 2003: 35-36).

Public health discourse produces subjects who know health-threatening risks and who are encouraged to change their behavior through health promotion. Examination of power in everyday encounters between providers and beneficiaries of health services will provide a comprehensive ground to explore how power relations operate in every aspect of life by designating healthy individual conducts through self-regulation.

2.1.2. Promoting Population Health

In the ways in which public health discourse and its activities such as health promotion operate, the genesis of new logic of "government" or "governmentality" based on Foucault's neologism and its adoption by Rose (1990); Dean (1991) and Rose, O'Malley and Valverde (2006) correspond to one of the major explanations in the literature on public health provision and healthcare expertise.

Foucault suggests that we live in the era of governmentality, firstly discovered in the eighteenth century, which is a paradoxical phenomenon, the problems and technics of government "become the only political issue, the only real space for political struggle and contestation, and at once internal and external to the state. This is because the governmentalization of the state is at the same time what has permitted the state to survive" (Foucault, 1991: 103). Tactics of government which enable making the definition of "what is within the competence of the state and what is not, public or private in its survival and its limits" by analyzing the regulatory power of governmental technics that is central to the regulation of the lives of the society at large, or biopower, "a politics concerned with subjects as members of a population" (Gordon, 1991 p: 5.).

I must note that Foucault's analysis of biopower embedded into governmental practice refers to the problem of biopolitics and the problem of life; the concepts of biopower and biopolitics are used interchangeably based on power relations constructed in the broad and lengthy history of two centuries of liberalism around three major themes: law and order, the state and society and politics of life. As Foucault points, the term biopolitics is related to the rationalization of a set of problems of living beings along with their emergence as "population" such as health, hygiene, birthrate and life expectancy since the eighteenth century.

As those issues gained a rising significance during the nineteenth century, they become inseparable from the "political and economic issues they have raised up to the present" in relation to "liberalism" (Foucault, 2008: 317). He explains the phenomena of "population" and its relation to liberalism by the designation of a domain of governmental reason, concerned about "respect for legal subjects and individual free enterprise" that characterize the main facet of liberalism by putting forward the question: "The line of organization of a "biopolitics" finds its point of departure here. But who does not see that this is only part of something much larger, which [is] this new governmental reason? To study liberalism as the general framework of biopolitics" (Foucault 2009, 382). He gives the example of the debate that took place in England in the middle of the nineteenth century concerning public health legislation (as cited from Leys, earlier in this chapter) as a practice or a "way of doing things" within liberalism that refers to the rationalization of the exercises for governing population (Foucault 2008, 318). His analysis of liberalism relying on Wayne's reflections:

> Liberalism, then, is to be analyzed as a principle and method of the rationalization of the exercise of government, a rationalization which obeys— and this is what is specific about it—the internal rule of maximum economy. While any rationalization of the exercise of government aims to maximize its effects whilst reducing its costs as much as possible (in the political as well as economic sense of costs), liberal rationalization starts from the premise that government (not "government" as an institution, obviously, but as the activity that consists in governing people's conduct within the framework of, and

> using the instruments of, a state) cannot be its own end (Foucault 2008, 318).

As his perspective suggests, the aim of maximum effect with minimum costs of liberalism frame governmental rationality behind the instruments of the state by expanding governmentality, regulating its development and therefore strengthening the state and maximization of government. From the point of the state's strength, health, birth rate, and hygiene find an important place and liberal thought facilitates to govern health-related concerns of the state through health institutions. In addition to this, public healthcare corresponds to a particular technology of government in the contradiction between the state and civil society.

As Gordon suggests, "Governmentality is about how to govern" (7) and the construction of a complex domain of governmentality, within which economic and juridical subjectivity can alike be situated as relative moments, are partial aspects of a more englobing element. "The key role which comes to play in this effort of construction and invention is, for Foucault, the characteristic trait of the liberal theory of civil society" (Gordon, 1991: 22).

Work of Burchell examines the contested reconciling civil society and state, law and governmental order by adopting Foucault's skepticism regarding:

> A politics confined to the affirmation of rights and a politics which re-invokes the (mythical) virtues of a civil society independent of and opposed to the state. Both propose a codification of the individual's relation to the state's power which, in important respects, avoids the problem of power at the level of government. There can be no right to health, Foucault notes. (Burchell 1991, 145).

His examination on the power at the level of government serves to sort out the reduction of civil society to the recognition of rights by the state. Beyond the discussions of an independent civil society and state's central power, regulatory power of governmental practices such as the provision of public health care extend the investigation of complex issues in everyday forms of government embodied in interlocutors, i.e. healthcare providers and the citizens. Studies that pose the

questions of how we are to be governed by others and how we ourselves are to be involved in the practices of governing others" (Burchell 1991, 146) and ourselves through self-governmentality open up spaces to challenge liberal governmental rationality in accordance with legal codification of health right on the basis of citizenship and to explore how health regulations operate in governing the populations.

2.1.3. Immigrant-Subjects through Medical Gaze

In addition to the importance of labor movement on the development of public health and health measures, historically, problems of crowding and spread of infectious diseases related to the emergence of urbanization (cf. Roemer 1976, 97) had a remarkable influence on the organization of efforts to protect, promote and restore population health (Günal 2008, 75). According to Foucault, eighteenth century and onwards, along with the growth in the density of population in urban space, great storms of epidemics became visible in city centers, however, death rate reduced, and the average lifespan increased through state-initiated programs (Foucault 1991, 187).

According to Lupton, those state programs, services, and institutions involved in health promotion based on concerns about infectious diseases such as cholera, smallpox and the plague has often been discriminatory that "those of foreign nationality, the poor and the working class have historically been singled out for attention by public health authorities as agents of disease, requiring forcible 'hygiene' programs sometimes involving the destruction of their homes and isolation from the rest of society" (Lupton 1995, 35-36). Foucault notes that community's care for illness was conducted through medicine presented to the vague category of "sick poor" that it was exercised as a "service", rather than "relief", through the aid for the poor which supported by charitable foundations organized with multiple aims of distribution of food and clothing, support of abandoned children, shelter for the elderly and disabled (Foucault 2014, 115). In other words, medicine provided to the poor through charity organizations refers to a kind of assistance that enhances the survival of poor individuals with no efforts of a reduction of poverty, and the contagious effects of

their diseases. According to Ong, modern medicine defines and promotes concepts and categories on hygiene, health, life, and death not through the authoritative pronouncements but through regulative power of medical gaze directed to the bodies of the poor and the immigrants (Ong 2003, 91). Drawing on her fieldwork with Cambodian refugees and healthcare providers in the USA, she argues that normative attitudes and practices play a significant role in the formation of subjectivities by transforming immigrants to citizen-subjects.

2.1.4. The Shift from Treatment to Prevention

Before going into details of public healthcare in Turkey and how it transformed in accordance with diverse welfare and citizenship regimes, there are some technical concepts needs to be described which are embodied in public health discourse. Primarily, as Günal (2008) defines, preventive medicine refers to a branch of medicine that the primary concern is "the prevention of disease and methods for increasing the power of the patient and community to resist disease and prolong life" through the first level of contact with people, which is termed as primary healthcare that promotes "taking action to improve health in a community" (Günal 2008, 38). In this definition, the contact corresponds to the encounters of patients to doctors, nurses and other healthcare providers in primary healthcare facilities such as policlinics whereas secondary healthcare service is specialized medical care at the hospitals.

Emergence of the new facilities such as family and community healthcare centers has varied the primary healthcare institutions; however, the distinction between primary and secondary services and access to hospitals via the referral of patient's primary contact in public health staff remain currently. As Günal argues, the goals of public health activities remain the same: to reduce the amount of disease, rates of premature death, and disease-produced discomfort and disability in the population in spite of changing technology and social values.

In order to extend the discussions based on public health as a movement and an approach developed and articulated in western societies, by adopting Lupton's perspective, I argue that close-reading the negotiations and dependencies among

several subjects, such as experts of medicine and receivers of health services, allows us to cultivate into the power produced in every aspect of life. Evaluating public health measures in terms of their *good* and *bad* intentions or of their *success* and *failure* based on the aim of the well-being of community would narrow the analysis of healthcare as a unilateral service that centers on state's administrative institutions. Instead, we need to trace the historical framework of health politics and reforms in Turkey and its association with Turkey's migration policies.

As the goals of maintenance and improvement of the health of all the people, including Syrian immigrants, remain in the agenda of health politics of Turkey, it is significant to explore the imagery of immigrant illnesses and medical knowledge produced through the adoption of these goals by healthcare experts. As far as I conceive, construction of immigrant healthcare through the implications of technologies such as public health policies, psychosocial support programs, and preventive healthcare campaigns is a way of exploring the subjectivity of healthcare providers in the making of patient immigrant subjects by bringing bodies of immigrants under medical attention. In the medical encounters with their patients, doctors not only work for the maintenance and improvement of the health, but also becomes the authoritative subject due to her power of directing medical knowledge based on the combination of sciences, skills, and beliefs.

2.2. Health Politics in Turkey

A process of reforms in which troubled relationships emerge between public and private sectors has now identified healthcare systems all over the world. Due to the greater increase in health expenses than incomes obtained from the health sector, every single country must consider re-regulation of healthcare services and expenses which corresponds to diverse changes such as small-scale arrangements or reforms, specific to that state (Keyder 2007, 33). Ağartan's (2007: 51) analysis of global transformation on health systems in the world demonstrates that due to the failure in meeting the health expenses, and the eventual upheaval of a global crisis in healthcare provision, conflicts in the health systems in different countries, either developed or developing ones, had to undertake reforms in their health systems. She

lists a series of factors impacted on the outbreak of the crisis and reform process on the aftermath: technological improvements in diagnosis and treatment and thanks to these the increase in the possibility in more effective medical treatments; the issue of aging of the societies and hence, more people in need of health services and more sophisticated and educated patient characteristics through the efficient use of the Internet (Ağartan 2007, 50). In response to the global crisis scenario, Obamacare in the United States and the reform of the National Health Service (NHS) in Britain has been established; however, they generated similar significant political conflicts and troubles in terms of healthcare providers and beneficiaries (Yılmaz 2017, 23). NHS could be described as the steadily growing role of private companies on marketization of healthcare in England, where public health services were well-established, by conversion of the public system of health services to public-private partnerships (Leys 2010, 18-19). The emergence of costs as an outstanding factor on public health services, i.e. patients paying the bills after the treatment, healthcare has become something consumed by transforming the meaning of health care providers who "sell" medical profession to the patient customers.

Within this framework, health programs of developing countries have attempted to elaborate the scope of the healthcare insurance for the entire population to reach, on the one hand, to manage the infrastructure and funding problems on the other.

2.3. Welfare State Policies in Turkey

All the governments that came to power in Turkey have tried to implement reforms in the health system since the 1980s (Ağartan 2007, 42). That was a critical period, marked by the introduction of a formal social security system of a corporatist type (Buğra 2018, 321). As Günal points out, Turkey's in-egalitarian corporatist type of social security system in the 1980s and 1990s, excluded not only the employees of urban informal workers and but also the employees within the rural population (Günal 2008, 185). On the other hand, the self-employed and the workers in the formal sector could access pensions and health care. According to Keyder (2007: 15), the welfare regime combining Bismarck's corporatism and a traditional, family-based emphasis shaped this hierarchy. Bismarck's corporatism proposes employment-

based social security by dividing the population into hierarchic groups according to their employment conditions and treats these parties differently. Each social programs structured by ignoring the citizenship-based characteristics become problematic concerning comprehensiveness since different type of solutions is required for citizens excluded from these groups. Those excluded have to develop family ties in risky situations due to the lack of a social assistance scheme. It is not only associated with the centrality of the family but also the obligation to rely on the ties with neighbors and charity organizations (Buğra and Keyder 2006, 21).

As Keyder (2007) points out, the welfare state gives priority to the male members through the employment so that females or children deserve healthcare services through their husbands or/and fathers. On the top of the occupational hierarchy, bureaucracy officers' rank and workers follow them, whereas the heterogeneous group including business owners and the category, officially enrolled as the weak fall into the bottom class. Those layers correspond to the state workers with Retirement Fund (*Emekli Sandığı*), whereas private sectors with Social Insurance Institution (SSK), Social Security Organization for Artisans and the Self-employed *(Bağ-Kur)* and Green Card owners.

In 1983, the concept of community medicine was developed by leading doctors such as Prof. Nusret Fişek, based on the constitutional status of health manifested about Human Rights Declaration and Constitution of the World Health Organization (WHO). Concerning that, the purpose of socialized healthcare services was partly accomplished that many public health specialists completed the training and began to work at community health centers in different regions of Turkey[14] (Bulut 2007, 18). That achievement signifies one of the first attempts at socialization and localization of health care services. Socialization ascribes the responsibility of health care services primarily to the state by emphasizing public health and preventive care. Population-

[14]. Due to many reasons, the Ministry of Health could not apply the legislation such as failure in the financial planning, lack of collaboration between health and financial institutions and economic crisis primarily influencing healthcare funds. However, the process of socialization of healthcare services in Turkey has provided the adoption of local healthcare services. The number of community healthcare centers has reached to six thousand and healthcare houses to twelve thousand.

based characteristics are the key to this typology of the health care system, and in order to achieve this, the establishment of local units such as those community health centers in the rural region which decentralized structure of health system (Günal 2008, 242).

Although neoliberal discourse makes similar proposals in different contexts and countries, predicaments related to healthcare system differentiate according to the characteristics of that country (Ağartan 2011, 56). Therefore, such specific obstacles prevent a solitary neoliberal transformation on the health sectors. According to Buğra (2018), modern social policy in Turkey, separately from Europe, refers to the design to provide social assistance to the poor. Therefore, the modern social policy has been set up based on the emergence of publicly financed and administered measures. It is also important to note that a considerable portion of the population still lacked the health coverage and the inequality between rural regions and urban settings was most visible at the beginning of the 1980s (Günal 2008, 512).

According to Şenses, in Turkey, the introduction of the stabilization and adjustment program in the early 1980s signaled the transition of neoliberal economic policies, which would penetrate almost all the aspects of economic and social life; policies and sectors ranging from the labor market, agriculture, health, and education. Özbay et al. (2016: 5) argue that the state has withdrawn from the health realm by gaining only the role of monitoring. Their study gathers the recent medical ethnographies on tackling body, health and sexuality issues in Turkey under the influence of all-out neoliberalism. The various ethnographies discuss the neoliberalism of medicine through new collectivities around patient organizations; the narratives of females through reproductive technologies; the transition from conscious/unconscious patients to biological citizenship based on breast cancer treatments and social construction of menopause in Turkey.

Specifically, research on the issue of child health in countries such as Turkey lacks analysis of the dynamics of the broader cultural context until the 90s. Gürsoy's (1992) anthropological fieldwork on infant mortality in a neighborhood in Istanbul stands as

one of the first studies on researching that challenges the existing emphasis on mothers and medical- physiological effects of childhood diseases and points to socioeconomic factors that influence children health in Istanbul. Her research points to a “shift of focus from mothers to fathers” that “will facilitate the discussion and analysis of the relationship between the State and the family, religion, and democracy and their influence on child health at national and international levels” (Gürsoy 1992, 147). She also acknowledged that throughout her research in the 90s, she found that there was no accurate data in Istanbul as to which children had been vaccinated. Therefore, being able to trace pre-school children who have and have not vaccinated is not a problem restricted to migrant children.

Social medicalization started in the 19th century and ongoing in the 1980s, refers to the medicalization of the everyday life of the self through the transformation on the perception of health (Özbay et al. 2011, 6) The transformation corresponds to the more individualistic terms, and self-decisions have determined concepts on the definition of health and every single stage of life ranging from the processes of pregnancy and birth to the delay of the process of aging about medical issues anymore (Lupton 2003). As Özbay et al. noted, welfare states exempted from the responsibility of protecting health right of the citizens, defined by WHO in 1948, thanks to globalization.

As noted by Ağartan (2007: 49), global economic and political factors lead to the division of finance and service by increasing the role of the state on funding and arrangements of health sector whereas its responsibility for providing health services decreases. Finally, the transformation of hospitals to a more autonomous structure with the assignment of professional managers instead of health experts to the administrative units of the hospitals and leaving the responsibility of the poor’s health to local governments come up to a shift in the definition of healthcare, health services, and healthcare providers.

2.4. Healthcare Reforms in Turkey in the 2000s

Turkey's healthcare system has been under reconstruction since the government of Justice and Development Party (*Adalet ve Kalkınma Partisi*), in power since 2002, have launched Health Transformation Program (HTP) in 2003 (Yılmaz 2013).

According to Ağartan's (2012) analysis on HTP addressed the problem of the 'poor and uninsured' segments of the population who had difficulty in accessing high-quality services and aims at achieving universalism. By the legislation of the Administrative Unification of the Social Security System Act in 2006 (Act 5502)[15] and the Social Security and Universal Health Insurance Act in 2008 (Act 5510)[16], single-payer system has been created, and it was called General Health Insurance (GHI). According to the system, participation and payment of the contributions to Social Security Institution (SGK) were compulsory for all citizens except the Green Card owners. In order to improve healthcare access, SGK developed four policy initiatives. Two of which are significant for my research on vaccination and primary health care: "(1) Children under the age of 18 are offered free care at any public facility regardless of the insurance status of their parents. (2) Primary care services are provided free of charge, regardless of failed attempts recently to introduce co-payments." (Ağartan, 2012: 464).

