WAR, MIGRATION AND HEALTH; EXPERIENCE OF TURKEY

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WAR, MIGRATION AND HEALTH; EXPERIENCE OF TURKEY

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CONTRIBUTORS (In alphabetical order)

- **A. Öner Kurt**
  Assoc. Prof. Dr. Mersin University Faculty of Medicine Department of Public Health
- **Ayşe Nur Usturalı Mut**
  Dr. R. A. Ege University Faculty of Medicine Department of Public Health
- **Bahar Marangoz**
  Dr. R. A. Trakya University Faculty of Medicine Department of Public Health
- **Cem Terzi**
  Prof. Dr. Dokuz Eylül University Faculty of Medicine Department of General Surgery
- **Dilek Aslan**
  Prof. Dr. Hacettepe University Faculty of Medicine Department of Public Health
- **Emel İrgil**
  Assoc. Prof. Dr. Retired Faculty Member, Uludağ University Faculty of Medicine Department of Public Health
- **Ergun Demir**
  Dr. İzmir Bornova Community Health Center Polyclinic for Syrians
- **Gamze Varol**
  Assoc. Prof. Dr. Namık Kemal University Faculty of Medicine Department of Public Health
- **Hande Bahadır**
  Dr. R. A. Dokuz Eylül University Faculty of Medicine Department of Public Health
- **Hür Hassoy**
  Assoc. Prof. Dr. Ege University Faculty of Medicine Department of Public Health
- **Işıl Ergin**
  Assoc. Prof. Dr. Ege University Faculty of Medicine Department of Public Health
- **Kevser Vatansever**
  Assoc. Prof. Dr. Ege University Faculty of Medicine Department of Medical Education
- **Kuvvet Lordoğlu**
  Prof. Dr. Kocaeli University Faculty of Economics and Administrative Sciences, Department of Labour Economics and Industrial Relations
- **Meltem Çiçeklioğlu**
  Prof. Dr. Ege University Faculty of Medicine Department of Public Health
- **Mehmet Gülay**
  M.D. Specialist Bursa Osmangazi Community Health Center

- **Mehtap Türkay**
  Asst. Prof. Dr. Akdeniz University Faculty of Medicine Department of Public Health
- **Muzaffer Eskiocak**
  Prof. Dr. Trakya University Faculty of Medicine Department of Public Health
- **Necati Dedeoğlu**
  Prof. Dr. Başkent University Faculty of Medicine Department of Public Health
- **Nilay Etiler**
  Prof. Dr. Kocaeli University Faculty of Medicine Department of Public Health
- **Nuray Özgülnar**
  Prof. Dr. İstanbul University İstanbul Faculty of Medicine Department of Public Health
- **Reyhan Uçku**
  Prof. Dr. Dokuz Eylül University Faculty of Medicine Department of Public Health
- **Şevkat Bahar Özvarış**
  Prof. Dr. Hacettepe University Faculty of Medicine Department of Public Health
- **Yeşim Yasin**
  Asst. Prof. Dr. Acıbadem University Faculty of Medicine Department of Public Health
- **Yücel Demiral**
  Prof. Dr. Dokuz Eylül University Faculty of Medicine Department of Public Health
- **Zeynep Altın**
  M.D. Specialist İzmir Tepecik Training and Research Hospital Internal Medicine Clinic
- **Zeynep Sedef Varol**
  Dr. R. A. Ege University Faculty of Medicine Department of Public Health

Prepared for Publication by:

- **Necati Dedeoğlu**
  Prof. Dr. Başkent University Faculty of Medicine Department of Public Health
- **Işıl Ergin**
  Assoc. Prof. Dr. Ege University Faculty of Medicine Department of Public Health

INTRODUCTION

Civil war continuing in Syria since 2010 displaced millions of people and led to a serious population movement. Many Syrians fleeing conflict in their country rushed to Turkey as the closest border country. Refugees arriving in waves now constitute over 3 per cent of Turkey's population.

Displacement as a result of armed conflict is beyond doubt is the worst form of migration. Can we talk about the "health" of people whose lives have been utterly upset, who had to leave all their assets back, suffering maltreatment and losses in their long journey? In an environment where even minimum living standards are denied, absence of health is unfortunately what can be expected.

This humanitarian crisis coincided with a period in which Turkey made her preference for a market-oriented health system abandoning community-oriented approach through first level health facilities.

Consequently we witnessed the insufficiency of response by the existing health system in the face of unexpected influx of refugees. It should not go without saying that individual efforts of health professionals and initiatives by civil society have gained critical function in these circumstances.

This book seeks to expose the state of Syrian refugees in Turkey. We hope this document to contribute to efforts to bring solutions to the problems of refugees who presently live in extremely unfavourable circumstances.

Our thanks are due to the Public Health Branch that managed this collection within a very short period of time and to all who made their contributions.

Hoping a world without wars where people can live in peace and well-being…

Turkish Medical Association
Central Council

FOREWORD

Necati Dedeoğlu

The present report was prepared within a period of one month by the Public Health Branch of the Turkish Medical Association (TTB) to be presented as the opinion of the TTB to the Symposium on War, Migration and Health to be held in İstanbul on 26-27 February 2016 under the organization of the World Medical Association (WMA). After determining the main features of the content of the report, parts were assigned, respectively, to a doctor or a group of doctors who have studies and experience in that area. To ensure the integrity of the report, papers were reviewed with some additions or deletions. We hope that the present report makes a positive contribution to the healing of the human tragedy now experienced in our region.