Regulations brought about by the HTP aimed at egalitarian reach by eliminating occupational-based inequalities. However, as Yılmaz argues, the reform has resulted in the genesis of income-based inequalities. Occupational status as the primary origin of inequalities in access to previous healthcare models has replaced by income status." (Yılmaz, 2013: 74). He also notes that the new health care system in Turkey has been restructured as a public-private partnership model. This model offers an alternative to private hospital visits with additional payments (Yılmaz, 2013: 71). Through the integration of private hospitals into public health insurance and

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[15] http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=80079 Accessed 12 July 2018

[16] http://www.sgk.gov.tr/wps/wcm/connect/1513fcb9-6954-42f1-9711-1708b08ff3a0/SOCIAL_INSURANCE_AND_UNIVERSAL_HEALTH_INSURNCE_LAW.pdf?MOD=AJPERES Accessed 12 July 2018.

selection of public training and research hospitals with private health insurance, boundaries between public and private health institutions have become ambiguous. (Keyder, 2007: 20) In connection with HTP and under liberal health policies, Turkey has rendered public health facilities in a way to compete with private hospitals. In other words, patients who can choose among public and private institutions have been assigned new responsibilities as customers in the marketplace (Ağartan, 2012: 465).

It refers to the new forms of subjectivities as sellers-clients by engendering commodification of health. Adopting global and liberalism discourses on standardization of the body with maximized health conditions serves to govern citizens as subjects who seek the best healthcare. These policies have led to all-encompassing projects such as public health, and occupational health and safety remain unfinished. Hence, the perspective of preventive medicine has shifted to therapeutic medicine, more dependent on medical technology and pharmaceutical industry (Özbay et al, 2011: 19).

The historical framework regarding welfare, state, and politics of family and citizenship demonstrates that the welfare state sustains its significance in regulating health care practices. Liberal thought corresponds to the new forms of governmentality presently shaped by the state relationship with private insurance and pharmaceutical companies. According to the analysis of Yazıcı (2012: 129), the state plays a significant role in further reinforcing the socioeconomic inequalities sustaining disadvantage for precarious lives. Her analysis argues that the vulnerabilities of poor women and children have increased by reforms of welfare restructuring. I suggest that welfare and globalism in the transformation of the Turkish healthcare system have shaped the limited access of Syrian women and children to health care services. In other words, undergoing healthcare reforms has engendered the integration of Syrians, who were already in disadvantageous positions, into the precarious category characterized by inequalities and restriction.

According to Canefe (2018: 44), Syrian women and children were a disadvantaged group in Syria; however, the ongoing war and co8nflict have added new forms of precariousness to their lives. The displacement and dispossession after the war in Syria have created unforeseen challenges influencing the lives of those trying to settle in Turkey (Canefe, 2018: 45).

In addition to the profound reforming attempts in the health system, the early 2000s indicates the membership process of the Turkish Republic to the European Union. Turkey has signed the Accession Partnership Document in 2001, which has prompted legal and institutional regulations on social policies also regarding migration and asylum issues. Transit migrants from East to the West have drastically increased, so Turkey has become the center of migration at the periphery of Europe since the 1980s (Keyder and İçduygu, 2000: 385). In 2003, Turkey agreed to strengthen the 1951 Geneva Convention as part of the Accession for Partnership Document, hearing and determining applications for asylum, and developing accommodation facilities and social support for Asylum seekers and refugees; in that sense, Turkey has officially guaranteed to adopt and implement the EU's Acquis and best practices for migration intending to prevent illegal immigration (Ekmekçi 2017: 1436).

2.5. Healthcare for Forced Immigrants in the world

While doing the fieldwork in İstanbul, I have researched medical sociology and anthropology literature on how welfare, migration, and refugee health care are analyzed. Within the historical framework, I proposed how global and political processes have shaped public policy in Turkey, first I will focus on the literature on welfare restructuring based on the realm of health care. I think the history of liberal transformation for the construction welfare states will provide an illuminating ground for discussing migration/policy/anthropology nexus.

According to Abadia-Barrero's ethnography on reforms of health care in Columbia, the historical and political forces change shape and transform the moral choice within the social interaction among insurance companies, public administrators, legislators and the public. He argues that the right to health care corresponds to the moral

experience of the individual with the politics of life and that defines the value of life under neoliberalism (Abad-a Barrero 2016, 76).
Jayaweera's (2018: 273) study explores how health security in England is used interchangeably with the protection of health, within a broader public health context. Based on her fieldwork she argues that post-migration entitlement and access to health security creates a "gap in understanding the effects of multiple interacting factors of gender, class, national origin, ethnicity, legal immigration status increases" the vulnerabilities and inequalities of migrant women in England (Jayaweera, 2018: 282).

As public health literature within the scope of refugee studies demonstrate, nongovernmental organizations take active roles in the healthcare access of migrants. I argue that it is connected to the new modality of government suggested by Ferguson and Ghupta (2002). Drawing on Rose's argument that proliferation of "quasi-autonomous non-governmental organizations as the social and regulatory operations of the state become increasingly de-statized", they argue that this is not a matter of less govern-ment, "responsibilization" of subjects who are increasingly "empowered" to discipline themselves (Ghupta and Ferguson 2002, 989). The increasing responsibility through the subjects refers to the formation of mechanisms that work all by themselves. It requires a transfer of the operating power of state entities to non-state elements such as the headquarters of nongovernmental organizations, which is termed by "governing at a distance"[17] by Rose et. al. (2006: 89).

In this regard, humanitarian aid projects conducted in Palestinian camps have received considerable scholarly attention and the ethnographies of the transnational NGOs providing healthcare services in those camps illuminates the examination of power relations between health experts and immigrant-subjects. Fassin's (2008) case study on mental health programs develops a critical analysis of subjectification

[17] I extend the analysis of the concept "governing at a distance" based on my ethnographic inquiry in Chapter 5.

through humanitarian psychiatry expertise. According to him, to speak about domination through talking about suffering corresponds to morals and politics with new words; expressing violence regarding trauma is defining a new modality of it; humanitarianism produces the victim as trauma produces the suffering being (Fassin 2009, 551).

The domination of psychiatrists lies in the hierarchy between the images of the needy and sick recipient and strong and healthy medical professionals. Caregiver bases his diagnosis on the universalized distress of the immigrants. As Fassin notes, "The presence of psychiatrists and psychologists in Palestine enables and makes necessary a particular form of subjectification through this interpellation." (Fassin, 2009: 533).

In one of those ethnographies, Feldman (2015) proposes the concept of "endurance[18] projects" for programs focused on trauma and psychosocial treatment in Palestinian Refugee Camps in Jordan. She argues that humanitarian projects introduce different ways of living with bad conditions -without changing any of them- to refugees (Feldman, 2015: 430). In that sense, psychological and psychiatric programs do not challenge the profound inequality of the lives of Palestinian refugees residing in camps, just ascribe values to their lives through therapy (Feldman, 2015: 430).

2.6. Healthcare for Syrian immigrants in Turkey

Healthcare system in Syria has been destroyed and key health services interrupted due to the brutality of war. According to a recent study, Syrian war corresponds to a strategy called weaponization of healthcare, that is, many health facilities deliberately have been destroyed and several healthcare workers have been kidnapped, tortured and killed. Therefore, Syrian asylum-seekers deprived of health services for a period of time without access to key health services in Syria. Due to the

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[18] "Endurance is part of the explicit language of my interlocutors — who talk about helping people bear or endure (*tahammul*) their conditions — and it is also a word that encompasses a range of other terms also used by humanitarians (such as resilience) and Palestinians (especially sumud [steadfastness]). I use endurance, which Elizabeth A. Povinelli (2011: 32) describes as the "ability to (continuing from previous page) suffer and yet persist," to describe a range of interventions that are aimed at helping people live better with circumstances they cannot change" (Biehl, 2015: 429).

immigrant's deprivation of medical assistance and a substantial increase in their health problems, health-related concern of Turkey rest as a key factor on discussing post-migration settlement process in several cities of Turkey.

In mid-2013, WHO and Turkish Republic Ministry of Health agreed upon the establishment of Health Working Group (HWG; now known as the NGO Forum for Non-Governmental Organizations Operating in northern Syria) in order to "provide coordination and information exchange for cross-border humanitarian health interventions from southern Turkey." (Patel et. Al.) It means that WHO is not directly involved in the provision of public health services by the host government. Instead, several NGOs working on both sides of the border will be in collaboration with Turkey on health-related concerns for Syrian immigrants. The agreement between WHO and Turkish Republic Ministry of Health serves to the multiplicity of actors in the field of healthcare.

Involvement of multiple actors such as social workers both at local and global NGOs and healthcare professionals on responding health needs of Syrians designates a site of government through the expertise of medicine and humanitarian assistance. As far as I have explored and observed, there has been an increasing tendency in the social sciences literature on how Syrian immigrants experience integration and adaptation to Turkey, almost all of which are recent. Most of them could be classified as project reports (Erdoğan 2017; Kayalı and Woods 2017) suggesting steps of solution to the bureaucratic authorities, especially municipalities through the statistics[19]. Research of Turkey's healthcare services for Syrian immigrants; on the other hand, are very few compared to the studies exploring the improvements in assistance provided to immigrants.

Inquiry of Kayalı and Woods (2017) searches for the quality of information that municipalities of Istanbul about Syrian immigrants and perceives assistance as

[19] By leaving the discussions that whether the academician must recommend policies to handle these issues, I will not adopt a solution-proposing approach. Instead, I will try to examine social adaptation issues regarding experts (continues from the previous page) giving service to Syrian children such as psychological counselors, social workers, public health doctors, nurses, and officers.

process management with the method of telephone surveys instead of face-to-face interviews. In the conclusion part, the study makes suggestions for more efficient utilization of economic resources by decreasing coordination with NGOs (Kayalı and Woods, 2017: 19).

According to Kaya, Refugee Studies has become a field of study since the 1980's, as a newly developing field which is relatively recent; however, it has lacked inquiry derived from fieldwork (Kaya 2017, 48). He is critical to the establishment of the discipline in Turkey for similar reasons that very essential elements, primarily analysis derived from anthropological research, are missing:

> Scientific studies held in Turkey regarding the state of the Syrian refugees often contribute to their statisticalization rather than to making their social, economic and political expectations visible to the receiving society (Kaya, 2016: 8).

Nevertheless, the studies of Baban and his colleagues, based on the theoretical discussion of refugee studies, could be exempted from Kaya’s critics. Drawing on their fieldwork conducted in five cities in Turkey, with Syrian refugees and representatives of Syrian and Turkish humanitarian and relief organizations, the first article was published in 2016. They argue that Syrians refugees mediate between the claim to citizenship rights and the limbo status under temporary protection. As they sustain the access employment and social services as part of humanitarian assistance, they continue to be part of the multiple pathways to precarity and differential inclusion (Baban et. al. 2016: 45).

The following study published by the same scholars in 2017 explores how the border politics regulated by the EU-Turkey deal distort Syrian political subjectivity. They argue that international refugee protection regime leads to the de-politicization of Syrian immigrants as subjects of humanitarian assistance which prevents them to speak for themselves and their rights (Baban et. al. 2017, 99).

In line with the analysis of international regime for Syrian immigrants, Biehl's (2008) ethnography explores the powerful governing effect of numerous actors invading everyday lives of Syrian refugees. Concerning displacement and its consequences, she suggests "protracted uncertainty" to define the experience of being an asylum seeker in Turkey and argues that uncertainty becomes one of the major causes of suffering. Protracted uncertainty caused by indefinite waiting procedure on refugee status determination creates precariousness invading in the everyday lives of immigrants (Biehl 2008, 14).

By exploring the concept of uncertainty from Foucault's theoretical standpoint, in the subsequent chapters, I will analyze governmentality of uncertainty both as part of asylum regime that corresponds to temporary protection and promotion of public health services by healthcare providers for Syrian immigrants in Turkey. Drawing on the analysis of Lupton (1997: 99) on how the disciplinary power in the medical encounter operates, I will discuss medicalization of the encounters between healthcare experts and immigrants.

CHAPTER III

RESPONDING MIGRANT HEALTHCARE: GOVERNING THROUGH TP IN ISTANBUL

As of April 2011, more than the half of pre-war Syrian population has been displaced due to the outbreak of civil war that marks the turn of 21st century (Canefe 2018, 3). According to the data updated on April 2018 by United Nations High Commissioner for Refugees (UNHCR), 13.1 million people are in need in Syria and 6.1 million of them have been internally displaced[20]. At least 5.6 million of Syrian population have fled their homeland and forced to migrate to Turkey, Lebanon, Jordan, Iraq, and Egypt according to statistics from December 2018[21]. Among those countries where Syrians have taken asylum; Turkey has gradually become the most immigrant-hosting country with more than 3.5 million of Syrian population according to the updated records of Directorate General of Migration Management (GDMM) on November 2018[22].

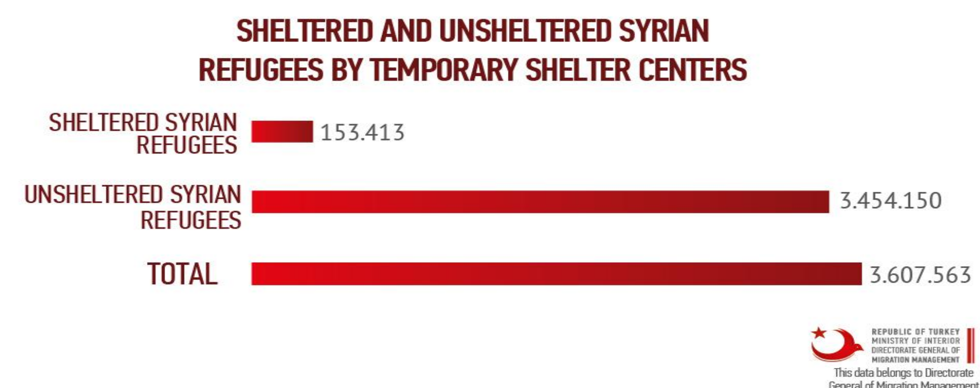

Figure 3.1.Syrian Population Residing Inside and Outside the Temporary Shelter Centers

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[20] These are the estimated numbers on February 2018. https://www.unhcr.org/sy/wp-content/uploads/sites/3/2018/02/Syria-Fact-Sheet-2017-2018.pdf Accessed 6 December 2018 For the most updated statistics estimated by UNHCR, please visit https://www.unhcr.org/syria-emergency.html Accessed 7 December 2018

[21] https://data2.unhcr.org/en/situations/syria?id=224 Accessed 6 December 2018

[22] See Figure 1, http://www.goc.gov.tr/icerik6/temporary-protection_915_1024_4748_icerik. Accessed 25 November 2018.

Due to the initial immigrant flow to Turkey, Syrians were hosted in temporary shelter centers, established by Prime Ministry Disaster and Emergency Management Presidency (AFAD)[23]. With the growing Syrian population[24], the number of these camps reached to 22, all of which are located in 10 cities in Turkey's southern and south-eastern regions, close to the Syrian border.

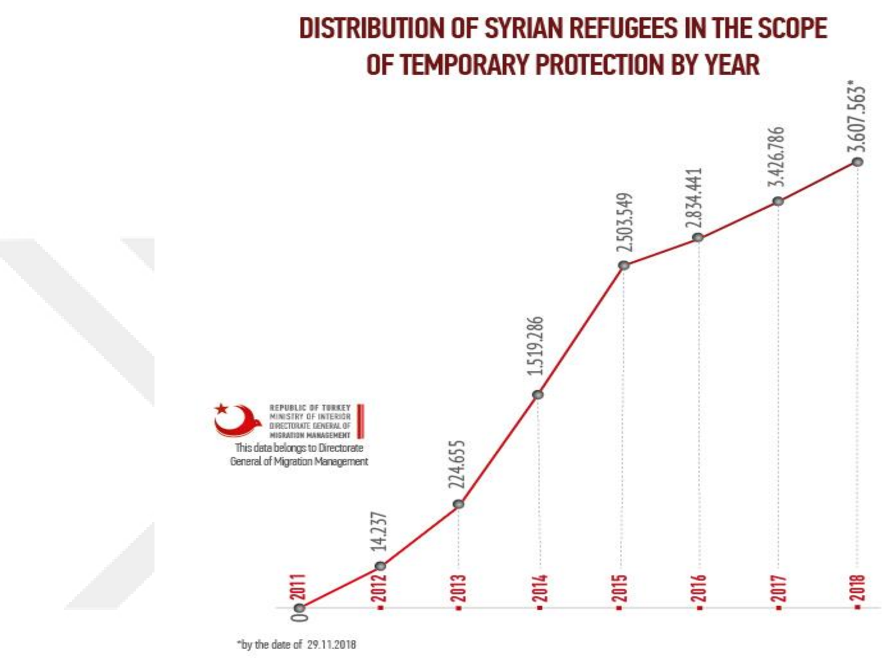

Figure 3.2.Syrian Population by years in Turkey

International organizations such as the United Nations Development Program (UNDP) appreciated the initial steps accomplished by Turkish government such as these shelters due to their adequate infrastructure, educational and health facilities (Terzioğlu 2017: 35).

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[23] https://www.afad.gov.tr/upload/Node/17962/xfiles/suriyeli-misafirlerimiz_1_.pdf , Accessed 6 December 2018.
Prime Ministry Disaster and Emergency Management Presidency (AFAD) is determined as responsible institution inside the camps. Establishment of tent cities was managed by Turkish Red Crescent. In coordination of AFAD; Ministry of Interior, Ministry of Foreign Affairs, Ministry of Health, Ministry of National Education, Ministry of Agriculture and Rural Affairs, Ministry of Transportation, Ministry of Finance, Presidency of General Staff, Governorship of Hatay, Presidency of Religious Affairs, Ministry of Customs and Trade and Red Crescent work in close collaboration. Source: http://www.goc.gov.tr/icerik6/temporary-protection-in-turkey_917_1064_4768_icerik Accessed 5 December 2018

[24] See Figure 2, http://www.goc.gov.tr/icerik6/temporary-protection_915_1024_4748_icerik. , Accessed 25 November 2018.

Besides, most of the local health care associations paid visits to these camps near the border in the early years of Syrian migration and Turkish Medical Association (TMA) published a report based on their observations on such visits called "Syrian Asylum Seekers and Health Services Report"[25] in 2014 (Özçürümez and Yıldırım 2017: 115). In this report, TMA examines the accessibility of public health services for Syrian immigrants in terms of how it differs based on the conditions of residence in and outside camps; allocation of health service personnel and their moral compass. Most highlighted findings and suggestions of their study could be listed as follows:

> Those residing in camps are more likely to undergo medical screening as there are medical clinics established within the camps. Syrians, who reside outside camps, need regular medical screening and to be informed about the Turkish health system in order to access it. Majority of health personnel have no experience in working under emergency conditions. The language barrier is one of the major problems that health care providers encounter in the camps. The number of translators is reported as insufficient when compared to the demand. The work overload on medical personnel at camps prevents the health system from performing properly both inside and outside the camps. There is a lack of standard operating procedures concerning health service delivery to the refugees resulting in inadequacies in the system; along with the need for training health care providers on how to function as needs arise in the humanitarian crisis (Özçürümez and Yıldırım 2017: 116).

As the research manifested, there is a considerable variation in Syrians' access among those residing in and outside of these camps due to the lack of standard operating procedures. Medical institutions have been available for Syrian temporary residents on camps, however, healthcare services have still been limited in terms of language barrier. Lack of experts specifically trained for medicine and translation in a time of an emergency has dramatically increased the challenges produced by unpreparedness and directly prompted difficulties in the relationship between healthcare providers and Syrian immigrants. In addition to the absence of expertise on migrant healthcare, the work overload on healthcare providers working at camps

[25] "Suriyeli Sığınmacılar ve Sağlık Hizmetleri Raporu" (TMA, 2014). http://www.ttb.org.tr/haberarsiv_goster.php?Guid=673309ea-9232-11e7-b66d-1540034f819c. Accessed 8 December 2018.

not only creates inadequacies in the health system, but also results in the failure of proper operation both inside and outside camps.

Another study conducted by Kaya points out the sufficient service delivery on camps, where only 10% of the total immigrant population in Turkey settled; such as shelter, food, water, non-food items (NFIs), medical services, water supply and sanitation, education, and psycho-social support by highlighting the difficulties in navigating with public services and support outside the camp as of March 2016. He underlies that service delivery by Turkish authorities for the majority of Syrian population in urban areas is not only overwhelming for Syrian immigrants, but also turns into a substantial challenge due to the language barrier (Kaya 2016: 7). In addition to a number of aid agencies providing assistance and protection to the immigrant population residing in urban settings, as he notes, an Amnesty International report published in 2016 indicated challenges of accessibility of social rights and services: "Refugees who live outside the government-run refugee camps struggle to secure a minimum of social and economic rights, such as education, housing and healthcare. Many families live in abject poverty, often in unsanitary, even dangerous, housing conditions" (Kaya 2016: 8).

While the challenges on access to public services for Syrian immigrants residing in camps and barriers for service providers such as lack of professional experience and training for the disadvantaged groups continued to exist, the year of 2013 refers to an important break for the governance of public services in terms of Syrian mobility outside the camps and legislative attempts to frame service provision for the immigrants. When the numbers of Syrians escalated to hundreds of thousands, these camps remained incapable for proper accommodation due to the multiplied security problems (İçduygu 2016: 14; Terzioğlu 2017: 35). Therefore, Syrian immigrants gradually started to migrate to other urban centers in the south-eastern Turkey cities such as Antakya and Gaziantep.

In addition to these cities near the Syrian border, they migrated to metropolitan centers such as Istanbul, Ankara and Izmir namely to other regions and consequently

to all over the country by the density varying from one region to another (İçduygu 2016: 13). Mobility of Syrians leaving the camps and moving to urban areas leads to the reconsideration of health services and centers in the cities of Turkey. Provision of primary healthcare services and psychosocial support at health centers and facilities in those camps was managed under the responsibility of AFAD in collaboration with Ministry of Health, the International Organization for Migration (IOM), WHO and NGOs such as Association for Solidarity with Asylum Seekers and Migrants (ASAM) (Özçürümez and Yıldırım 2017: 107).

Along with the Syrian settlement in the cities, health care providers started to encounter immigrants at the emergency health units of state hospitals already giving service to Turkish citizens. The most severe challenges on treating the immigrants for health professionals have been language barrier due to the lack of properly trained interpreters at the hospitals and the absence of legal standards for registration of Syrian patients. Therefore, Syrian population settled in various cities of Turkey manifests a series of questions regarding access to healthcare services: How does the health system respond to the diseases and psychological problems of Syrian immigrants? How do the conditions in their accessibility to public health services influence health politics and services? Are the existing health institutions sufficient to address health issues of the displaced population or the institutions giving specific service for migrant healthcare are required?

Pointing to the questions above by Turkish political and medical authorities gains significance while urban Syrian population has been increasing due not only to the departure from camps but also to the escalated exodus. Since the clashes between Assad regime and conflicting armed groups have become more chaotic as the involvement of the United Nations and the oversea states such as the USA, Russia and France has multiplied the actors by complicating the process for stability in Syria. As İçduygu and Millet (2016) point out, “at the onset, the conflict was expected to be resolved in a relatively short period of time”. However, as the exile of Syrian immigrants in Turkey and other neighboring countries prolonged, the initial open-door policy of Turkey describing Syrian population as guests with no legal rights has

been extended to the status of "temporary protection" based on the legal regulations regarding registration, the right to stay, work permit and access to health services in Turkey (İçduygu and Millet 2016: 5).

3.1. Legal and Administrative Regulations for the Immigrants in Turkey

In this section I examine the short history of migration policy in order to conceive the perspective of Turkish governments. By focusing on migration to Turkey and how that issue is associated with health politics, I trace the legal regulations based on the political turning points within and outside the country.

İçduygu (2016) identifies a series of political issues influenced Turkey with the emergence of "refugee" flows as the Soviet occupation in Afghanistan, the Iranian Revolution in the late 1970s, and political instability in various parts of the Middle East, Africa and Asia in the 1980s and 1990s. Since the 1980s, transit migrants from East to the West have drastically increased, so Turkey has become the center of migration at the periphery of Europe (İçduygu and Keyman 2000: 385). In the late 1980s and onwards, Turkey has experienced a dramatic growth in the asylum applications also from European countries and received Bulgarians, Bosnians and Albanians from Kosovo who sought refuge (Biehl 2015: 69).

In her PhD thesis, Biehl indicated that 1951 Geneva Convention and its Additional Protocol signed in 1967, created an uncertainty in the status of the immigrants who achieved to arrive at Turkish Republic especially during the 80's and 90's. Turkey as a signatory country of the convention has an exceptional status based on geographical limitation: "Turkey grants asylum only to refugees who have European origins, whereas non-European refugees are granted only temporary asylum in Turkey until a 'durable solution' has been found." In that expression, the accurate description of durable solution is missing and it leads to generate new vulnerabilities on the living conditions of non-European immigrants in Turkey. According to Biehl, by leaving all the responsibility of providing assistance to UNHCR, Turkey aimed at handling a series of challenges: "security considerations, proximity to countries on its' Southern and Eastern borders marked by instability, and fears over becoming the European Union's

‘dumping ground’” (cited by Kirişçi 1996, 2001b, 2002, 2004). As Terzioğlu noted, the clause added by Turkey on the Geneva Convention aims at integrating ethnic Turks coming from the Balkan countries and Russia based on “the country’s aspirations to be secular and Western, which has been quite prominent since the nineteenth century” (Terzioğlu 2017:35). Although Turkey kept on refusing the removal of the geographical reservation due to these factors until the EU Accession Partnership Period has been initiated, the measure of temporary asylum for non-Europeans failed to prevent growing immigrant movements (Biehl 2015: 69).

EU-Turkey relationships has escalated during the 2000s based on the regulation of social rights as a pre-condition of acceptance as a member of EU. In addition to the profound reforming attempts in the health system in Turkey, the early 2000s indicates the membership process of the Turkish Republic to the European Union. In line with the reform process on social policies such as the reconstruction of healthcare services protecting the right to health, EU has been one of the main driving forces on migration and asylum-related issues within the political and legislative agenda of Turkey (İçduygu and Millet 2016: 3). Turkey has signed the EU Accession Partnership Document in 2001, which has prompted legal and institutional regulations on social policies also regarding migration and asylum issues.

In 2003, Turkey agreed to strengthen the aforementioned convention and its additional protocol as part of the Accession for Partnership Document and adoption of EU directives on asylum and migration (Şimşek 2018: 2); which is defined as a “milestone in coping with irregular migration in Turkish migration literature” (Canefe 2018: 115). In this regards, Turkish Government carried out a series of regulation such as Law on the Work Permit for Foreigners (LWPF) enacted in the same year aimed at facilitating legislative issues of labor immigrants for search for work and employment. In March of 2005, the Action Plan on Asylum and Migration maintained by the government laid out the tasks and timetable that Turkey intends to experience EU-isation of asylum and migration legislation (İçduygu and Millet 2016: 3).

3.2. Terminology on Temporary Protection

Turkey has become a country of migration and transit for a while, especially since the 80s due to the political conflicts stated above. However, the country had never experienced such a dramatic increase in the immigrant influx driven by the protracted Syrian war in such a short time span. Migration of the substantial Syrian population makes Turkey as receiving country of the most migrants (Terzioğlu, 2015: 35). Therefore, changing asylum regime and transformation in the policies based on EU directives have gained significance for the investigation of healthcare services and expertise within the case of Syrians' forced migration.

Regulations in order to enhance the integration of Syrian population influx are highly related to policy changes in Turkish healthcare system. In other words public assistance for Syrian immigrants intertwined with the political transformation in access and socialization of health right and services in terms of citizens, healthcare providers and society at large.

Turkish Republic initially implemented open-gate policy and accepted immigrants as "guests" determining applications for asylum, and developing accommodation facilities and social support for asylum seekers as I mentioned earlier. Until 2014, Regulation on the Center for Disaster and Emergency Management, enacted on February 2011 was the only legal basis for "Syrian guests" that recognized Syrians' asylum and used to guarantee providing healthcare services under the responsibilities, coordination and organization of AFAD (Bilecen and Yurtseven 2017: 117). Regulation undertakes the right of Syrian immigrants to health in Turkish health system and allocates the responsibility of healthcare expanses to AFAD[26]. However, it did not present an illuminating framework on Syrians' access to medicine and medical treatment- i.e. which healthcare institutions and categories of services are

[26] http://www.istanbulsaglik.gov.tr/w/sb/saggel/belge/Av_Elif_Selen_AY.pdf
"Suriyeli Mültecilerin Sağlık Hizmetlerine Erişimi", Accessed 13 December 2018.

assigned for Syrian patients other than free emergency services at state hospitals located at the cities where an immigrant is registered[27].

In line with the complicated relationship between EU and Turkish governments, Syrian influx becomes one of the main milestones that leads to the shift in migration patterns. The dramatic increase in the Syrian immigrants fled to Turkey as the transit country to Europe associated with the context of the accession negotiations with the EU and strict border regimes of EU member states. In 2013, Readmission Agreement for Third Country Nationals and Stateless Persons was signed between Turkey and the EU, in order to ‘‘to establish on the basis of reciprocity, effective and swift procedures for the identification and safe and orderly return of persons who do not or who no longer, fulfill the conditions for entry to, presence in, or residence on the territories of Turkey or one of the Member States of the Union, and to facilitate the transit of such persons in a spirit of co-operation.’’[28] With the agreement, Turkey accepted readmission of the detained migrants from EU member states and their temporary stay in the readmission centers for 12 months.

Ekmekçi pointed out the challenges in Turkish readmission system in relation to health services: limited number and capacity of readmission centers in terms of public services including healthcare and social support; the burden of providing health services to the 2 million Syrian immigrants (according to the data in 2017) and the least number of medical doctors per capita in Turkey when compared to the other EU member states (Ekmekçi 2017: 1437).

Although EU is supporting the establishment of these centers through the EU funds, the agreement forced Turkey to revise its legislation on refugees and migrants by the requirement of enhancing the provision of health services (Ekmekçi 2017: 1438).

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[27] Syrians living in Turkey was recognized as “temporary guests” and health services are defined in the basis prepared by Emergency Health Services Directorate. https://dosyasb.saglik.gov.tr/Eklenti/1376,saglik-bakanligi-gecici-koruma-yonergesi-25032015pdf.pdf?0 Accessed 13 December 2018.

[28] http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A22014A0507(01). Accessed 13 December 2018.

Since 2013 most of the key legislations have been published to draw the framework of the asylum rights and the conditions under which Syrian immigrants can access health within Turkish political context towards the immigrant flow (Mardin 2017: 4). The government released a circular in 2013[29] to extend the free emergency healthcare access to all 81 provinces of Turkey regardless of registration, whereas all registered Syrians can technically receive free healthcare in public hospitals (Mackreath and Sağnıç 2017: 7).

The Turkey-EU joint statement enacted on March 2016, had three important components: "The first involves the return of all new irregular migrants crossing from Turkey into the Greek islands as from 20 March 2016. Second, the statement declared the resettlement of one Syrian from Turkey to the EU for every Syrian being returned to Turkey from the Greek islands. Third, financial aid will be channeled to Turkey to improve living conditions of refugees in Turkey." (Üstübici, 2017: 66). According to EU- Turkey joint statement which would be in force as of 4 April 2016, as İçduygu et al (2016) noted:

> "Turkey has agreed to take any necessary steps to keep the passage into Europe under control. In exchange, the EU has agreed to the disbursement of 3 billion euros to the Facility for Refugees in Turkey, which will fund the support and aid efforts including healthcare, education and food for the Syrian migrants. In addition, in exchange for this deal, visa requirements for Turkish citizens were to be lifted by the end of June 2016, 'provided that Turkey fulfills all benchmarks required for such a lift.'" (İçduygu et al, 2016: 5).

3.3. Uncertainty Stemming from Temporary Protection and Refugeeness

In this regards, the first key legislation is Turkey's EU-inspired new "Law on Foreigners and International Protection (LFIP)"[30] that came into full effect on April 2014. LFIP aims to prevent violations of fundamental human rights of asylum seekers by establishing visa and residence policies and to help reduce irregular migration to

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[29] http://www.istanbulsaglik.gov.tr/w/sb/saggel/belge/Av_Elif_Selen_AY.pdf Accessed 13 December 2018.

"Suriyeli Mültecilerin Sağlık Hizmetlerine Erişimi", accessed 13 December 2018.
[30] http://www.goc.gov.tr/files/files/eng_minikanun_5_son.pdf

Europe (Ekmekçi 2017). As Canefe explained, requirements for residing and working in Turkey, procedures and categories of residence status and the processing of asylum applications are some of the significant changes introduced by the law for all irregular migrants, especially for Syrians, but not limited to their case (Canefe 2018: 116).

As part of the pillars brought by LFIP, Directorate General of Migration Management (GDMM) was established as a specialized institution, which took over the official responsibility for implementing the new laws of immigration and integration carrying out the strategies and policies related to migration (Canefe 2018: 94).

By extending Article 91 of Law No. 6458 on LFIP, Turkish government developed a legal framework called "temporary protection". Temporary Protection Regulation (TPR) was published on October 2014 in order to define public services and basic human rights standards would be provided to displaced persons. TPR describes the immediate asylum including access to State in the event of a mass influx under the spirit of the GDMM:

> Temporary protection may be provided for foreigners who have been forced to leave their country, cannot return to the country that they have left, and have arrived at or crossed the borders of Turkey in a mass influx situation seeking immediate and temporary protection.[31]

In the definition part of the Law, it is guaranteed in a way that Syrian immigrants entitled to temporary protection:

> Protection status granted to foreigners, who were forced to leave their countries and are unable to return to the countries they left and arrived at or crossed our borders in masses to seek urgent and temporary protection and whose international protection requests cannot be taken under individual assessment[32].