As of January 2016, there are officially about 2,500,000 refugees in Turkey (**Ministry of Interior, 2016**). However, local governments report, for their regions, figures much above what is officially declared. Experts of the issue report that the number of refugees in Turkey is already above 3 million. In fact, it is quite difficult to give an exact number of refugees in Turkey. From April 2011 when Syrians first started to come in until January 2013 no record was kept since it was believed that they would soon return back. Moreover, it was actually impossible to keep the record of entries that could reach around 100,000 on a single day. Then, first the AFAD and then the Ministry of Interior General Directorate of Migration Management started to give identity numbers to incoming refugees, record those placed in camps and identify other scattered to various cities in the country. However, an important part of Syrians in Turkey has never been recorded since they have never been reached. Even those who were reached did not get themselves recorded since they had no idea of staying in Turkey. Some were afraid that they could be deported while others worried that their identities might later be learned by the Syrian government.

Refugees make up a quite dynamic group; there are some returning back to Syria, there are newcomers, those leaving Turkey by crossing the sea, others changing their places within Turkey, there are also new-borns and other who died while in Turkey. According to AFAD sources there are 270,000 refugees in 25 camps located in 10 border provinces; ten times as much as this are out of camps, mainly in such border provinces as Urfa, Hatay and Gaziantep where they stay with their relatives or just anywhere, trying to survive. There is a large group settling in İstanbul. There are others concentrating in such Aegean provinces as İzmir and Çanakkale planning to cross to Greece. There are Syrians in almost all 81 provinces in the country.

LIVING CONDITIONS

Fleeing their homeland just to stay alive, refugees lose it in other ways. It is estimated that so far at least 100,000 refugees had drowned in the Aegean Sea. According to human traffickers, about a half of those leaving the shores of Turkey, drown. In cities like İzmir, sales of feeble life vests and zodiac boats and collection of 1,000 Euro by traffickers from each refugee take place openly before all, including the authorities.

There are also infants, children and adults not losing their life at the sea but on the land for malnutrition, lack of decent shelter, illness with no medical care or work accidents. It

is clear that the right to life comes before the right to health. There is no respect to human rights, young Syrian girls are marketed on the Internet, forced to marriage, taken as second bride and driven to prostitution. In fact, both the war in Syria and what follows it, is a crime against humanity, abject violation of human rights.

Healthy status can be attained only if people can subsist, have food, shelter and live in hygienic conditions. We know that some Syrian refugees arriving Turkey are well off materially and they live in nice houses at urban centres. There are also some establishing their own businesses, workshops and so in Turkey, employing other Syrians. According to the Ministry of Economy there are 2,827 firms established by Syrians, but it is reported that including informal ones this number is actually as high as 10,000 (**Erdoğan M, Ünver C, 2015**). This does not include those opening and running shops and restaurants.

The state of those living in camps is better than other refugees living out of camps. They still have a shelter even if it gets too hot in summer and too cold in winter (of 25 camps, 15 are made of tents). Tents are crowded, water permeable and there is risk of fire. But in camps there are various facilities including health units, school for children, playgrounds, laundry, bathing places, social service units, canteen, bank and TV rooms. Those staying in camps can also benefit from relief materials from Turkey and abroad. Still, some refugees leave camps to seek a less restricted life and in some cases newcomers cannot find place increasing the number of those living without shelter. Problems related to fragmented families, single women, elderly people, orphaned children and persons with disabilities are of course greatest of all.

The state of those living out of camps is problematic. They concentrate in specific parts of urban centres which are mostly poor neighbourhoods. Refugees who have their jobs and regular income pay as rental double the amount paid by a Turkish citizen. A single house may room in 6-7 persons (sometimes two families sharing the same house). Toilet, bathroom and kitchen facilities are not satisfactory, consumer goods (refrigerator, washing machine, flooring, etc.) are either absent or worn out. Indoors are mostly damp, ventilation is poor and hygiene is not observed. Others having no income try to find themselves places to shelter in public parks, deserted buildings, construction sites and shops. Municipalities are hesitant to show these people places to stay weary of the possibility of their permanent stay. This summer, for example, there were refugees staying around the İzmir International Fair area whose gates were kept locked and consequently refugees around were denied the means of using toilets and fountains within. It is still uncertain how these people have some heating in approaching winter months.

Three meals a day are served in camps, but refugees are not satisfied with the quality of what is served. There are occasional cases of food intoxication. Refugees are not allowed to cook their food in tents because of the risk of fire. Out of camps, the nutritional status of refugees is mostly bad, only limited number of them can have 3 meals a day. In general, they feed on bread and vegetables. A survey conducted at a provincial centre found, among women in the age group 15-49, iron (by 50%) and B12 vitamin deficiency (by 46%) (**Şimşek Z and Ark, 2014**). It is a problem to find infant food while some mothers cannot breastfeed for having their milk cut out. Infants die for such preventable causes as pneumonia and diarrhoea.

Now Syrians can work in Turkey legally. But still, incidences of informal employment and child labour, which are both already prevalent, are expected to rise. People staying out of camps have no regular assistance. Even when some aid comes from NGOs, inter-

national organizations and local governments it is hard to say they are distributed equally and fairly. Some refugees are employed at workplaces established by other refugees or owned by Turkish citizens. These are mostly in the sectors of textile, construction and agriculture. They work by getting 1/3 of what is normally paid in a given sector. Since their employment is in most hazardous works and without preventive measures, the incidence of work accidents and the risk of occupational diseases are high. Many workers are children, as they are preferred to adult workers. Refugees living in south-eastern provinces work as agricultural labourers in summer, getting half of the normal wage rate.

Children in camps can be taught in Arabic. Out of camps, there are also some schools launched with the support of NGOs and some local governments, but they are very few. Working children cannot attend school and there are few Turkish language and vocational training courses for adult males and females. This will lead to an army of unqualified and cheap labour for the future. Legally, these children have the right to attend schools, even universities in Turkey; but due to language barriers it is impossible for them to exercise this right, apart from refugees of Turkic origin. Recently, TÖMER courses were made available to Syrian students who would attend university to learn Turkish first. Still, because of these language difficulties many Syrians are unaware of their rights and services that are available. The problem is serious since less than 10% of Syrian refugees in Turkey can understand and speak Turkish. This places them in difficult position especially in health facilities, government institutions and community life.