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[31] http://www.goc.gov.tr/icerik6/temporary-protection-in-turkey_917_1064_4768_icerik Accessed 5 December 2018

[32] http://www.goc.gov.tr/files/_dokuman28.pdf Accessed 5 December 2018

With the implementation of TPR the 'guest' status changed to a semi-legal 'temporary protection' one, however, TP is still ambiguous that it assigns Syrians to the cities they were once registered, if there is a change in their address or if they would travel to another city, they are required to get the legal permission of GDMM (Terzioğlu 2017: 36). The requirement of notifying Turkish authorities would lead to difficulties in if there is no hospital capable of providing medical treatment in the city they are registered. Even if there are available health institutions in the patient's city, her or his selection of hospitals is restricted to state hospitals since they cannot go directly to private or university research and training hospitals (Bilecen and Yurtseven 2017: 118).

Article 27 of the Temporary Protection Regulation (TPR) describes health services provided to Syrian refugees[33] that those registered have the right to access primary health care services. In other words, the GHI covers all registered Syrians as temporary protection beneficiaries. They have the right to apply health care services free of charge such as Family Health Care Centers (FHC) and Community Health Care Centers (CHC)[34]. On May 2018, a circular was published that describes Migrant Health Care Center (MHC)[35] as a subsidiary unit of CHC and these centers are still under development.

As Osseiran (2017: 102) argues, temporary protection regulation outlines the access of Syrians to healthcare, education and labor rights by "setting forth a new type of status in the Turkish migratory regime"; however, the status mostly refer to inequality based on "service provider, the refugee in question, the neighborhood or city the person lives in".

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[33] http://www.goc.gov.tr/files/_dokuman28.pdf Accessed 5 December 2018

[34] Family Health Care Center (FHC): Aile Sağlığı Merkezi
Community Health Care Center (CHC): Toplum Sağlığı Merkezi. CHCs are established under the umbrella of Public Health Centers in every municipality.

[35] MHCs have been established most-refugee hosting districts such as Fatih, Esenyurt, Bağcılar, and Sultanbeyli. For more information, please visit http://istanbulism.saglik.gov.tr/TR,54032/gocmen-sagligi-merkezleri.html, http://www.resmigazete.gov.tr/eskiler/2018/05/20180525-1.htm Accessed 4 November 2018

Due to the problematic aspects of depicting Syrians as people under temporary protection, I mostly refer to Syrians as immigrants in order to “stress that they are not currently granted refugee status” as Terzioğlu suggests (2017, 35). However I will keep the words “refugee” when quoting from the works of other scholars in order to respect the authenticity and preferences of those studies.

One of the major reasons of the uncertainty created by temporary protection is associated with the contradictory definitions formulated by actors involving in healthcare provision for Syrians. Basic human rights of Syrians’ such as health and education are protected by UNHCR, whereas temporary protection does not define their rights in legitimate system of Turkey, but define the available healthcare services for them. Thanks to the legal arrangements, they can benefit from free primary healthcare services, emergency healthcare and treatments for several illnesses (such as cancer) in public hospitals.

> As for their health issues, a mass vaccination campaign for the Syrian children only started in 2014, without any checks as to what vaccinations they had already received. As a result, Syrian children are especially blamed in the media and social media for spreading almost eradicated diseases, such as tuberculosis and poliomyelitis, in accordance with the ‘blame the victim’ ideology exposed above. Negative discourses about the Syrians are not only caused by their poor health and problematic legal status, but are also related to their general image within Turkey (Terzioğlu 2017, 42).

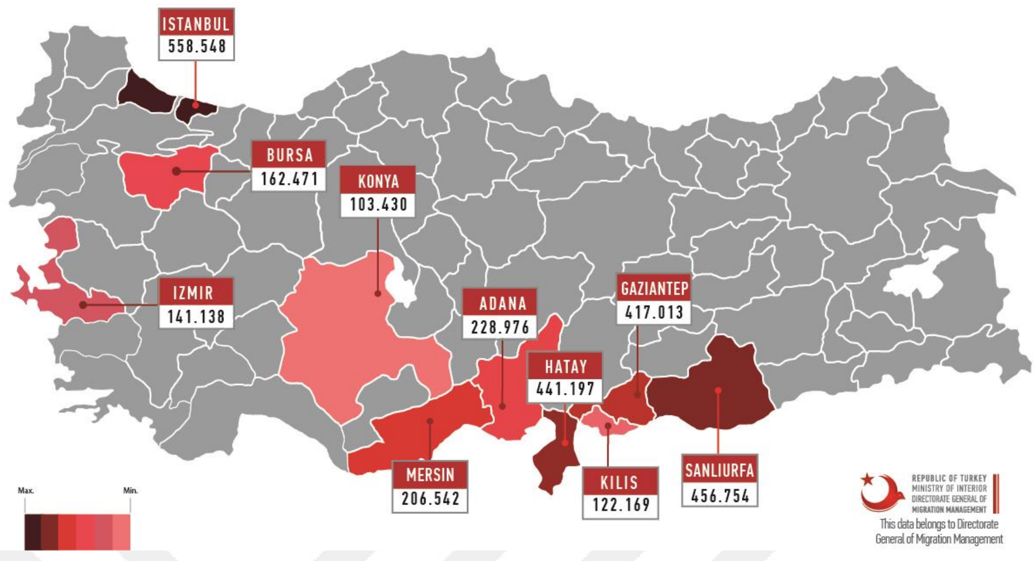

Figure 3.3.Syrian Population under Temporary Protection by 10 Provinces with Highest Population

3.4. Istanbul as the new *destination* for Syrians

Syrian immigrants seem to be scattered all over Turkey on the period between 2011-2013, as İçduygu indicated "the most populated regions" as "south-eastern and southern regions, hosting about 38 per cent and 29 per cent of the total Syrian population respectively" followed by "Istanbul, the country's biggest metropolitan city, appears to host a significant share with 20 percent of the total Syrian refugee population" (İçduygu 2017: 14). Updated statistics of GDMM in November 2018 demonstrate that Istanbul stands as the most important attraction center for the immigrants, the province hosting the highest share of Syrian population[36].

As I stated earlier, the geographical location of Turkey makes the country as a transit country to move on to Europe. The country's significance on irregular migration routes leads to the dramatic increase in the international migration flows to Turkey. Despite the growth in its attraction for irregular migrants, which is relatively recent,

[36] 558.548 of total Syrian population live in Istanbul. See Figure 3, http://www.goc.gov.tr/icerik6/temporary-protection_915_1024_4748_icerik Accessed: 25 November 2018.

since the 1990s; it is possible to notice emergence of social-cultural networks among various refugee and migrant communities settled in particular neighborhoods in Istanbul. According to Biehl, the main reasons behind the established presence of the newcomers is finding accommodation easily in these neighborhoods such as Tarlabaşı, Dolapdere and Zeytinburnu (Biehl 2015, 79) and informal labor opportunities the city offers (89).

In line with the reasons behind Istanbul becoming an attractive city for the immigrants' residence as explained above, Osseiran's ethnography on how Syrians experience temporary protection in relation to their migration process to reach Europe, relates their selection of Istanbul to conditions and opportunities in the city, and their decision to continue to Europe (Osseiran 2017: 22). Kaya's study (2017: 46) underlines that although Syrian refugees have been under the brink of starvation, Istanbul has become a metropolitan where Syrian immigrants insistently stay. Because they barely feel social exclusion and racism in their neighborhoods, and most of them considers Istanbul as a transit city to Europe whereas most of them do not think of abandoning the city.

Another research conducted by Kaya and Kıraç (2016) in collaboration with the association, Support to Life (STL) demonstrates that most of Syrian informants states the reason of settlement in Istanbul as job opportunities the city offers, whereas a considerable segment of them point to the social networks built upon family and relatives in the city. The study highlights two main networks that facilitate to start a new life for Syrian immigrants in Istanbul that are labor and family networks; both of them are widely used in the process of migration. The former helps potential migrants to be informed about the available job positions and to settle before finding a job and the latter supports with the feeling of hospitality and familiarity that gives the confidence of preserving their culture and close ties with their families (Kaya et. al. 2016: 20).

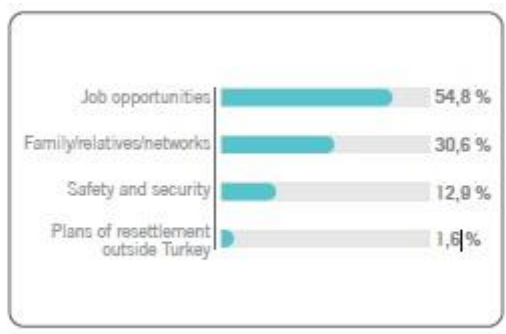

Figure 3.4.Reasons of Resettlement in Istanbul[37]

As all of these studies based on anthropological research point out, Istanbul forecasted as a transit space of border crossing process to EU countries turn out to be a destination where they seem to reside more than expected.

Erdoğan's study on Syrian immigrants and the process management of municipalities by focusing on the case of Istanbul conducted in 2017, describes non-camp Syrian immigrants, dispersing from camps to city centers all around Turkey as urban refugees. According to him, the emergence of urban refugees is an unusual issue because the presence of Syrian immigrants have affected local governments primarily (Erdoğan 2017, 11), and especially municipalities in Istanbul. They had to start dealing with problems and needs of immigrants mainly concentrated in Esenyurt, Sancaktepe, Sultanbeyli, Küçükçekmece, Bağcılar, Zeytinburnu and Fatih (Erdoğan 2017, 49). They had to provide emergency support to refugees, but as the period of refugees' stay in the cities prolonged, municipalities have had to provide services to the immigrants in these areas that they have never planned before and that might be considered controversial in the sense of their legitimate power. Due to the legal obstacles, municipalities tended to describe providing certain services to Syrians not as a migration-related integration issue, but as part of a poverty issue they have already been doing for the poor in local community through projects developed by NGOs (Erdoğan 2011, 69).

[37]Kaya, Ayhan and Aysu Kıraç. (2016). "Vulnerability Assessment of Syrians in Istanbul", Report, Support to Life Association, Istanbul.

His research also points to the preferences of districts for the immigrants which are associated with solidarity, cheaper life in those municipalities in addition to services provided (Erdoğan 2011, 29). Kaya (2016, 20) notes that the perceptions of the host community and stakeholders is key to Syrians' choice of location of settlement as the comprehensive understanding of service providers on vulnerabilities and needs of the immigrants is highly influential on high immigrant population in certain municipalities.

On my fieldwork, some of the informants indicated that the similarities with host community based on the social issues such as income make easier the immigrants to adopt certain neighborhoods and keep them away from other districts such as Kadıköy, Şişli and Beşiktaş:

> O insanları mesela Kadıköy'de bulamayız başka bir yerde bulamayız. Kendilerine benzeyen insanların olduğu yerlere gidiyorlar. Daha nasıl diyeyim Sultanbeyli, Esenler gibi yerlere. Daha yoksul yerlere. Aranızdaki fark azalıyor, sadece dil farkı oluyor. Onun dışında öbür türlü olduğunda, Kadıköy Beşiktaş gibi, sosyal fark kültürel fark savaş mağduru olmanın getirdiği farklılıklar, ihtiyaçlı ve o ihtiyacı karşılayan kişinin getirdiği farklılık bunların hepsi bir araya gelmiş oluyor (Meltem, psychologist, 22, December 2017).

In her narrative, she stressed the significance of the low social and cultural difference between service providers and the immigrants in diminishing the challenges to a single factor, language barrier. In line with her point, Buse (social worker and translator, 28) noted that Syrian immigrants are easily accepted as inclusion in the neighborhoods at the periphery of the urban centers where they can access economic resources. These narratives of service providers demonstrate that social support mechanism established in specific districts based on poverty engenders willingness of the local stakeholders and providers to develop social support projects for Syrians and facilitate immigrants to access to them.

CHAPTER IV

READING THE IMMIGRANT BODY: ENCOUNTERS OF HEALTHCARE PROVIDERS

In this chapter, I will search for the definitions and understandings produced by health-care and civil society experts based on the health-related concerns for Syrian immigrants in Istanbul. I will analyze the perspective of health care providers in implementing public health approach by following the power produced in everyday experiences through various programs such as immunization, health literacy, psychosocial support and family medicine. Within the encounter between health care providers and immigrants, there are two main actors: public health and mental health professionals.

The search for the experts' conceptualization on preventive and curative health care is built on how mental and primary health care providers first met the immigrants and how they read the immigrants body by focusing on their health conditions. As partners, who are highly involved in the diverse realms of technologies of health government such as health policies and relief programs, I will explore how health care providers interact with immigrants through psychosocial therapy, healthcare trainings, and vaccination campaigns. While following the boundaries within the construction of health care services and expertise through the narratives of health experts, I will mainly explore these questions: How have the nongovernmental actors become medicalized and how do the two professions overlap? Is it possible to assume a tangible construct of health care according to narrative accounts of this research? I will also tackle how the power produced by public health and civil society discourses challenges the experts on reconsidering their professions. By examining the policies promoting medicalization of everyday life, I will analyze the manifestations by experts as they encounter with immigrants, medics and translators.

4.1. Reaching Out Asylum Seekers

As I explain in the first two chapters, status of "people with temporary protection" stands out as a tool for describing the perspective of health experts. As I stated

earlier, resettlement procedure of Syrian immigrants is challenging due to the asylum regime in Turkey.

In line with the liminality of temporary protection status framed by the asylum regime, most of the informants primarily addressed the problem of determining the location of immigrants. According to them, the challenge of reaching to Syrians is associated with the consistent mobility outside the camps due to the failure of sheltering operations and unreliable residence records. Therefore, they have difficulty in locating neighborhoods populated with Syrians and introducing health care campaigns to them.

Ayşe, delivery nurse for 10 years, described the vaccination campaign as “hunting the Syrians” due to the contradiction between the unreliable records of Syrians kept by Governorate Health Directorate and the reality in the field:

> Kızamık salgınıyla birlikte birinci basamakta çalışan herkes sokağa döküldük. Ben de Suriyeli aşılama kampanyasına katıldım. Altı aylık bir süreç içerisinde toplam üç ayında sürekli sokaktaydım tam bir Suriyeli avı...resmen avcılık yapıyorduk. Hekim ebe hemşire hatta şoförüne kadar nerde yıkıntı bir ev var, yanık, çer çöp dolu bir yer var “Burda Suriyeli olabilir” deyip insanları rahatsız ettik. Bir çalışma yaptı il sağlık müdürlüğü var olan kayıtları hazırladı sözde bize ama o kayıtlarla önümüze çıkanlar aynı şeyler değildi ki. Zaten barınma verilmediği için sürekli yer değiştiriyorlardı (Ayşe, nurse, 36, March 2018).

4.2. Accessibility in the Times of Emergency

Murat, a psychologist designing psychosocial support projects for Syrian children, points out the problem of unpreparedness for the probable challenges of the campaign. As he notes, collaboration of state institutions with NGOs is vital to solve how to meet the child participants:

> Karmaşanın nedeni zaman içerisinde biz bu psikolojik danışmanlık biriminin sorunlarını karşımıza çıktıkça düşünmeye başladık. Baştan çıkabilecek sorunlar üzerine düşünmemiştik. 10-12 okulla görüştük herkes kişi başı 3 okul aldı, herkes kendi okulundaki çocuklarla görüştü. BM’den fon alma için yazılan bir proje kapsamında birim kurulmuş

> oldu. Psikolojik danışmanlık birimi kapsamında koruma programı yapmaya başlamış olduk. Okullarda proje müdürümüz projemizi ve birimimizi anlattı. MEB'in de katıldığı bir süreç oldu (Murat, psychologist, 27, January 2018).

Ayşe added the complicated aspects of promoting the vaccination campaign. As she notes, although the medical team consisted of public health doctors and nurses accompanied by Turkish speaking Syrians in the neighborhood, the first reactions were not always positive. She addressed the failure in the public announcement of immunization program conducted by Public Health Centers:

> Olumsuz olan kapıyı suratınıza kapatan bir sürü insan vardı. Ben olsaydım da öyle yapardım. Çünkü kapınıza bir çantayla bir insan geliyor ve ben size aşı yapacam diyor. Hiçbir şekilde anlatılmamış önceden, medyada duyurulmamış. Bir şekilde aşılamanın ne olduğunu bile bilmiyor (Ayşe, nurse, 36, March 2018).

Similarly, Hakan's narrative shows that Syrians who rejected the vaccination describe vaccine itself as a pathogen.

> Aşıyı reddeden Suriyeliler, kapı kapı dolaşarak aşı yapıldı bir de kapıyı açmadılar, içeri almadılar. Aşı yaptıramam, çocuğum hasta oluyor dediler ve yaptırmadılar üstüne üstlük (Hakan, doctor, 53, May 2018).