Another serious problem that refugees face is discrimination. They are not wanted and this is made explicit in many spaces including schools, hospitals, official places, workplaces and neighbourhoods. They are perceived as a threat in economic and cultural terms. They are debased on such grounds including "pushing rents up, losing jobs because of their existence, pressing down wages, longer queues in hospitals, increase in cases of theft, begging, noise, etc." all these make the integration of refugees too difficult and lead to the emergence of ghettos in cities. Syrian refugees are not organized. They can have their voices heard neither in camps nor out. As to Ezidis and Kurds coming in from Iraq, their situation is even worse. None of the rights accorded to Syrians are accorded to these people. There are about 200,000 Syrian babies born while in Turkey since 2011 and they have no country. They are not Syrian citizens and not considered as Turkish citizens.

HEALTH PROBLEMS

Health services used to be quite organized in Syria before the conflict broke out. The state of maternal and infant health was fine and the rate of immunization was high. Syria produced her own medicines. The case was so in spite of the fact that Syria too, like Turkey, had launched a "Health Reform" in 2010 leaving health to market dynamics, going ahead with privatizations and making people pay more from their pocket. Walking for miles to save their lives, being injured, assaulted and faced violence on their way, Syrian refugees were quite worn out in terms of physical and psychological health when they reached Turkey. While their situation was ameliorated to a certain extent through health services, hospital treatment and surgeries at camps, many could not benefit from these services.

In such cases, the most frightening possibility for the host country is communicable diseases carried together with incoming people. It is known that cutaneous leishmaniasis, typhoid fever and Hepatitis A are endemic in Syria (**Sharara S, Kanj S, 2014**). There

was also polio cases spotted recently. Yet, we know that these diseases, with the exception of polio, are also observed frequently in Turkey too. In other words, Syrians cannot be said to have brought in a serious threat of communicable disease. To the contrary, they run the risk of getting communicable diseases here for being in an alien environment and living in rather bad conditions. The leading one among these is drug resistant tuberculosis. There are also risks emanating from living in crowded environments including meningitis, scabies, pneumonia and bronchitis. Since infancy and childhood period immunizations are interrupted, child refugees are vulnerable to chicken pox, diphtheria, whooping cough, mumps and neonatal tetanus while adults must be checked for sexually transmitted diseases and new ones such as Crimean-Congo haemorrhagic fever. Since refugees are given polio and measles vaccines in and out of camps, the risk of breakout is low though some sporadic cases may be seen.

Of all services extended to Syrians, the greatest gap is seen in maternal and child health services which are of protective nature. 54% of all refugees are under age 18 and the majority of the remaining is women. Pregnancy care and monitoring, postnatal and newborn care, disease screenings, infant and child monitoring and family planning services are problematic even in camps. Out of camps, these services are mostly crippled. There is no examination and with the exception of some Community Health Centres (TSM) there is no pregnant women and infant monitoring either. Since family planning services for refugees are not available, there are unwanted births and increase in infant mortality. Already under stress, women additionally face risks of gender discrimination, sexual violence, early marriage, and miscarriage and birth complications.

Problems such as anxiety, depression and post-traumatic stress disorders constitute important health problems especially for children and women. Whereas there are psychologists and psychiatrists assigned to camps by the state and some voluntary organizations, it is too difficult for refugees living out of camps to receive these services. Males feel themselves as useless and lost. It could be expected that these problems will be further aggravated as a result of past and future traumas, worries about the future, fear of being deported, deprivation and exclusion. But, for the time being, Syrian refugees are not problematic in terms of public order and getting involved in crime.

There is now regular treatment services provided to Syrians. Those in camps can consult health centres established there or receive services from hospitals they are referred to. For out of camp Syrians, it is only recently that health services started to be extended to refugees who have registered. These registered refugees can, within the province of their registration, consult family doctors and Syrian polyclinics launched in community health centres for first level health services and to hospitals under the Ministry of Health for second level services. They can receive treatment in university hospitals or private health facilities on the condition that they have their referrals there. But they can receive no service unless they ask for it. At the first level, they pay 20% of the cost of medicine and they can receive treatment and operation free at the second level (**Ministry of Health, 2015**). However, in some cities refugees cannot reach medicines because there is yet no agreement between the AFAD and pharmacies. Further, since there are problems in AFAD's reimbursement to pharmacies, there are cases when pharmacies ask patients to cover the full cost of medicine prescribed. Syrians cannot properly benefit from health facilities due to language related communication problems and even when they can, their health problems re-emerge after returning to their environments of poor housing and

malnutrition. It is reported that in İzmir a patient undergoing a heart surgery later lost his life for not being able to buy Coumadin.

Elderly people are mostly uncared with their chronic illnesses. They are deprived of such services as dialysis, cancer prediagnosis, physical rehabilitation and follow up. Persons with disabilities can hardly reach any service if out of camps. Dental health services are mostly restricted to camps.

In some provinces, various foundations, associations and local governments launched polyclinics employing Syrian doctors and nurses. There is also a private hospital in İstanbul launched by a Syrian doctor, serving Syrian patients. However, not all refugees can reach these services. There are hundreds of thousands of unregistered Syrians having no access to services except for emergencies and communicable diseases. There are many professional including doctors, engineers and teachers from Syria who are yet not mobilized. But the problem can be mitigated since they have recently been granted permission to work.

Health personnel working in camps and provinces where there are many Syrian refugees are confronted with various problems. These problems include intensive work engagement for long periods, difficulty in communicating with Syrians due to language barriers and cultural differences and being subject to violence. It is not certain for how long those physicians with temporary assignments will stay and none has been trained for a service of this kind.

Following sections will provide a more detailed account of problems briefly summarized here.

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OVERALL STATE OF REFUGEES

Hür Hassoy

Migration movement have their various driving forces including war, poverty and political oppression but eventually proceed in a way to augment capital accumulation in central capitalist and in migration giving-receiving countries. Parallel to this, migration policies of countries vary with respect to periodic needs of capitalist economy. While seeking to eliminate barriers to the free circulation of capital, globalization is discriminatory and restrictive as to the free movement of labour and people. People's move particularly to advanced economies from developing countries is seriously limited by legislative and administrative measures.

Turkey is an outstanding country in terms of migration movements. The list includes Jews fleeing Spain in the 15th century; then Hungarians and Poles running away from the oppression of Austria; 300,000 ethnic Turks from Bulgaria in the 80s; 1 million people during the war between Iran and Iraq; people coming in from Asian and Caucasian countries following the collapse of the Soviet Union, 500,000 Kurdish refugees in the aftermath of the Gulf War; 25,000 Bosnians coming in upon the break-up of Yugoslavia and more recently millions more from Syria…

At their point of departure, social injustices, poverty, unfavourable living and working conditions, armed conflict, individual or institutional violence, lack of access to health services and diseases are important risks for migrants. Health problems existing prior to migration are related to the public health status of the country of origin. Often, these countries are characterized by the prevalence of violence, political and economic instability. The journey too often does not take place in safe conditions and specific health problems emerge. Other risks include those related to transportation, particularly risks in seas which lead to the drowning of many. Once in their destination, irregular migrants cannot benefit from existing health services either from lack of information about these services or legislation in effect or both.

In terms of workers' health, migrant workers contribute, in line with the needs of capital accumulation process, to the creation of a reserve industrial army particularly in crisis periods and thus serve as a kind of buffer. The competition between domestic and foreign workers lead to the lowering of the cost of reproducing labour and weakening of the workers' side in class struggle. Displaced people suffer worst form of humiliation, exclusion and otherization in destination countries, having no alternative but working at starvation wages based on excessive levels of exploitation.

Turkey became a State Party with geographical reservation to the 1951 Geneva Convention on the Legal Status of Refugees and its Annex Protocol dated 1967. This reservation excludes refugees coming in from non-European countries. Hence, Syrian citizens are not formally regarded as refugees. Although those staying in camps and registered in cities are accorded temporary protection documents, they are still subject to this restriction stemming from geographical reservation to the convention concerned.

Pursuant to a decree issues by the Ministry of Interior in October 2011 registered Syrians in Turkey are given "temporary protection status". The relevant regulation defines "temporary protection" as protection provided to those who were forced to leave their coun-

try, unable to return back, arriving to and crossing Turkey's borders in groups or individuals during mass influx seeking temporary protection and whose requests for international protection cannot be considered at individual level. The temporary protection regime provides Syrians the right to stay in Turkey for an indefinite time period, to be protected from forced return and response to their urgent needs. Moreover, sheltering, food, education, health services, access to safe water, etc. are provided to those living in camps. Those who have not registered for several reasons have none of these rights.

The countries of the European Union are quite clear about migrants: They don't want them within the Schengen boundaries. They have included all kinds of difficulties in their legislation for attaining migrant status. For the EU as the "cradle of human rights and democracy" keeping migrants out of the borders of Europe is the most crucial issue and Turkey appears as the most suitable country for keeping them off as witnessed by ongoing negotiations. It will not take long to see refugee camps turn into working camps where cheap labour is exploited to the very end.

According to data by the United Nations High Commissioner for Refugees (UNHCR) updated as of 10 January 2016 there are 4,597,436 registered Syrian refugees. Turkey rooms in 1.9 million refugees while Egypt, Iraq, Jordan and Lebanon together have 2.1 million registered Syrian refugees. There are 26,700 Syrians refugees now registered with the countries of North Africa. 49.3% of refugees are males and 50.7% are females. Age composition is as follows: 0-4 (17.6%); 5-11 (21.6%); 12-17 (12.7%); 18-59 (45.3%) and 60 and over (2.9%).

According to data provided by the General Directorate of Migration Management (Ministry of Interior) biometric registration of 2,415,494 Syrians was completed as of 18 December 2015 and their temporary protection documents were issued. Of these refugees, 265,180 are located in 25 Temporary Sheltering Centres (19 tent settlements and 6 container settlements) in 10 provinces established by the Disaster and Emergency Management Authority (AFAD). So there are 2,150,314 Syrians out of these facilities. Available data is limited only to registered refugees and does not fully reflect the actual situation.

Anywhere in the world, the basic needs of refugees include security, sheltering, food, health services, protection from violence and abuse, education for children and employment. So is the case for Syrian refugees in Turkey. In this wave of migration commanding very large numbers, it is necessary for the state to intervene. As far as health services are concerned, accessibility will be improved if these services are organized horizontally in places where refugees concentrate, together with some special arrangements (i.e. translators, etc.).

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DETERMINANTS OF HEALTH IN REFUGEES

PROBLEMS OF REFUGEES IN CAMPS

Kevser Vatansever

During humanitarian emergencies caused by war or armed conflict, fleeing the home country is the most dramatic form of migration and refugees constitute one of the most vulnerable groups affected by such emergencies (Noji, 2000). Refugees and migrant constitute the most vulnerable group in terms of health status due to their difficult living, sheltering and feeding conditions, difficulties in accessing health and social services, violence etc. (Karadağ & Altıntaş, 2010; Perrin, 1996).

Armed conflict in Syria started in Daraa on 15 March 2011 when the opponents of Bashar Assad launched an armed uprising to, according to their own statement; establish the free state of Syria (Paksoy, et. al., 2012). As of 10 January 2016 about 7,650,000 Syrians had to leave their homes and over 2 million Syrians took refugee in Turkey (AFAD, 2016a).