Most of the social workers in the NGOs I interviewed shared that Syrian patients have the comprehensive knowledge of the right to medical services and what temporary protection covers. However, they indicated the challenging part of the problem as the complexity of the tedious and long-lasting procedure they have to undergo including taking separate appointments from Centralized Doctor System for examination, tests, test results, treatment and prescription. Buse, a social worker who provides counseling and translation to asylum seekers on medical issues shared the consideration of Syrians on health system in Istanbul by remarking their prewar experiences in Syria:

> Suriye'de devlet hastanelerinin ücretsiz olduğunu sürekli söylüyorlar. Sağlık hizmetlerinin ve ilaçların çok ucuz olduğunu belirtiyorlar. Türkiye'de en çok randevu sisteminden şikayet ediyorlar. Mesela

herhangi bir şey için tekrar tekrar gitmeniz gerekiyor. Tahlil sonucu için tekrar randevu alıp gelmen gerekiyor. MR çekileceksen onun için tekrar randevu alıyorsun ve 2-3 ay sonra gelmen gerekiyor. Tüm bu süreçler onlara çok karışık geliyor. Suriye'de mesela MR çekileceksen hemen çekilirsin doktor hemen ona bakar ve gönderir. Ameliyata karar verme süreçleri burda çok uzun mesela. Eğer Suriye'de ameliyat olacaksan hemen ertesi güne randevu verir doktor ve olursun. Randevu sistemi, o gitgeller çok zor geliyor çünkü alışmadıkları bir pratik (Buse, social worker and translator, 28, March 2018).

4.3. Emergence of New Technologies

Resettlement programs of NGOs where I conducted the fieldwork has been designed to introduce health care services, increase their adaptability to health system and facilitate the access and to medical institutions. Meltem, a psychologist working in the unit of Mental Health and Psychological Support Center, explained the NGO plays a critical role for the medical assistance they seek. It also shows the construction of the subjectivity based on their new task of training Syrians about the nuanced ways of public health implementations in Turkey.

Suriyeliler devlet hastanelerinden faydalanabiliyorlar. Ama genelde bunu nasıl yapacaklarını bilmiyorlar. Bu konuda bir iletişim ve bilgilendirme eksikliği var. Mülteciler dernekte Suriyeliler bize diğer devlet hastanelerinden randevu almaya geliyorlar. Ordaki çevirmenler orayı arayıp devlet hastanelerinden randevu alıyorlar mesela Suriyeliler için (Buse, social worker and translator, 28, March 2018).

Along with the challenge in the adaptation to the health system, Temporary Protection Foreigner ID Card (TPFI Card) has a significant role for certifying that health insurance covers the immigrant. However, as examined in the study of Mardin, the right of access to free health services is restricted to the city where one registered (Mardin, 2017: 4). If an asylum seeker is not notified or unprepared about that issue, she or he has to pay the full amount determined by Health Budget Law for polyclinic services. Buse stressed that the most challenging side of her duty of accompanying Syrian patients is to follow the regulations about TPFI Card and to assist them who has not yet updated their ID's in the emergent visits to state hospitals:

> Şu an en büyük sıkıntımız şu YTB'niz (Yabancı Tanıtım Kartı).Bu Suriyelilere verilmesi gereken bir çeşit kimlik kartı, yoksa hiçbir sağlık kuruluşuna gidemezsiniz. Aralık gibi YTB verilmesi durduruldu İstanbul'da, geçici bir şey mi yoksa artık vermeyecekler mi o konuda bilgi sahibi değiliz. Ya da mesela o kartı aldığınız il dışında başka hiçbir şehirde tedavi göremezsiniz. Mesela gitmiş YTB'sini Batman'dan almışsa ve iş bulamayıp İstanbul'a gelmişse yeni bir YTB çıkarılıyor, YTB'sini de değiştirebiliyorlar. Ama bunu bu sefer sosyal yardımda, sağlık hizmetlerinde kullanamıyor. Evde küçük çocuk vardır ya da doğum olacaktır doğumdan sonraki rutin kontroller vardır ama hastaneye gidemiyorlar o kartla hastanelere başvuramıyorlar. Kimliği yoksa hiçbir şey yapamıyor. Evde doğum yaygın bir şey değil genelde hastanede doğum yaptırmak istiyorlar çocuklar da burda doğuyorlar. Ama YTB geçerli değilse o zaman da özele gitmek zorunda kalıyorlar (Buse, social worker and translator, 28, March 2018).

4.4. Othering

As I have stated earlier, discriminative discourses towards Syrian immigrants are normalized both in mainstream media and social media. Terzioğlu's study (2017) shows how these discriminatory discourses reproduced by doctors and nurses treat Syrians in Istanbul in healthcare institutions and NGOs. She argues that Syrians are perceived as" the cause of major political, social and economic predicaments" based on their representation with embedded "otherisation, discrimination and racism" in local media; as health-care providers reproduce othering by blaming them for the reappearance of formerly eradicated diseases in Turkey such as measles and polio (Terzioğlu 2017, 37).

One of the public health workers, Hakan's narrative includes discriminative discourses towards Syrians. He often refers to Syrian mothers and children as ignorant, dirty and cheaters by "warning" me: "Don't be so naïve to believe in their innocence, they have many evil plans. They trick our health and education system by taking medical reports for their children's arbitrary absence." He expressed the importance of health education for asylum Seekers in terms of protecting the society of the received country[38] "despite their ignorance" by building dichotomy between religious beliefs and contemporary medicine:

[38] He refers to Turkish society as our society, host society.

> Sadece çocuklara değil annelere, aile planlamaları, rahim içi araç ve yöntemleri, doğum kontrol yöntemleri öğretilebilir. Ne kadar cahil olurlarsa olsunlar öğretilmesi gereklidir. Bunlar bir kadına öğretilebilir ve ihtiyaçları var buna. İnancından dolayı bu yöntemleri reddedenler, doğurganlığı devam ettiği sürece üreme isteğinde olanlar ayrı. Ama onlardan bile onu öğrenmek isteyenler oluyor. Bu en önemli. İki kişi bir araya geliyor mesela kol kola girmiş geliyorlar. Bilgi almak istiyorlar doğum kontrol yöntemleri hakkında (Hakan, doctor, 53, May 2018).

4.4.1. Hygiene Perspective of Medics

Rose describes health care providers as "medical police" that refers to the novel forms of authority. According to him, it is such a form stems from the role ascribed to them in the eighteenth century such as hygienic reforms and the regulation of foodstuffs. It is inevitably far beyond the diagnosis and treatment of diseases. Hakan addressed the issue of hygiene as a generalized problem within Syrian society. He gave an example of a newborn baby suffering from *conjunctivitis*[39] by relating her disease to her mother's dirt. He also linked that case to the hygiene perspective of all Syrian families and children and then to those who works in catering sector in Istanbul:

> Hijyen hiç yok, Suriyelilerde...Onlara bu memlekette su sabun dahi sağlanmış olmasına rağmen hijyen yok. Çocukların eğitimine gelince de bizim çocuklara ne veriliyorsa onlara da verilebilir. Okudukları okulda ülkelerinde durum neydi öğrenmediler bilmiyorum ama ilkokulda burada öğrenebilirler. Çocukların eğer bu toplumda yaşayacaklarsa ki burda yaşayacaklar. Restoranlarda, gıda sektöründe, berberlerde, orda burda bu hijyenden bihaber bir şekilde Aksaray'ın göbeğinde bu insanlar çalışıyor, Şam tatlıları, Tarmus mu Tartus mu bilmemneleri üretiyorlar, burada birsürü Suriyeli çalışıyor, orada da hijyen yok. Ve bunlar Suriyeli olarak gıda sektöründe ruhsatlarını almışlar. Güzel güzel bu memleketteki insanları da besliyorlar, dolayısıyla bunların bu halde bu sektöre girmiş olmalarını ben tehlikeli görüyorum. Denetimleri yapılsa bile ne kadar önüne geçilecek bilmiyorum (Hakan, doctor, 53, May 2018).

[39] Conjunctivitis is an inflammation or swelling of the conjunctiva. The conjunctiva is the thin transparent layer of tissue that lines the inner surface of the eyelid and covers the white part of the eye. ... A viral or bacterial infection can cause conjunctivitis. https://www.aoa.org/patients-and-public/eye-and-vision-problems/glossary-of-eye-and-vision-conditions/conjunctivitis

Along with containing discriminative expressions, his narrative shows that how the concepts of hygiene and illness intertwined in the medical discourse. As Lupton notes, notions concerning societal order and control correspond to symbolic conceptions of hygiene, cleanliness and dirt. Ruling the boundaries of the body by controlling what enters the body is related to bio-politics (Lupton 2003, 36). Lupton also criticizes (cf. Waitzin), that medicine serves to conceal "the social and political determinants of ill health by rendering illness as individual". It is mainly maintained by medicalization and disassociation from political and social structural contexts of personal suffering within doctor–patient encounters (Lupton 2003, 116).

On the other hand, Nurhan, one of the doctors I interviewed underlined that providing health care to asylum seekers and citizens differs with respect to social and political conditions they experience. She defined stereotypes made by workers in immigrant-assisting fields as ignorance, stigmatization and lack of cultural sensitivity and empathy:

> Bu bence cahillik ve damgalama. Tabi empati yoksunluğu çok fazla bir savaştan hele de bir iç savaştan kaçmak, daha sonra pis deniyor. Ben heralde onların kaldığı şartlarda kalsam onlar kadar hayata tutunamazdım diye düşünüyorum. Çocuklara soruyorduk gene de temizler yani. "Nasıl başarıyorsunuz nerde napıyorsunuz" diyorduk. Camiye gidip orda yıkanıyorlarmış çeşmesinde. Yani bir şekilde bir yolunu bulup hayata tutunuyorlardı (Nurhan, doctor, 56, April 2018).

As Douglas notes, hygiene as an absolute phenomenon refers to disorder and "it exists in the eyes of the beholder" (1966: 2). What we call dirt and its connection to body are based on the individual's self-knowledge. The relationship between the body and the dirt is "symbolic of the need to maintain control of the body politic" (Lupton 2003: 116). Therefore, according to some healthcare providers, contemporary medicine needs a reconstruction by regarding immigrant's cultural, social and political expectations. Cultural sensitivity has a key role in reconsidering healthcare delivery regarding health care services for Syrians. Murat explained that they plan and implement physical and mental healthcare activities called station

system designed for immigrant children to meet their peers who include instructive plays, videos and pictures for supporting their healthy diet and hygiene awareness.

4.4.2. Blaming the Victim

Ayşe, working as an obstetrician and as a nurse for ten years, compared the service for Turkish citizens at the very beginning of her carrier with the process of delivery for Syrians experienced recently based on questioning the improvements achieved by established health system and immunization program. She stressed that vaccination calendar was definite and even extended with initiation of new vaccines which were paid and merely provided at private hospitals in Turkey such as meningitis. She pointed out that the great labor for healthcare services is wasted and the immigrant flow is resulted in "vaccinating Syrian children available in an unplanned way" by "feeling the fear for our children". Her comparison of Turkish and Syrian children reflects that she made a distinction between her professionalism and her emotions. Othering "their children" that are assumed to be dangerous to "ours", reveals the embedded ideology of "blame the victim" based on the negative discourses for Syrians articulated without ignoring the quality of health services in Turkey:

> Ben mezun olduğumda ebelikten, Türkiye'de bir sağlık bağışıklama programı oturmuştu, aşılama takvimleri belliydi hatta daha da ileriye giderek piyasada özel yapılan aşılar yavaş yavaş aşı takvimine sokuluyordu. İlk senemde yenidoğan yoğun bakım servisinde çalışırken menenjitten ölen çocukları görünce çok üzülüyordum. Neden bu aşı paralı? Devlet neden bu aşıları yapmıyor diye iç hesaplaşması yaşarken bir yıl sonra menenjit aşısı aşı takvimine alındı. Tam düzeldi derken onun mutluluğunu yaşıyorken o savaş göçüyle birlikte o yaptığımız hizmetlerin hepsi birden çöp oldu. Bizden öncekilerin 60-70-80li yıllarda yaptıkları sokağa çıkıp aşılama hizmetine geri dönmeye başladık tekrardan. Bulduğun çocuğa aşı yapmaya çalışmak, o emeklerin çöpe gittiğini görmek üzücü. Bir taraftan kendi çocuklarımız açısından korkuyorsun tamam bizim çocukların hepsi aşılandı ama onların çocukları aşılanmadıklar için bizim çocuklar için de tehlike arz ediyorlar. En büyük bizim yaşadığımız sıkıntı aşılama oldu benim karşılaştığım şey (Ayşe, nurse, 36, March 2018).

As she indicated, the risk of infectious diseases caused by the fact that immigrant children were not vaccinated they crossed the border had a dramatic influence on reconsidering primary health care services and immunization campaigns.

Hakan, doctor at a migrant health care center, also addressed his anticipation of danger due to the mobility of immigrants from camps at the border to the cities. He also stressed that the political stability of Turkey that *we* could have taken the measures for acting on epidemic diseases. His emphasis on precaution refers to not only preventive characteristics of public health care but also the one that is preparedness.

As all the public health experts I have interviewed noted, there is an uncertainty in the immunization program and vaccination rates in Syria. Although most of them have little knowledge about the health conditions of Syria before the war, they pointed out the first medical reaction of district healthcare directorates was to respond the possible threat of epidemics. One of the initial motives enabling the act on treating immigrants is not related to improve health conditions of immigrants, but to deal with the speculation about the immunization of Syrian children appeared on media and everyday conversations of citizens. Creating an image of Syrian body which evokes epidemics and psychological instability favors the medical gaze directed to them.

However, Nurhan criticized the above-mentioned speculation that "Polio or measles rates increased because of the Syrian migration" by questioning the immunization rates in Turkey before the immigrant flow. She also indicated the same perspective produced in health care workers, too:

> Mesela çocuk felcinden başlayalım. Çocuk felci Suriyeliler geldi şöyle oldu. Kızamık mesela yine aynı şekilde onlar yüzünden oldu gibi bir algı var. Aslında öyle bir şey yok. Etkisi var tabi ki bizim de Türkiye'de belli aşılama oranlarında olmamızın da etkisi var. Her şey birbirine karışıyor ve tek suçlu olarak Suriyelilere atfediliyor. Sağlık çalışanları arasında da var ne yazık ki (Nurhan, doctor, 56, April 2018).

Although he works at the field of migrant health, Hakan stressed that he is assigned to the institution by Ministry of Health based on a regular appointment after his experience at the field of public health for 30 years. In other words his assignment is based on an organizational arrangement in the health system not characterized by his expertise specific to the field of treatment for immigrants. He emphasized the suggestion that the health personnel and trainers specialized in migrant health care could have provided primary health care services in an isolated territory near the border. Is it possible for the medics to specialize on immigrant medicine? In parallel to this, the same doctor pointed out that he is always questioning the institution of migrant health center in the middle of the biggest metropolitan of Turkey by asking "Isn't it weird to have a migrant center in the heart of Istanbul?"

> Hastalıklar vesaire ortaya çıkacaktır. Bunların Antep Urfa gibi hazırlanan göç kamplarında, konteyner kamplarında ve çadır kentlerde bunların halledilmesi gerekiyordu. Bu topluma refüze etmesine izin verilmemesi gerekiyordu. Aşılarının da eğitimlerinin de bu topluma kazandırılmalarının da temeli ordan atılmalıydı. Bunlar yapılmadı, savaş belki hazırlıksız yakalanılan bir şeydir, tamam ama biz savaşta değildik, bunun önlemini alabilirdik. Yerinde kontrol edip veya sınırın gerisinde sınırlı ve korunan bir alanda, göç konusunda eğitimli sağlık personelleri ile eğitmenler tarafından bu eğitim ve uyum meselesini halledebilirdik (Emel, psychologist, 24, February 2018).

The health services provided to immigrants mainly the primary health care which is established based on a universal understanding and includes the same procedure for citizens. In other words, migrant health care centers does not respond to the war-related diseases directly originated by war such as landmine injury, but the preventive health care as a consequence of the interruption in health services due to the war and forced migration.

CHAPTER V
RECONSIDERING MIGRANT HEALTHCARE

Before I delve more into the shifting mechanisms and conceptions in providing public healthcare by the emergence of migration-related factors, it would be comprehensive to highlight striking reflections of healthcare providers, for setting the context of fieldwork. Focusing on the narrative of one doctor, Nurhan (56), specialized on Family Medicine, who leads the medical team will illuminate planning immunization programs through medical and administrative interventions.

Most of the informants raised the topic of deficiencies in the health infrastructure. Some of them often underlined that public health care paradigm is an acknowledged concept by health institutions and sector. However, they often indicated that the conventional organization in the healthcare provision is unable to respond medical assistance for Syrian immigrants. On the other hand, they made the emphasis on such a substantial immigrant flow to Turkey as an unexpected experience for health care providers which they caught unprepared for taking necessary measures before they encountered Syrians in the field.

One doctor works in Public Health Center stressed that reaching Syrian population in the field was the primary challenge they faced while planning the immunization program. She pointed out that eradication of transmissible diseases had already been accomplished for Turkish citizens before the entrance of Syrians to Turkey. She indicated that as the subdivision of public health care services into the citizens and the immigrants delayed, the burden on primary health care providers has become dreadfully heavier.