It can be said that there are four groups of Syrian refugees in Turkey.

The first group comprises those who, having their regular and relatively higher income, prefer to live in places other than camps with higher standards of living.

The second group is composed of refugees trying to start a new life in Turkey by engaging in seasonal agricultural works, low-paid informal jobs or even begging, or save some money to eventually make it to Europe.

Refugees in the third group are those who left camps or houses they once lived at the cost of living in streets and moved to places on the Aegean cost, now in an open-ended waiting for the time to cross the sea and reach Europe.

Finally, the fourth group is made up by Syrians who have been in Turkey for longer than other living out of camps. They entered Turkey without passport and earn less than average income with limited possibilities to live out of camps.

According to Prime Ministry Disaster and Emergency Management Authority (AFAD) there are 268,843 Syrian refugees in 25 temporary centres in 10 provinces as of 11 January 2016 (AFAD, 2016b). These camps are located in Adana, Adıyaman, Gaziantep, Hatay, Kahramanmaraş, Kilis, Malatya, Mardin, Osmaniye and Şanlıurfa. These temporary sheltering areas also room in 11,282 refugees from Iraq, 9,548 in İslahiye-2 Tent camp and 1,734 in Nusaybin Tent Camp.

This paper is based mainly on AFAD reports and other studies by the Turkish Medical Association (TTB) or other professional organizations and CSOs.

1. Characteristics of Refugees Staying in Tent Camps of AFAD

52% of Syrians living in camps and 26% of others not in camps have made their entry to Turkey from official border gates without passport. Those entering Turkey with their passports make up only 4.9% of camp dwellers and 27% of other not living in camps (AFAD, 2014).

While over three-fourths of refugees living in camps have been in Turkey for longer than 7 months, 30% of these people had no registration with AFAD or the camp (AFAD, 2014).

As to age composition, 37% are under age 12, and refugees at age 55 and over make up only 5% of total. A report issued in June 2013 informs that 18% of children (4.984 children in total) in 20 camps populated by 201,032 Syrian refugees were born in Turkey (Döner, Özkara, & Kahveci, 2013).

While 49% of refugees living in camps are male, females constitute 51%. Among refugees 40% of females and 32% of males are separated from their families (AFAD, 2014). Population per tent or container in camps is, on average, 5.1 (2.8-8.4) (AFAD, 2016b).

Household income levels are strikingly low (monthly average is 162$). This average is higher for those living out of camps (monthly average is 239$) (AFAD, 2014).

1.1. Social life in camps

AFAD reports state that a system of *muhtarlık* (head person) is introduced in the management of camps and personnel is employed in such areas as security, food, education, health and religious affairs. This system is welcome by refugees as well. Over 60% of refugees state their content with this system (AFAD, 2014).

Among refugees 60% of them, both males and females, living in camps say they are "very much satisfied" or "satisfied" with health services they receive (AFAD, 2014). Nevertheless there are still some problems resulting from language barriers and religious beliefs. As one female refugee puts it:

> *"We have the problem of having no female doctor in health services. It is against our convictions to be seen by a male doctor. And we also have the problem of not being able to communicate to doctors what we complain about due to language barriers. Lately, one doctor gave me birth control pills instead of flu medicine that I wanted as a result of mistranslation that I noticed later."* (Yıldız, 2013)

It is reported that 82% of children aged 6-11 receive education, 16% are officially enrolled to regular schools, 29% are guest students and 38% attend education centres established by municipalities or CSOs (AFAD, 2014). Refugees thinking playing grounds are insufficient constitute 60% of total.

For at least half of refugees staying in camps is no more preferable. In camps, 52 per cent of males and 54 per cent of females want to live out of camps (AFAD, 2014).

1.2. Health problems in camps

Under the international and national literature, the following are the most frequently observed health problems among refugees:

- Vitamin deficiencies (Vit A, Vit C, Niacin), anaemia
- Unwanted and risky pregnancies
- Miscarriage, birth complications
- Retarded development and growth in children, anaemia
- Chronic diseases and their complications

- Infectious diseases including diarrhoea, malaria, meningitis, typhoid fever etc. and vaccine-preventable diseases (measles, TB, hepatitis, etc.)
- Sexually transmitted diseases including HIV/AIDS
- Injuries associated with physical violence and sexual abuse
- Depression, anxiety, exhaustion, sleeping disorders, prolonged mourning and post-traumatic stress disorders
- Dental health problems (Eskiocak, 2013; Karadağ & Altıntaş, 2010)

According to AFAD reports and various studies most common complaints include diarrhoea (23%), skin problems (23%), fever (18%) and headache (16%). One/third of patients in need of medicine have difficulty in access (AFAD, 2014).

The risk of psychological problems is high for refugees due to their pre-migration experiences including emotional and physical violence, genocide, witnessing the death or injury of very close relatives, destruction, looting, child trafficking, material deprivation and traumatic events. Following migration, new risks derive from legal barriers, homelessness, uncertain future, language and cultural barriers, etc. (Önen, et al., 2014).

Fifty five percent of women and 50% of men need psychological support (AFAD, 2014). Seven percent of families have members with chronic diseases, 25% have children with sleeping disorders and 24% have adults with the same problem (AFAD, 2014). A survey conducted in Akçakale Camp covering 450 persons over age 18 found severe anxiety indicators in 19% of respondents and severe depression indicators in 9%. Statistically significant difference was found between the form of being exposed to violence, future expectations and anxiety and depression scores (Önen, et al., 2014).