She stressed that the public health team including doctors, nurses, civil servants and drivers could not find children less than 5 year-old targeted within the campaign at their registered addresses. As she noted, when they noticed the addresses they had are useless, they had to reorganize the ordinary procedure of primary healthcare and

cooperate with Ministry of National Education, *Kızılay*[40], Social Assistance and Solidarity Foundation and several NGOs. Although their cooperation helped them to manage the vaccination campaign, they also had to walk the streets, search for children door-to-door and vaccinate them. Due to the consistent mobility of Syrian families, she compared the usual vaccination task, one of the main parts of primary health care services to the one they provided to Syrian children that they could not restricted the location to one single municipality. Therefore, they had to make the planning for other regions beyond their responsibility and readapt their preparations such as finding the most proper and healthiest way of vaccinating them in different fields instead of medical institutions. That differentiation in the standardized medical implementations creates a transformation in the relationship between health care providers and their profession.

In this chapter, I will explore the subjectivities produced in conducting migrant healthcare and health assistance. By focusing on the shifts in the standardized way of acting as experts, I will explore which adjustments they have to make in everyday practices of healthcare in order to respond specific needs of immigrants due to language barrier, cultural problems and challenges in access to the immigrants. Considering these challenges, I will also trace the transformation in doctor-patient relationship through the emergence of technologies of government and regulating power of novice actors on the concepts of suffering and treatment.

5.1. Divergence from Medical Profession

As the narrative accounts of the informants demonstrates, the determination of who the receivers of the services are and where they are living and planning visits for medical follow-ups after the vaccination became part of their tasks which are defined as the duty of public health directorates. They had to fulfill not only the job of medical expertise but also the organizational one. Their focus has been divided into two

[40] Red Crescent is an organisation “which is taken as a model in Humanitarian aid service in Turkey and in the world; and the Organisation which is with people in their hardest time"and “providing aid for needy and defenseless people indisasters and usual periods as a proactive organization,developing cooperation in the society, providing safeblood and decreasing vulnerability".Please see https://www.kizilay.org.tr/Home/Index

professions: medicine and management. The negotiation between the two competences produces new subjectivities which I will call medico-managers. The novel characteristics of the transformation in the standardized vaccination program occurred with the transportation of medical equipment to the field, medicalization of the ruins which are immigrant’s temporary residences. Selection of the most convenient strategies to sustain preventive medical care not by waiting for the patients to come but by urgently going out of their clinics to reach them resulted in the extension of their responsibilities.

Emel noted that psychology profession has strict principle about coolness even if a psychologist gets emotional when the client is sharing something sad. However, she highlighted the importance of evoking that she understands and feels the client instead of behaving in a professional way.

> Danışan bir şey anlatırken duygulansan bile duygularını belli etmemen gerekir çok katıdır aslında. En fazla yansıtma yaparsın. ben öyle görmüyorum. Gözlerimin dolmaması gerekir sözde ama gözlerim dolduğu da oluyor ama dolmaması gerekiyor. Ama çıkmam gerekiyor bir dakikanızı alabilir miyim diyip çıkıyorum sonra geri dönüyorum. Bu çok profesyonel görünmeyebilir işini yapmayı devam ettiriyorsun çünkü ama başka bir şeyi de sağlıyor yani. Onu anladığımı onu hissettiğimi, “Evet yani bu sizin için çok üzücü olmalı” gibi bu tarz bir ilişki kurmaktan bahsediyorum. Danışandan onu anlamasam da bana bakmasını istiyorum (Emel, psychologist, 24, February 2018).

The suggestion that psychologists showing emotions in psychological care could help to overcome language barrier leading to discussions on reframing psychology expertise with humanitarian perspective by flexing the firm standards of the profession. It also refers to the reconceptualization of public health with the construction of new branches in immigrant medicine such as immigrant psychological care and immigrant psychiatry.

When I asked Hakan whether he has problems in communication with Syrian immigrants, he noted that there is no need for dialogues thanks to the online systems based on algorithms:

> Gelen insanların önce kimlik çıkarmaları gerekiyor, aralarında vatandaşlık numarası almış yabancı uyruklu vatandaşlar da var. Önce legal olarak kayıt olmaları gerekiyor. Tercümana da gerek yok aslında algoritma üzerinden yürüyen bir sistem olduğundan sorun çıkmıyor. Önemli olan aslında sistemleri kullanmak. Karşıdaki hiç beni duymasa bile anlamasına gerek yok. Reçete kodu yazıyoruz aşağıda eczanede Arapça bilen kalfa var. Ona kodu söyleyip ilacı alıyor (Hakan, doctor, 53, May 2018).

Reducing the medical encounter with immigrants to numbers and codes hinders them from asking questions about their health conditions and removes the disease narratives. I think the preventive function of public health paradigm has to be reconsidered at the instance when there is no conversation as in a standardized doctor-patient relationship.

5.2. Uncertainty in the Boundaries of Two Expertise

As Nurhan pointed, she noticed that the primary concern was forming the reassurance of immigrants by fulfilling their deprivation as of vaccination team first entered the field.

> Biz aşı diyorduk onlar işte bebek bezi, tavuk diyorlardı. İşte yiyecek giyecek bir de çok kötü yerlerde kalıyorlardı. İşte bu yıkılacak evlerde, penceresiz, bacasız, yıkık dökük yerlerde filan. Biz bulabildiğince kendi içimizde bir şeyler toplayaraktan onları vererekten tabi güven sağlamamızda da onun etkisi de oldu (Nurhan, doctor, 56, April 2018).

Ece described the relationship they built with immigrants by means of the aid campaign they organized as shopping; buying the consent for vaccination through distributing their needs. She explained that “the process that they accepted us does not have any positive aspects” by underlining their expectations for material benefit.

> Bizi kabullenme aşamalarının çok olumlu bir tarafı yoktu. İlk başta etrafımıza bir duyurduk. Çok kötü durumdalar, giyecek kıyafetleri yiyecek yemekleri yok. Biz kendi aramızda para toplamayı ve onlara yiyecek almayı düşünüyoruz dedik. Belki bir kamyon dolusu kıyafet toplanmıştır toplum sağlığında. Onları dağıttığımız için onları alabilmek için aşıyı olanlar oldu. Kimisi aşıyı reddetti, ben aşıyı oldum orda dedi. Kiminin akrabası ben yaptırdım sen de yaptır dedi, kimi tavuk getir

> yaptırayım, tavuk yiyemiyorz dedi. Kimisi 100 lira ver yaptırayım dedi. Her gittiğimizde yardım beklediler arabanın etrafına baktılar. O yüzden çok da olumlu bir ilişki değildi yani. Daha çok alışveriş gibiydi (Ece, nurse, 34, April 2018).

Drawing upon the narratives of the informants, I noticed that health care expertise conducted not through communication but through charity and symbolic definitions. As Ece explained, immigrants understood that the team was there for medical assistance through the brochures with vaccine icons on them and the vehicle belongs to Ministry of Health; however, they hoped for food and substantial needs:

> Elimizde broşürler vardı. Üzerindeki aşı resmini görünce anladılar zaten. Araçla gidince Sağlık Bakanlığı'nın aracını gördüler. Daha çok yardım anlamında gıda maddi yardım anlamında bir şeyler beklediler bizden. Onlara da elimizden geldiğince sağlamaya çalıştık. Küçük çocukları olan, evlerinde oyuncak olmayanlara oyuncak getirdiler temiz kıyafetler getirdiler onları dağıttık. Maddi manevi imkanları onlara sağlamaya çalıştık zaten (Ece, nurse, 34, April 2018).

Murat pointed out that no state hospital psychiatry services provide mental health care for immigrants in spite of the high rates of depression, post-traumatic stress disorder, and anxiety and adaptation problems. Therefore, he stressed that mental health care providers of NGOs have undertaken psychology and psychiatry services for immigrants but they are insufficient for responding properly:

> Mental sağlık en büyük problem. Hiçbir hastane psikiyatri servisi mental sağlık yönünden Suriyelilere bir şey vermiyor. Depresyon mesela normal bir toplumda %3-5'tir. Mültecilerde %30'lara çıkıyor. Travma sonrası stres disorder normal toplumlarda %5'tir mesela, mültecilerde %50'lere çıkıyor. Hatta Gaziantep'te %80'lere çıkan çalışmalar var. Endişe, korku, adaptasyon sorunları çok fazla. Hiç bir şey verilmiyor. Bunu kim veriyor? Ben veriyorum sivi toplumda çalışan psikologlar veriyor. Çok büyük bir yoğunluk var STK'lar üstlenmiş psikolojik destek meselesini ama yetişemiyorlar (Murat, psychologist, 27, January 2018).

Emel addressed the problematic aspect of their perspective in healthcare delivery as an *ex-parté* relationship that excludes immigrants' requests and exposition which makes the concepts of involvement, giving and need.

> Çok tek taraflı bir ilişki olarak görüyorum onların talep ettiği değil bizim verdiğimiz. Karşı taraf bir şey talep etmeyince daha doğrusu dahil olmayınca ve sözünü söylemeyince dolayısıyla talep etmeyince tek taraflı oluyor. Türkçe öğretmenim var Türkçe dersi veriyorum ama mesela gelen Fransızca istiyor. Onun adına konuşup onun ilk ihtiyacı olan şeyin Türkçe olduğuna onun adına karar veriyorum. O yüzden belki de onun ihtiyacı başka bir şeydir. O yüzden bir kısır döngü ve vermek olmuyor. O ihtiyaç hala kalmaya devam ediyor (Emel, psychologist, 24, February 2018).

She gave an example of language education for immigrants that I find significant for reconsidering healthcare access. Due to the lack of immigrant participation in the processes of planning adaptation programs, health care services available for immigrants fail to acknowledge their essential demands. Since deciding on which services would be provided regarding the preparedness for the risks immigrants brought about, arrangements in mental and physical healthcare delivery stand not for the well-being of immigrants but for the citizens. It also refers to the lack of medical solutions specific for the immigrant healthcare and carrying out the services by providing the same standards, mostly even the possibilities remaining from the citizens.

Temporary protection for asylum status does not guarantee social rights they would have by this status except the right to stay in the country. The legislation defines the status by service-based arrangements and lacks the emphasis on human right-based approach. Therefore, access to health care services is not standardized by the right to health but by the health care services which is difficult to frame. Since recognition of legal rights regulates the doctor-patient relationship, its absence causes arbitrariness in the obligations of health care providers produces vulnerabilities such as the individual available for immigrants. That arbitrariness mostly refers to humanitarian purpose.

Ece stressed that they implemented vaccination plan generated by the district health directorate mostly by extending based on their initiatives and possibilities in the everyday encounter in the field:

> Kızamık salgını nedeniyle kızamık aşısı yapıldı, sonra çocuk felci kampanyası yapıldı geçen sene. Ama bu sene bütün bebeklik aşılarını yaptık. Hepatit B'ye kadar.. beşli karma aşı difteri, tetanoz, boğmaca, menenjit ve kabakulak. Bir de kızamık yaptık üç aşı. Hatta elimizde pnömokok aşısı varsa onu da yaptık, müdürlüğün verdiği planı da aşarak. Müdürlüğün verdiği yaş aralığını da genişlettik, normalde beş yaş ama on yaşa bile yaptık. Çünkü şimdi anneye şunu diyorsun bak bunu yaptırmazsan çocuğun hastalanabilir, ölebilir, sakat kalabilir. Büyük de diyor ki e ben de hastalanabilirim şimdi bu çocuğa ne diyeceksin diyor çünkü öleyim mi ben? Diyor. E mecbur yapıyorsun. Bireysel insiyatif kullandık (Ece, nurse, 34, April 2018).

Hakan narrated a striking comparison between the opportunities offered to doctors and immigrants by describing service provision as the generosity of the state. He indicated the challenges of Turkish citizens such as insurance premium debit preventing them to access to medication and tests by calling them "my people":

> Çalışan hiçbir devlet memuruna başka sağlıkçılara günde bir öğün bile sıcak yemek verilmezken göçmenlere kamplarında 4 yıldır 5 yıldır 3 öğün sıcak yemek çıkarıyor bu devlet. Benden de bunlara bakmamı istiyor. Onlar için ülkenin tüm varlıkları ayaklarına serilmiş durumda. Türk vatandaşı olup da birsürü sigorta prim borcu olup bu tahlillere, ilaca ulaşamayan benim insanım varken bu insanlar ulaşabiliyorlar. Şu gördüğün EKG cihazı mesela, göçmenlere kalp kontrolü için gönderilmiş. Bu cihazın burda olması gerekmiyor ki, burası birinci basamak. Sen hastanede olması gerekir, demir, D vitamini eksiklikleri var. Biz gebelere, tahlilini yaptığımız kişilere bedava veriyoruz. Diğer ilaçları da bakanlık kapsama almış. Böyle bir toplum sağlığında halk sağlığında bu kadar cömertlik başka yerde yok (Hakan, doctor, 53, May 2018).

All the narratives of health care experts about the implication of health care programs for immigrants sort to the core concepts of the discussions that this thesis tries to make: Is health care delivery for Syrians associated with social right or philanthropy?

Aylan's narrative about her experience with Turkish health care system prompted a series of everyday challenges that raise the discussion of social right in immigrant healthcare. She viewed that lack of the right to have a family doctor in Turkey and satisfying information and communication about the diseases and medication they have caused confusion for immigrants:

> Suriye'deyken daha kolaydı burda sıkıntı yaşıyoruz sıra beklemiyorduk, ilaç içip iyileşiyorduk. Sıra bekliyorsun burada, randevu alıyorsun. Randevu alıp gittiğinde bile muayenede rahatlayamıyorsun. Çünkü hastalığının ne olduğunu doktorlar açıklamıyor anlatmıyor. Suriye'de ilaç içince iyileşiyordun. Burda ilaç içip iyileşemiyorum. Bilmiyorum ilaç mı farklı geliyor vücuduma, bilemiyorum. Bizim aile doktorumuz vardı mesela, direk giderdik, çok güzel bir iletişim kuruyorduk. Özel sektör zaten daha çoktu devlet sektörü daha azdı tabi daha ucuzdu. Burda kendi doktorumuz yok devlet hastanelerine ulaşabiliyoruz. Ben genelde özel hastanelere gidiyorum sıra ve ilgilenme konularında daha iyi olduğu için. Aslında sigorta var ben çıkarttım ama sigortaya bazı hastaneler dahil sadece. İkamet tezkeresi ile kimlik çıkardım, işyerinden sigorta çıkardılar ama işe yaramadı. Bir kere hastaneye gitti sistemde devlet sigortam çıkmadı. Kendileri bana indirim yaptılar. Fazla da araştırmak istemiyorum artık, bunlar benim aklımı .çok karıştırıyor (Aylan, social worker, 25, February 2018).

As her case shows, even if they have income-based social security which would have served to the elimination of challenges in the liminal temporary protection status, they could still have limited access to health services. It is a significant example characterizing the failure in the regulation of health system and governmental adaptation and recognition of Syrians as the right holders.

5.3. Developing Health Literacy

All of the informants who work at immigrant-assisting NGOs have been conducting several psychosocial support projects for the adults as well as workshops towards children for enhancing the adaptation. These workshops combine psychological counseling sessions such as music, drama, art and dance therapy with several trainings.

Murat viewed that the primary objective of these workshops called as four-step station system to improve the inefficient motor coordination of immigrant children due to post-traumatic syndromes. He stressed that they aim at preparing those children who are unable to socialize with other children outside or at kindergarten due to the poor economic conditions of their families for managing the challenges

they would have by schooling. In other words the station system scheduled for three times a week functions as a kind of kindergarten:

> İstasyon sistemimiz var her grup bir sınıfta yarım saat zaman geçiriyor. Akran iletişimi sağlıklı beslenme temizlik sorumluluk duygusu aileyle iletişim konularında Suriyeli çocukların ihtiyacı olan alanlarda çalışma yapıyoruz. Görsellerin videoların oyunların olduğu bir etkinlikler dizisi gerçekleştiriyoruz. Birincisi oyun alanı, serbest, arkadaşları ve öğretmenleri ile oyun oynayabilecekleri bir alan. İkincisi değerler eğitimi. Akran iletişimi, sağlıklı beslenme, temizlik, sorumluluk duygusu, arkadaşları ve aileleriyle iletişimlerindeki sevgi saygı gibi değerleri davranışları geliştirdiğimiz bir alan. Üçüncüsü kesme biçme psikolojik danışmanlık etkinlikleri yapıyoruz. Dördüncüsü ise zeka oyunları. Stres atmalarını, kutu oyunlarıyla bilişsel becerilerini geliştirecekleri bir istasyon (Murat, psychologist, 27, January 2018).

The activities planned within the projects supporting immigrant children refer to the diversified realms in the process of adaptation. As Murat noted, they have not only held workshops for coping with stress but also enhance children’s knowledge and experiences to carry out healthier ways of life.

Buse pointed out instructional activities towards elder groups about sexual and reproductional healthcare they conducted at the youth center also by associating healthcare training to socialization.

> 18-30 yaş arası cinsel sağlık ve üreme sağlığı çalışması yaptık. Gençlik merkezi açıldı, akran eğitimi üzerineydi. Gençlik merkezine gelip yılda belli zamanlarda gerçekleştirilen eğitici eğitimlerine katılıyorlardı. Üreme sağlığı, cinsel yolla bulaşan hastalıklar, erken evliliğin önlenmesi. Toplumsal cinsiyete dayalı şiddet eğitimleri alıyorlardı. Sekiz günlük bir eğitimdi. Sonra bu eğitimi alan gençler gençlik merkezlerinde ya da dışarda kendi sosyalleştikleri alanda kendi akranlarını eğiterek karşılıklı olarak çarpan etkisi yapmaları hedefleniyordu (Buse, social worker and translator, 28, March 2018).

Inefficacy in the access to health care services corresponds to the failure in acquisition of primary health care information. Therefore, social workers at NGOs plan more detailed trainings for developing health literacy in Syrian immigrants concerning their age difference and agents of socialization. Psychosocial and health

care professions overlap, as the boundaries of public health care and humanitarian assistance become uncertain.

5.4. Generating Cultural Sensitivity

Aihwa Ong's ethnography on Cambodian American communities focuses on the analysis of the technologies of citizen-making process, governed by medical, social welfare and economic institutions in the US. She particularly analyzes the power of biomedicine discourse of practitioners and how their relationship with immigrants under the domination of scientific interpretations. She also searches how the disease narratives of the immigrants interact with cultural beliefs and challenges the medical knowledge. Therefore, as she shows, immigrant clinics became the site of a struggle between biomedical expertise and immigrants' own conception of their experiences (Ong 2003, 102-103). Most of the psychological counselors I have interviewed indicated the prevalence on the rejection of psychological disorders and therapy. They noted that seeing a psychologist refers to madness and psychiatrists and psychologists refer to shrink for Syrian families. As Murat points out, most of Syrian males hesitate to apply for hospitals with physical pain stemmed from depression – somatic symptoms- because of the fear of diagnose as "mad":

> Çoğu için psikoloğa gitmek delilikle eş anlamlı. Kültürel bariyer çok var. Somatik olarak depresyonun travmanın etkilerini yaşıyorlar ama bunu kabullenmiyorlar. Bedensel olarak eğer biraz şikayet ederlerse deli tanımları konulacak diye başvurmayı tercih etmiyorlar. Ama kadınlar bu konuda daha açıklar, bilinçliler psikolojik destekle ilgili; öğrenmek istiyorlar (Murat, psychologist, 27, January 2018).

Evaluation of another psychological counsellor in the same psychosocial support center shows that connotation of psychological and psychiatry domains are mostly negative in Syrian culture. It is not only inherited from one generation to the other, but also stressful for younger immigrants continuously. She noted:

> Suriyeli psikolog bir kadından öğrendiğime göre çok çok az psikolog sayısı ve çok tepki var. Orda da psikologmuş ama çok zorlanıyormuş. Bu sadece Suriyelilerle ilgili bir şey değil aslında ama benim anneannem bile deli doktoru diye tanımlıyor. Ben sizi duydum beni

> deli doktoruna götürmek istiyormuşsunuz diye isyan etti bir çocuk. Ben senin iyiliğin için olacak dedim. Psikiyatriste götürecektik. Ama hala hayır siz beni kötü bir yere götüreceksiniz dedi. İnsan kanser olunca tedavi olabilir ama depresyona gidince tedavi olamaz gibi bir algı var aslında (Emel, psychologist, 24, February 2018).

As it is seen in the views of psychology experts, dealing with mental health distress of traumatized Syrian children is a much complicated case for implementation the standardized therapy. According to Ong (2003), universal diagnostic procedure used by health workers assumes a linear model of immigrant psychology. A model "assumes that the sufferings of diverse populations follow generic patterns and that mental health constructs are universally applicable." (Ong 2003, 98). Therefore, in Syrian case, too, experts have challenge with immigrant psychology taken for granted; therefore they have to make adjustments in health and psychology profession by considering "power dynamics of acculturation" (Ong 2003, 96) in the encounter between asylum seekers and health care experts. In addition to cultural problems within a more proper communication with clients, language emerges as an enormous problem in this confrontation and psychologists carry out psychodrama sessions using music, dance and art as adaptable technics for immigrant mental health-care.

I will discuss more on how cultural sensitivity concerns of health care providers shape immigrant medicine in the next sections. In order to discuss social, cultural and humanitarian aspects of health right and services for immigrants, addressing cultural problems narrated by health experts plays a key role in the initial contact with Syrian families.

Meltem admits that her predictions based on the assumed cultural intimacy between two communities –Syrian and Turkish- contradicted while she was on the house visits to introduce support center. She pointed out a collapse and then a transformation in the universal codes of mental health expertise she had trained by describing the adaptation process as reciprocal:

> Mesela evlere ziyarete gittiğimizde benim yanımda erkek de var ve genelde kadınlar evde yalnız oluyorlar. Hani böyle mutlaka bir kadının da erkeklerle birlikte olması lazım. Bir erkek yanında bir kız olmadan o eve giremezdi. Ve de kapıyı çaldığımızda erkekler arkalarını

> dönüyorlardı. Çünkü Türk kadınları genelde kapıyı başörtülü bir şekilde açarlar ama Suriyeli kadınlar açık da açabiliyorlar hani evlerinin içi olduğu için muhtemelen. O yüzden erkekler arkasını dönüyor kapıyı çaldığında. Ben fark ettim çocuklar öyle yaptılar Suriyeli çocuklar (Meltem, psychologist, 22, December 2017).

She also indicated the difference in cultural meanings of age between two cultures and connected the major accomplishment in their project to their respect for nuanced aspects of traumatized children:

> Bizde bir çocuk 15 yaşına kadar ya da 16 yaşına kadar çok ergin gibi sayılmaz, hala kendisine çocuk gibi davranılır erkek çocuğuna.. Ama onlarda bu yaş kavramı biraz daha farklı. 12 yaşında 13 yaşında bir kız artık tamamen yetişkin konumunda. Dolayısıyla artık yetişkin gibi davranılmasını bekliyor kendisine, bir erkek de öyle...Bir Türk çocukla çalışırken 12 ya da 11 yaşında bir çocukla çalışırken elini çok daha rahat tutabilirken ama Suriyeli bir çocukla çalışırken kendisine saygıdan dolayı elini tutmam. Ya da sorarım mesela elini tutmamda bir sakınca var mı diye (Meltem, psychologist, 22, December 2017).

5.5. Language Barrier

As all of the informants indicated, communication with patients is one of the main problems while providing health care and talking about the symptoms and psychological needs. Throughout the interviews, they emphasized the importance of proper communication in primary health care services. Ece stressed that the failure of establishing migrant healthcare centers stems from the absence of Arabic speaking doctors. Public health center where she works serves as one of those migrant centers due to the high Syrian population in the neighborhood and explained that other family members performed as translators during the visits:

> Biz birinci basamakta çalıştığımız için önce biz devreye giriyoruz, göçmenlerle ilgileniyoruz. Önce göçmen poliklinikleri oluştu semtlerde. Arapça bilmeyen sağlıkçıları birebir karşı karşıya bırakmak zorunda kaldı dilini anlamadığın insanlara nasıl hizmet vereceksin. Ailede muhakkak birileri Türkçe biliyordu. Kendisi bilmiyorsa kocası biliyordu, kocası bilmese çocuğu biliyordu. Dille ilgili çok büyük sıkıntı yaşamadık. Bir de uzun süredir burda oldukları için çoğu biliyordu (Ece, nurse, 34, April 2018).

Murat's narrative points out the language is still a barrier even in the presence of notifications in Arabic on the walls since there is no Arabic speaking doctors at hospitals. Therefore, Syrian parents depend on their children with a better command in Turkish who try to handle trauma and experience problems of adaptation. Immigrant child who translates the medical story and symptoms of their parents becomes an actor in the triangular relationship produced in immigrant medicine. Therefore, the absence of a translator serves the construction of immigrant subjectivities not only as an adult, but also as a partner of medical team.

> Hastanelere gidip sıra bekliyorlar. Arapça bilgilendirme tabelaları var ama Arapça bilen doktor yok. Aileler çocuklarıyla birlikte gidiyorlar. Çocuklar ailenin dış dünya ile iletişimini sağlıyor. Hem travmayla baş etmeye çalışıyor hem uyum sorunları yaşıyorlar. Aileler çocukları ile beraber işi götürüyorlar bu yüzden çocukluk yaşında yetişkinlik rolüne bürünüyorlar. Çok zor bir durum bu (Murat, psychologist, 27, January 2018).

Murat termed learning Turkish as a traumatizing experience for Syrian students since the curriculum is not shaped inclusively for them. Besides, speaking Turkish better than their parents does not necessarily mean they have proper understanding in doctor-patient relationship. Murat related that issue to the recent increase in the number of Syrian children reported as disabled. According to his narrative, most of them are often directed to Counseling and Research Centers[41] and psychological counselors there mostly diagnose them with autism based on careless assessment by asking few questions:

> Sağlık konusunda ilgilenilmiyorlar.Bir de son zamanlarda dikkat ettiğim şey çocuklara çok fazla engelli raporu veriliyor. Bu şuna benziyor. Türkler ilk Almanya'ya gittiğinde Almanya'da Türkleri dil bilmedikleri için Sonnerschule'ye gönderirlerdi eğitim seviyesi düşük olan çocuklara adaptasyon sıkıntıları vardı engelli raporu veriyorlardı. Kürt illerinde çok fazla vardı. Çünkü psikolojik danışman ve psikologlar dil bilmiyor, tercümanları yok. Bir iki soru soruyorlar çocuk anlamayınca %40 engelli raporu veriyorlar. Otizmli deyip geçiyorlar. MEB de engelli raporuyla ilgili masraflarını karşılamıyor. Rehabilitasyon merkezleri

[41] RAM: *Rehberlik ve Araştrma Merkezi*, which are established by Ministry of National Education in several municipalities.

veriyor MEB’e bağlı bu raporları ama bununla ilgili proje yok. Çok fazla zihinsel hem fiziksel engelli çocuğun gencin bu merkezlere ulaşımı yok. Aylık tedavi masrafları 700-800 tl civarında. Rapor için RAM’ a yönlendiriliyorlar. Heyet raporu 600 tl. Zaten istihdam yok. Tedavi edilemiyorlar engelli çocuklar gerçekten var güven korunmuşluk gibi durumlar depresyon, travmayla baş edemedikleri bir sürü neden var. Çocuklar anne karnında bunlara maruz kalıyor ve bu ortamda büyüyor, beslenemiyor. Zihinsel gelişimlerini bedensel gelişmlerini sağlayamıyor. Çocuklar o kadar evde durmuş ki kalem tutamıyorlar. Kalp hastalıkları gibi fiziksel sıkıntılar çıkmasıyla birlikte zihinsel kognitif davranışsal uyum hepsinde -5 -10 dan başlamak anlamına geliyor (Murat, psychologist, 27, January 2018).

He continued to explain his idea of writing a project about establishment of Rehabilitation Centers for Syrian children:

> Belki rapor ilerde engelli maaşı getirisi olabilir, ilerde Suriyeli çocuklar için rehabilitasyon merkezleri kurulabilir –ki benim kafamda var bu, böyle bir proje yazmak istiyorum- o zaman bu raporlar işe yarayabilir, çocuklar da oradan faydalanabilir. Ama aileler otizmli, engelli çocuğa nasıl davranılır bilmiyor. Zaten ötekilerken çocuk ötekinin ötekisi oluyor. Zaten mülteci ama statüsü yok üstüne üstlük bir de engelli statüsünde oluyorlar (Murat, psychologist, 27, January 2018).

Social conditions experienced by Syrian children affect their competence in adaptation to Turkish educational system, particularly in understanding, reading and writing skills. Medical intervention by psychiatrists invokes the attention to medical gaze rather than the attention for migration-related social and cultural problems. Definition of language barrier is made by medical terms such as disability, autism, depression and hyperactivity. Syrian parents and children must become familiar to the medical language. Therefore, it is mostly impossible to describe the process as integration. Rather what is at stake is the medicalization of Syrian immigrants through health related concerns. Alongside the adaptation attempts far from the achievement, Syrian asylum seekers are subjected to the adoption of medical terminology and framework and healthcare providers play significant role in the making of immigrant-subjects.

5.6. Overcoming the Language Barrier

Interviews show that regular procedures of health care delivery fail to respond immigrants' expectations because of the difficulties in communication with Syrian patients. Therefore, health care services for immigrants require a series of adjustments in terms of availability and reassurance.

Demet, one of the nurses I interviewed pointed out one of the individual solutions for announcing vaccination campaign. She explained that one of her colleagues came up with an idea of using cars touring on the streets by playing songs in Kurdish and Arabic and songs about vaccines:

> Öncesinde araçlar dolaştı, aşının duyurusunu yapmak için. Türkçe dilde anonslar yaptılar ama arkaya internetten bulduğumuz Kürtçe Arapça kısa kısa müzikler sözlü şarkılar koyduk. Aşıyı anlatan şarkılar bulduk. Bu fikri bir arkadaşımız bulmuştu. Sonra kısa o şekilde bulup hatta olmayanları çevirerek Türkçe sözleri Arapçaya çevirdi sonra anonsları. Onları kullanmaya başladık (Demet, nurse, 27, April 2018).

Concerning psycho-social support projects, Murat pointed to some rearrangements in the practice of trauma treatment as well. He emphasized that he loves and prefers to work with Turkish-speaking children. However, he relates his interest in art therapy to less usage of words and more projection of emotions. He noted that the relationship between psychologist and immigrant children can be improved with extending normative technics of mental health care and art therapy is a way of overcoming language barrier.

> Eğer çocuk Türkçe biliyorsa onla çalışmayı tercih ediyorum. Çünkü çocuklarla çalışmayı çok seviyorum. Türkçe bilen çocuklarla çalışmayı daha çok seviyorum. Ben sanat terapisiyle ilgileniyorum. O biraz da dil bariyerini aşmaya yardımcı olan bir şey. Daha az sözcük kullanıyorsun, genellikle yansıtıyorsun bir şekilde müzikle, resimle. Yetişkin ise Türkçe bildiğim için tercümanı daha efektif bir şekilde kullanabildiğimi hissediyorum (Murat, psychologist, 27, January 2018).

Meltem addressed the language barrier as the most compelling aspect of the encounters within the activities. Rearrangement of alternative treatment methods

by the psychologists in the project of psychosocial support through body movements refers not only to language-sensitive, but also culturally sensitive perspective. As she noted, they use alternative methods that are specific to different ages. In the art therapy, they encourage children at early ages to communicate by means of music, drama and art. Since they notice the resistance of a specific group of children against behaving "childishly", they initiate breathing exercises instead of dialogues particularly to adolescents:

> Bizim uyguladığımız sanat terapileri bunu daha aşan bir yöntem çünkü daha insanın kendisini müzikle resimle ifade ettiği bir şey olduğu için daha bir kolaylık sağlıyor. Tabi bunda daha önce ben asistanlık yapıyordum kendim yönetmiyordum seansları şimdi ben yönetiyorum dolayısıyla seansları şimdi daha bir dil bariyerinin etkilerini görüyorum. Bir grubum var 6-8 yaş arası onlar müzik şeyini çok seviyorlar. Hep birlikte başlıyoruz müzikle ilgili bir hareket yapıyoruz. Ondan sonra ama mesela büyük bir grup var 11-12 yaşlarında onlar çok hoşlanmıyor özellikle erkekler böyle bir dirençleri var eğlenmeye ve çocuklaşmaya karşı. Onlarla nefes egzersizleri yapıyoruz (Meltem, psychologist, 22, December 2017).

Aim of the project is to support immigrant children to express their feelings using their bodies and their skills on art. At the beginning of each session, they come together within a circle and make facial expressions to tell that emotion such as joy. Regarding the cultural meanings of different age groups, psychologists go beyond the standardized, universal art therapy. As they construct the alternative type of the expertise, they contribute to the establishment of cultural sensitive immigrant medicine as a specific expertise.

Most of the psychologists stressed that dealing with mental well-being within psychosocial support projects is less complicated than conducting therapy sessions. They addressed the need of translation since doing therapy requires verbal communication and finding and employing Arabic speaking psychotherapists in Turkey is almost impossible. Therefore, as Buse explained, most NGOs give the responsibility of translation to Syrian immigrants with good command of translation:

> Bu alandaki en büyük sıkıntı insan kaynağı bulabilmek. Sahada yapılacak bütün işler için Arapça dil bilen insana ihtiyaç var. Bu birçok alan için sağlanamaıyor. Psikolojik danışmanlık için Arapça bilen psikolog bulmak o kadar zor ki mecburen işte tercümanla iletişim yoluna gidiliyor. İnsan kaynağı sıkıntısını saha için şöyle çözmeye çalışıyorlar vakıflar. Suriyeli mültecileri işe alıyorlar (Buse, social worker and translator, 28, March 2018).