1.2.1. State of health services and health problems of refugees in camps with examples

AFAD CAMPS

Midyat Tent Settlement

In this temporary settlement area with 1,330 tents there are 3,137 Syrian and 1,747 Iraqi refugees (AFAD, 2016b). Health services in the camps are provided by 3 doctors and about 20 other health workers. An examination conducted by a TTB team in 2014 revealed that there was no specialist, leaving aside a dermatologist visiting the camp two days a week. Practising doctors were assigned to the camp by community health centres (TSM) for indefinite periods. These doctors are on-call duty 10 days a month and work in TSMs on days without on-call duty without any pay for their overtime work (Zencir & Davas, 2014).

It was observed that while there are thousands of unnecessary medicines in the field hospital of the camp, health centres lack even most essential ones; there is not a single sink and no privacy. While camp managers say there is no language problem health workers say there are language problems emerging during polyclinic services (Zencir & Davas, 2014).

In the tent camp where only polyclinic services are delivered there is no on-site risk group monitoring or surveillance. In polyclinic applications, the **problems most frequently observed** include upper respiratory infections, gastroenteritis, dental problems (there is

no dental unit), parasitic diseases (louse), gynaecological problems and cutaneous leishmaniasis (Zencir & Davas, 2014). Contagious diseases spotted as of January 2014 are cutaneous leishmaniasis, hepatitis A, chickenpox and diarrhoea.

Most crowded guest house: Akçakale Süleymanşah boarding facilities

Remaining under ISIS control until May 2015, Tel Abyad was taken by YPG-FSA following an intensive fighting from 6 May to 15 June. According to official records of AFAD, 23,253 people passed to Akçakale after 3-4 June 2015. Local sources say this figure is actually as high as 40,000 (Gökalp, et al., 2015).

The largest of all camping facilities established by AFAD (AFAD, 2014) is the Süleymanşah facility in Akçakale-Urfa (5,000 containers) (AFAD, 2016b) where there are 29,418 Syrians as of 11 January 2016 following large influx of refugees in May-June 2015 (Gökalp, et al., 2015)

According to an examination conducted by a team composed of representatives from the TTB and local chambers of medicine, healthcare tents are staffed with one internist, one paediatrician, one family medicine specialist, one general practitioner and four nurses-midwives. It is stated that general practitioners are too frequently in rotation which has its negative effects on work conducted. Approximate numbers of daily admissions to respective polyclinics are as follows: Emergency 350-400, family medicine150-200, internal medicine 150-200 and child health 100-150. Immunization of children aged 0 to 15 taken from border gates is made by the Public Health Directorate. There are no psychosocial counselling services though there are refugees in the camp for four years now. (Gökalp, et al., 2015). It was also observed that no support was given to Akçakale State Hospital despite its increased work burden, there is no specialist in many branches and that there is only one gynaecologist in the hospital where on average 180 patients are given treatment and about 10 deliveries take place (Gökalp, et al., 2015).

MUNICIPAL CAMPS

Camps in Suruç (Sürenkök, Gökalp, & Vatansever, 2014)

Following the heavy attack of ISIS to Kobane in September 2014, there was large flow of Syrians to Suruç-Şanlıurfa just across the border. Starting from the very first days of migration full infrastructure and logistics in camps were provided by local municipalities including that of Suruç in the first place. There are 8,700 refugees in Rojava, Kobane Şehit Nejat Ağırnaslı and Arin Mirkan camps. Eighty percent of refugees staying in these camps have their identity documents issued by AFAD.

Health services are delivered on voluntary basis by members of chambers of medicine and unions from the region or from other regions. These services mainly cover polyclinic, health training, medicine provision and referrals.

In Arin Mirxan Camp there is presently 4,000 people in 450-500 tents. At the gate of the camp, there are groups of children selling food items on their tables. While there are sufficient toilets and baths in the camp there is problem in regular supply of water. The camp was given electricity starting from October 2014. The mobile kitchen of Diyarbakır Municipality serves meals and there is education for 3-10 years old children on 2-3 days a week. A two-room container used as infirmary is open on specific hours of day.

In Kobane Suphi Nejat Ağırnaslı Camp there is 2,500 people in about 250 tents. The Municipality serves three meals a day. Hygiene is stated as a problem although means of toilet and bath seems to be sufficient. There are problems in water supply.

In temporary sites established by municipalities there is no UN organizations and, in spite of too many children, no UNICEF. The Turkish Red Crescent provides meals to 20,000 persons from its Çukobirlik facilities.

2. Environmental Health in Camps

Twenty-seven percent of Syrian refugees in AFAD camps say access to drinking water is difficult while they find access to such materials as soap, diapers, female hygienic equipment and others relatively easier (AFAD, 2014).

According to observations conducted by the TTB delegation over camps in Hatay and its districts following the start of armed clashes in Syria and mass departure of people, population of some tent camps approached or even exceeded the population of closest district centres This creates an excessive pressure over the capacity of available resources including water in the first place (Karababa & Yavuz, 2011).

It is reported that there insufficient supply of safe water to the camp in Midyat and there is one toilet per tent, but there are no control measures taken against vectors (Zencir & Davas, 2014). In the Harran camp water samples are taken 3 days a week for examination and there are regular measurements and chlorination. Given that no bacteriologic pollution is identified, the prevalence of cases of gastroenteritis and parasitic diseases in both Midyat and Harran camps suggest the existence of problems related to food and personal hygiene (Zencir & Davas, 2014). In Akçakale camp there are problems in food-water and personal hygiene (Gökalp, et al., 2015).

Tents in Akçakale are poor in terms of ventilation and lighting and field type health tents pose the risk of collapse in their frame parts (Gökalp, et al., 2015). Although tents in caps are cold-proof, there are concerns that they will not be so helpful with expected cold weather and snow in winter (Zencir & Davas, 2014).

An interesting point about the ground is that crushed stone covering in Suruç Arin Mirxan camp gives dust, which increases the risk of respiratory tract problems (Sürenkök, et al., 2014).

Another environmental problem is high risk of fire. Camp dwellers in Midyat and Harran requested cooking devices to prepare meals in their preference and consequently electrical ovens were distributed to tents. People are now cooking with these devices within tents which is quite risky in term of fire and burns. It is a shortcoming that there is no common kitchen for cooking (Zencir & Davas, 2014).

3. Ezidis as a Group With Special Needs

Ezidis living on the slopes of Şengal (Sincar) mountains in Iraq were attacked by ISIS forces on the night of 2 August 2014 which forced them to flee on foot first to Syria and then to Turkey. They have no intention to return at least in the short-term because of fear of slaughter and Sunni people cooperating with the ISIS (Support to Life, 2014). Neither do they want to live in Turkey as a Moslem country nor do they want to reach Europe (Support to Life, 2014). Some Ezidis placed in vacant houses wanted to move to camps since they did not feel safe within a Moslem community (Zencir & Davas, 2014).

Fifty-five percent of Ezidi refugees are children under age 17 and women make up 52% of adult refugees (Support to Life, 2014)

Visits made by various professional organizations observed that drinking and use water needs of refugees are sufficiently met by the Municipality. Also, meals are regularly served in camps managed by municipalities (DİSK, et al., 2014). There are sufficient toilets, separate for males and females, wastes are collected and there is medication against insects.

Health services are delivered by volunteer teams and a polyclinic and a small vehicle are allocated to these services by Cizre Municipality. There is also the 112 service facility of the Ministry of Health (DİSK, et al., 2014). According to polyclinic records, Ezidi refugees are mostly diagnosed of ARI and pain on back, which do not point out to any special case, but there are serious trauma indicators among women and children (DİSK, et al., 2014).

Having their unique cultural norms, Ezidis may face some problems in food; for example they never consume lettuce. As a matter of fact, they protested the kitchen in Diyarbakır Yenişehir (Fidanlık) camp and asked for cooking devices (Support to Life, 2014). They have their own norms in outfits too; for instance, elderly people wear only white dresses they sew and never have any outwear coloured purple or dark blue.

Conclusion

For refugees to cope up with difficulties they face, to have relief from their traumatic experiences and adapt to their new life, it is necessary to have supportive interaction within their social environments. In this process, healthy sheltering, sufficient and continuous health services not pendant to demand and social services including psychosocial support are of crucial importance.

In Turkey, the AFAD is the major agency in charge of organizing urgent response in emergencies. International agencies including the UN and UNHCR took rather delayed steps from the establishment of camps to provision of medicines throughout the 4-year period as conflict and migration flows continued. Given this, municipalities located close to the southern border of the country took initiative and undertook actions which should normally be launched by international agencies like UN and UNICEF and also by Red Crescent and AFAD.

Given limited size of camps with tents or containers living space per person is insufficient and, beyond, there may be occasions when it is even hard to breathe. As to camp life, there are quite a few camp residents complaining about management and personnel. Further, playgrounds are quite insufficient given the high number of children.

Health services in camps established by AFAD or local governments can be maintained thanks to the dedicated efforts of limited number of health workers.

On the other hand, the work burden of health services given by hospitals located at province and district centre where camps are under heavy pressure and health workers in these services serve in both their normal posts and in camps without any extra payment.

While there are 24 hours long services in some camps, service systems in others are limited to normal daily working hours. Particularly apparent is shortfall in medical expertise and psychological support services. This is a problem given the high incidence of psychological problems including anxiety and depression.

Besides psychological problems associated with this mode of life, prolonged stay in temporary shelters inevitably brings along the risk of infectious diseases. As a matter of fact many cases of infection and infectious diseases associated with congestion are reported from camps.

It is observed that the reason for refugees to keep staying in camps is their poverty and lack of registration/identity documents. Both limited services and living spaces in camps and insufficient support from the state and international agencies constitute the major problems that bar refugees from transition to normal out-of-camp life and become productive to have a decent life.

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REFUGEES LIVING OUTSIDE OF CAMPS: WORKING, INCOME, EDUCATION, HOUSING, WATER, HYGIENE AND NUTRITION CONDITIONS

Hande Bahadır, Reyhan Uçku, Zeynep Sedef Varol, Meltem Çiçeklioğlu, Ayşe Nur Usturalı Mut

At present Turkey is one of the countries with highest capacity of camps for refugees. However, due to continuing influx of refugees even this capacity falls short and many Syrians in Turkey live outside of the camps. According to reports by government authorities and civil society organizations, Syrians living in camps mostly have no problem in accessing health services **(AFAD, 2013; Yıldız Ö., 2013).** But the state of others not living in camps is quite different. Indeed, almost 90% of Syrian refugees in Turkey are out of camps and face many problems including shelter, health services, nutrition and hygiene which are essential in terms of health **(USAK, 2014).** The striking divergence between those living in camps and others is apparent in AFAD survey: while about 94% of women in camps can utilize health services, this is only 58% for other living out of camps **(AFAD, 2013).** Though mitigated to a certain extent, this difference is also true for males: While 90% of male refugees benefit from health services, this is 60% for males living out of camps **(AFAD, 2013).** This difference indicates the unmet health service needs of those living out of camps, not that these people do not need health services. Access to health services is guaranteed by both our Constitution in its articles 17 and 56 **(Constitution of the Republic of Turkey, 1982)** and in international instruments including the Universal Declaration of Human Rights **(Universal Declaration of Human Rights, 1948).** In access to health services, such factors as poverty, unemployment and housing conditions play an important role **(Yardım MS and Özcebe H, 2010; Şimşek H and Kılıç B, 2012).** As is the case with other disadvantaged groups, these social determinants must be borne in mind for Syrian refugees in Turkey as well.