Aylan is one of those immigrants who work at the guesthouse for females and children. She addressed the problem of marriages, pregnancy and childbirth at early marriages. As she noted, pregnant women who are below eighteen are not admitted to state hospitals. She stressed that she was too young to manage such immense difficulties while she had many problems in her own family due to the resettlement in Istanbul. However, her supervisors convinced her not to quit since she is a native speaker and that they appreciated that she was devoted to the job.

> 1- 1 buçuk sene konukevinde çalışıyordum. Yani o süreç çok zordu hatta biraz benim yaşım çok uygun değildi. Zihinsel sıkıntılı engelli aile vardı. Bazı sıkıntılar var tabi, dediğim gibi sağlık konusunda sağlık alanında mesela erken evlilik mesela şöyle bir durum bazı kızlar erken evliler. Doğum durumunda hastaneye gidiyorlar 18 yaş altı olduğu için almıyorlar. Sen düşün yani bazen insan ailesiyle ilgilenemiyor. 12 aile vardı hala benimle iletişim kuruyorlar. Anne gibi hissettim kendimi gerçekten onlar beni yoruyordu, hep fedakarlık yaptım ve yaşları büyük ama (Aylan, social worker, 25, February 2018).

5.7. Translators as the *Medical* Actors

5.7.1. Translator in Accessibility

In order to overcome language issues, there is an often need for translation in doctor-patient relationship. As the informants explained, some state hospitals employ translators. However, the NGOs can assign them to help scheduling the appointments, to accompany immigrants to the hospitals and to give the details of the diagnosis, treatment and medication. Buse stressed that she voluntarily works in the field of Syrians who need medical care. She described the purpose of accompanying them by stressing the concept of social rights:

> Ben şu an tercüme yapıyorum. Gençlik merkezi koordinatörlüğü yaptım ama şimdiki işimde tam sahadayım kendi isteğimle aslında

> tercüman olarak girdim. Türkiye'de hakları olup da kullanamayan kişilere haklarını kullanmalarına yardımcı oluyoruz. Ben hassas vakalarda hastane eşliği yapıyorum (Buse, social worker and translator, 28, March 2018).

Existence of third parties in the examination of Syrian patients by medics affect the relationship built between medical experts and the receivers of health care. Separately from who would facilitate the communication in the clinic; Turkish-speaking relatives, Arabic-speaking social workers or professional translators, assuming a standardized doctor-patient relationship is much more difficult. It becomes indirect communication which multiplies the actors which I will call a triangular relationship[42]. Participation of new actors produces new ways of talking about the medicine. The normative doctor-patient relationship gains more fragmented characteristics. It limits the concepts of accurate treatment and well-being to the competence of the translator in understanding and replying the questions of doctors correctly.

5.7.2. Perspective of Healthcare Provider

As most psychologists pointed out during the interviews, there is an identical construction of a triangular relationship also in mental health consultation. Meltem explained that she previously worked with Syrian psychology students who completed their training in psychotherapy for trauma among disadvantaged groups and Syrian immigrants in particular. However, she expressed her mistrust in the qualification of newly employed translators at the association not only the credibility of translator to obey privacy codes but also of his or her qualification in correct translation.

Murat agreed with the requirement of translators in therapy sessions and their insufficiency in mental healthcare by addressing the strategies of efficient use of

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[42] Triangular relationship is a used for defining "transnational citizenship", the popular term that refers to the cross-border activities of individuals: "the relationship between individuals and two or more independent states in which these individuals are simultaneously assigned membership status and membership-based rights or obligations." (Bauböck, 2007, p. 2395, cited by Köşer Akçapar and Şimşek) It corresponds to "changes in rights to dual citizenship and institutional transformations of membership and legal rights". In this study I will use the term of triangular (continues from the previous page) relationship to refer the emergence of third parties in the relationship of medical experts with refugees throughout the thesis.

translator. He explained that he gives the detailed information on the expected behaviors from the translator before every session. He noted that although she obeys the rules during the sessions, most Syrian clients stressed the disturbance they experience in the presence of translators:

> Tercümanların mental health konusunda çok donanımı yok. Tercümanın olması ile olmaması arasında inanılmaz bir fark var. Ben tercümana görüşme öncesi gerekli bilgileri veriyorum. Görüşme sırasında nasıl durması, nerde konumlanması gerektiğiyle ilgili konuşuyorum. Ama karşı taraf bazen kendini ifade edemiyor aileler ve çocuklar. Yetişkinler tercümana takılabiliyor. Açıklamama rağmen ısrar edebiliyorlar. Anlaşamayabiliyoruz (Murat, psychologist, 27, January 2018).

In line with Meltem's mistrust to the translator, Murat also points out the suspicion of the patients about the translator in terms of violation of privacy. As he noted, although he makes necessary explanation to the patients about that he needs translator, clients are not always comfortable with the translator and sometimes their questions about the translator interrupt the sessions.

Meltem stressed that although they prefer alternative art therapies instead of standardized one to one psychotherapy for children, they still need translators to tell the instructions for coordinately working on group activities such as music and dance therapy. She pointed out the often interruption in the activities caused by the repetitive translation and loss of concentration for the children and herself. She compares art therapy for immigrant children with the standard therapy between therapist and children with regard to the emergence of translator as the third factor.

According to the narratives of psychologist informants, triangular relationship built for the medical treatment also refers to the violation of privacy and it could affect the accomplishment of face to face therapy. Emel stressed that she tries to handle the challenge produced by the presence of the translator by building direct contact with the clients so that they could easily assume and trust that they are talking in private with the therapist:

> Tercüman olsa da odada beni anlamasa bile ona –terapi için gelen Suriyeli danışana- bakmaya çalışıyorum. Ondan da bana bakmasını istiyorum. Tercümanı yok saymak değil ama çünkü orda tercüman danışanın sesi. Ama hiçbir zaman tercümana dönüp şey demem mesela "Şöyle mi gelmişler? Şöyle mi yapmış". Böyle değil. Direk karşımdaki anlıyormuş gibi (Emel, psychologist, 24, February 2018).

On the other hand, Emel indicated the challenge for the translators themselves. Talking about trauma and sharing private experiences of war, loss and emotions is not only difficult for the clients, but also for Syrian translators who are listening, interpreting and quoting the traumatic stories of the clients at therapy sessions. As she pointed out, clients' narrative on their experiences based on war, loss and migration could be a reminder for translators' own traumas related to death:

> Tercümanın da zorlandığını hissediyorum mesela bir hikaye alırken. Suriye'den nasıl gelmişler vefat var mı bunu öğrenirken tercüman da travmasını hatırlıyor bazen çok zorlanıyorum. Bazen tercümanların bazı şeyleri çeviremediğini de görüyorum. Diyelim ki danışan bir kazadan bahsediyor. Doğal olarak sormak zorundayım çocuğunu kaybetmiş mi sormam lazım mesela. Ya da abisinin vefat edip etmediğini sormak zorundayım. Bu savaşla ilgili bir şey ise orda çok zorlanıyorum.Tercüman bazen soramıyor onu söylüyor zaten soramadım diye. Onu başka şekilde soruyor. Evde kaç kişisiniz gibi? (Emel, psychologist, 24, February 2018).

Buse described being the facilitator in the therapy sessions itself as a traumatizing experience for a Syrian immigrant. She stressed that the criteria for employing a Syrian is only her/ his good command in Turkish. She also pointed out the production of vulnerability for Syrian translators who lack the training for self-protection methods in therapy sessions.

> Suriyeli bir mültecisiniz. Savaştan siz de çıkıp gelmişsiniz ve savaştan çıkıp gelenlere psikolojik destek sağlıyorsunuz bu aslında çok travmatik bir şey. Benzer hikayeler yaşamış olabilirsiniz, çevrenizdekiler benzer hikayeler yaşamış olabilirler. Ben de çok seansa girdim psikologla. Farklı bir deneyimdi ama bende bıraktığı etkiyle bir Suriyelide bıraktığı etki farklı olacaktır. Kendini koruma yöntemlerini tam bilmiyor olabilir. Şu şekilde seçilmiyor yani tercüman etiğim seviyesi ne zaten kendisinin de bu alanda deneyimi var zaten suriyede psikologmuş diyerek

> alınmıyor. Ordaki ilk kıstas şey oluyor Türkçe biliyor mu evet Arapça biliyor mu evet (Buse, social worker and translator, 28, March 2018).

Correspondingly, Emel explained that Syrian translators attending therapy sessions should be supported by supervision in health service psychology education and training programs. As she noted, she believes that providing clinical supervision to them, as it is provided to psychologists-in-training, would maintain techniques of self-protection and professionalism. It would also facilitate to overcome the bias against psychological support among Syrian immigrants.

Most of the NGOs address language problems with translators, however, people working for that task lack of training on vocational translation principally medical terms in Arabic or Kurdish. She does not have training about medical assistance; however, there is an absence of employers who can solve the difficulties in communicating details.

5.8. Governing through Bureaucracy

The uncertainty between the boundaries of the two professions, public and mental healthcare, also falls under each of the expertise. In other words, as the public health and mental health expertise intertwine, it is much more difficult to pose the questions in the context of humanitarian purpose that "What does psychology expertise assembled in NGOs do for civil society and how is it framed within the projects? How does humanitarian assistance mold psychology and psychiatry professions? How does the concept of funding the projects affect mental health experts?"

Emel indicated that social workers who are involved in budget planning of psychosocial support projects give the priority to the quantity of child attendees to receive funds:

> Görece burası çok iyi ama hala yeterli olduğunu düşünmüyorum. Bazen kafa sayısı nitelikten önce geliyor. Daha çok çocuğa ulaşalım ki proje başarılı olsun gibi bakıyorlar. Projeyi yazıyorlar hibe alıyorlar hibenin devam etmesi için daha çok kişiye ulaşmaları gerekiyor (Emel, psychologist, 24, February 2018).

She addressed another challenge which is creating distinct forms of uncertainties in the objectives of psychological counseling projects. Economic problems lead to an anxiety for continuity of the projects. In that case, social workers focus on certifying the high numbers of children who get the support instead of the quality of service provision. Ignoring the goal of ensuring psychological well-being influences the expertise. Psychologists are not always motivated by the quality of the psychology expertise; rather they may keep on working for the sake of projects:

> En son travmayla ilgili bir belgenin çevirisini yaptıramadım. Projenin amaçlarını anlatan böyle bir iki sayfalık onam formu. Türkçeydi imzalamazlar diye bir çekindim ama orda anlatılanları konuştum en son belgeyi çıkardım. Tercüman anlattı neler yazdığını sonra imzaladılar. Ama şöyle bir çekince oldu, kaydolmasını istiyorum ve sosyal medyada fotoğraflarının paylaşılmasını istiyorum diye bir madde var. Çünkü proje bazlı olduğu için fotoğraf kanıt niteliğinde oluyor (Emel, psychologist, 24, February 2018).

These projects have been financed by EU-funds and the mechanism established in order to monitor the achievements of the projects. I conceive that mechanism as part of the aforementioned concept of "governing at a distance" termed by Rose and Miller (1992). Governing at a distance refers to a new form of governmental technology, "seeking to create locales, entities and persons capable of operating as a regulated autonomy" (Rose et. al. 1992, 173). As Rose and his colleagues delve into the analysis of the concept (2006), they pointed to the varied alliance between political actors such as headquarters of a nongovernmental organization "acting from a center of calculation". Funding by European Union for the projects of health assistance in Syrian migration correspond to the technology of government and facilitates governing at a distance by creating local partners to operate in the name of the desires and activities of the union.

Rose and co-writers of the study also point out to "the operationalization of programs of governing at a distance characterized the forms of new public management taking shape under rationalities of advanced liberalism" (Rose et. al. 2006, 95). As I draw

how liberal thought creates customer-subjects, mechanisms established through EU-funded projects established for the surveillance of the project objectives designates bureaucracy. I conceive that bureaucracy in accordance with what Lipsky (2010) manifests from his examination of the mass immigrations from southern and eastern Europe:

> …the bureaucracy has a stake in teaching clients what is expected of them. This phenomenon has been observed in the case of new immigrants to Israel, who, coming from traditional societies, often lack simple understanding of the functioning of modern social institutions. Teaching the client role is not confined to children or immigrants new to modem institutions. While novices may have to be instructed from the start, it is more commonly the case that people are attuned to the requirements of their dependency and only incidentally reminded of proper client behavior (Lipsky 2010, 61-62).

CHAPTER VI
CONCLUSION

In this thesis I mainly focused on how immigrant healthcare management is conducted by public healthcare expertise and social service planning. My fieldwork demonstrates that immigrant healthcare governance has been conducted through the uncertainty in the reestablishment of the public health system and consistent health reform policies overlapping the welfare system in Turkey. As narrative accounts of the fieldwork demonstrates, healthcare providers search and discover alternatives in order to facilitate the relationship with immigrants. Health programs for immigrants differ from public health politics designed for Turkish citizens based on alternative methods of preventive medicine, diagnosis, treatment and therapy. They make several adjustments in everyday experience of practicing healthcare. Based on my findings, psychologists and public health experts are the main partners in the contested preparedness for the most severe refugee crisis in the history of the Turkish Republic. In other words, they are highly involved in the diversified realms of integrated service provision from Syrian communicable diseases (epidemic) to psychological well-being (trauma).

The boundaries of public health care and mental health become uncertain. While social workers at NGOs help Syrians to develop health literacy, public health doctors and nurses do charitable work such as collecting funds, clothes, and food. Besides, they provide additional vaccine such as pneumococcal for females and children although it is not within the scope of the vaccination campaign. In their everyday routine, social workers plan and conduct psychosocial therapy sessions for refugee children to handle post-traumatic stress disorder. Usually, they also help the families of these children clients to get an appointment from doctors and accompany them to the hospitals or migration health centers for the treatment. Besides, public health doctors give the training of hygiene, balanced diet, and vaccination corresponds to the governmentality of immigrants in the urban setting.

I suggest that neoliberalism and globalism in the transformation of the Turkish healthcare system have shaped the limited access of Syrian women and children to health care services. In other words, undergoing neoliberal reforms has engendered the integration of Syrians, who were already in the disadvantageous positions, into the precarious category characterized by inequalities and restriction. Even if they have access to healthcare facilities, most of them have to deal with mainly the lack of translators at the hospitals and negative attitudes of healthcare service providers. Negative discourses about the Syrians caused by their bad representation on local and social media forge otherisation of Syrian immigrants and could render the emergence of discriminative and racist attitudes of healthcare providers.

More exposure to bureaucratic relationships and hierarchy in the projects serve to produce dominant forms of power governing the interactions between providers and receivers. Discussing the determination of the purpose, sustainability of funding and reports proving the achievement of the objectives corresponds to an analysis of the political rationality that assembles technologies of power. Examination of that rationality would form a basis for researching the construction of immigrant medicine expertise and embodiment of new subjectivities as socio-psychological workers.

Concerning psycho-social support projects, narrative accounts of the informants pointed to some rearrangements in the practice of trauma treatment as well. Art therapy and communicating through body movements ensures less usage of words and more projection of emotions. Therefore such adaptations in therapeutics not only extend the normative technics of mental health care, but also help to overcome communication challenges in therapy sessions. He noted that the relationship between psychologist and immigrant children can be improved with extending and art therapy is a way of overcoming language barrier.

I should express that I do not totally agree that the intentions of mental health care providers, coordinators and other actors, within the hierarchy of the projects or associations, ignore the good purpose of well-being for Syrian immigrants. However, mechanisms, and bureaucracy, designated among spatially and organizationally

distinct political actors such as global institutions, nongovernmental and local organizations and municipalities in Istanbul has regulative power on everyday endeavors of medical profession and everyday encounters of healthcare experts within migrant healthcare.

Liminal status of temporary protection refers to the definition and protection of the health services instead of rights. Therefore, healthcare provision for the immigrants is managed through health programs and projects funded by global institutions. Bureaucracy established within global actors due to the uncertain regime of TP reproduces new technologies of power to govern at a distance unless we challenge TP and start to discuss refugeeness in the Syrian case.

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APPENDICES

A. EXAMPLES OF INTERVIEW QUESTIONS

1. Bu işte çalışmaya nasıl karar verdiniz?

2. İşinizle kurduğunuz ilişkiyi nasıl tanımlarsınız?

3. Suriyeli göçmenlerle kurduğunuz iletişimi nasıl değerlendirirsiniz?

4. Proje kabulü sürecini nasıl değerlendirirsiniz?

5. Suriyeliler' in Türkiye'ye göç etmeden önce deneyimledikleri sağlık koşulları ve iyileştirme yöntemleri hakkında bilgi sahibi olabiliyor/ sohbet edebiliyor musunuz?

6. Suriyeli göçmenlere verilen sağlık hizmetlerini nasıl değerlendirirsiniz?

7. Suriyeli göçmenler alanında sosyal araştırmacı olduğunuzu bilen diğer ihtiyaç sahiplerinin tepkilerini nasıl değerlendirirsiniz?

8. Diğer kurumların Suriyeliler için uyguladığı proje ve programları nasıl değerlendirirsiniz?

9. En çok hangi grupla çalışmaktan hoşlanıyorsunuz? Peki neden?

10. Güven ilişkisi kurarken dikkat ettiğiniz hususlar nelerdir?