Asylum seekers and refugees constitute one of the most vulnerable and fragile groups **(El-Khatib, Z et. al., 2013)**. According to the study by Esin et. al. covering Syrian refugees in İstanbul, responding households state that they can only meet their most basic needs **(Esin et. al., 2014).** The main reason for low income is unemployment. Studies show that only a small portion of Syrian refugees in Turkey is employed. For any legal employment, Syrians must have their residence permits and only 80,000 Syrians have such permits **(Erdoğan, M. and Ünver, C., 2015).**While some studies suggest that one in each 2 Syrians is employed, **(Türkmen Sanduvaç ZM, 2013)** there are only 3,856 Syrians with work permits **(Erdoğan, M. and Ünver, C., 2015).** It is estimated that there are about 1 million Syrian refugees in Turkey who work informally. These people are mostly employed in sweatshops and low quality jobs and get half of what is paid to Turkish workers even if they do the same job **(TTB, 2014).** It is reported that the average monthly earning of Syrians in employment is 230.9 USD **(AFAD, 2014).** This low economic status is one of the most serious obstacles to access to health services. In a study conducted in Bursa by Kalkan and others, 31.6% of refugees not able to consult health services say this is because of their very low earning **(Kalkan, O. et. al.., 2014).** Meanwhile Syrian refugees are discriminated against by local people for

being a cheap source of labour **(TTB, 2014).** According to UNHCR while Turkey ranked as 15th among industrialized countries receiving individual applications for asylum in 2010 it jumped to the 5th in 2013 with 45,000 applications **(UNHCR, 2013).** This remarkable increase is closely followed by Turkish employers. The press statement by Hikmet Tanrıverdi, President of the Union of Garment Exporters (İHKİB) demonstrates that Syrian refugees are regarded as source of cheap labour: '*I agree that Syrian refugees are problematic in terms of employment in the eastern region, but in Marmara region they offer a significant source for our sector, in fact they save the region*' **(İSİG Assembly, 2014).** This blatant policy seems to further aggravate local people's discriminatory attitude to Syrian refugees. For example, according to a study by Economic and Foreign Policy Research Centre, 86% of respondents think it is necessary to stop receiving refugees and about 30% say they must be returned to their countries **(EDAM, 2014).**

The level of education is another social determinant of health status. 19% of Syrians living out of camps are not literate and 61% are primary school graduates or dropouts **(AFAD, 2014).** In Turkey, on the other hand, 49% of males and 36% of females are in education status higher than primary level **(TNSA, 2013).** This gap in levels of education must be taken into account while dealing with inequalities. Another dimension of the issue of education is the education of Syrian children. Of out-of-camp children aged 6 to 11, only 14% continue with their education **(AFAD, 2014).** There is no information on the education status of children over age 11 and neither is there any information on how children attending school cope up with such problems as language and curriculum adaptation **(AFAD, 2014).** According to information obtained from interviews with education experts, about 40,000 Syrian children attending school receive education through a curriculum prepared by a Syrian Education Commission by deleting pro-Assad and pro-regime statements on the assumption that these children will eventually return back to their home country **(USAK, 2014; UNİCEF, 2014).** About 6,000 children from families who have residence permits receive education in Turkish, in Turkish schools **(USAK, 2014).** As to education of children living out of camps it is mostly delivered by schools run by civil society organizations, municipalities or private persons **(USAK, 2014).** Turkey is a State Party to the Geneva Declaration of the Rights of the Child (1924) that establishes all children have right to education no matter what their nationality is. Hence, Turkey has the responsibility of providing education at least in minimum standards to Syrian refugee children **(INEE, 2010).**

Out-of-camp Syrians mostly live in poor neighbourhoods in houses they rent with their own means **(TTB, 2014; Mersin University, 2014).** These and some barracks are mostly very low quality dwellings not so fit for living in **(Türkmen Sanduvaç ZM, 2013; Yılmaz H, 2013).** Rise in rentals as a result of high demand puts both local people and Syrians in an economically difficult position. Even those who are able to pay high rentals still get low quality housing while others room in deserted buildings (13-16%) or in tents (10%) **(USAK, 2014; AFAD 2014).** There are families sharing the same household as a result of material pressures **(TTB, 2014).** The average household size is found as 8.6 by AFAD and 11.0 by "Mavi Kalem" **(AFAD, 2014; Türkmen Sanduvaç ZM, 2013**). According to AFAD survey 57.7% of Syrians find their housing conditions unsatisfactory in terms of size, 56.3% in terms of comfort, 55.3% in terms of climatic conditions and 21.0% in terms of security **(AFAD, 2014).** 43.6% of Syrians state they have no heating in their dwellings and those who have means of heating mostly use firewood **(AFAD, 2014).** The common problem in many dwellings is dampness

which is closely associated with such health problems as asthma, bronchitis, allergies and chronic pain **(Yılmaz H, 2013).** Further, congested spaces bring along the risk of air-borne and other communicable diseases (**Uçku R, 2008).**

Malnutrition that plays an important role in further spread of communicable diseases is one of the priority problems of Syrians in Turkey. The TTB survey in İstanbul found that Syrians refugees have only one meal a day which consists mostly of carbohydrates, weak in protein, micronutrient and vitamin intake and thus suffer serious weight losses **(TTB, 2014).** Another study by AFAD found that 74.7% of Syrians have no sufficient food-stuffs and 70.6% live in houses with no sufficient kitchen equipment **(AFAD, 2014).** According to a field survey by TTB a half of households have no means for cooking and the number of plates, glasses, forks and spoons per person is much lower than what is needed **(TTB, 2014).**

Access to safe water is closely associated with the quality of neighbourhoods and dwellings that people live in. The AFAD study finds that over 20% of Syrians face difficulty or extremely difficulty to get access to safe drinking water **(AFAD, 2014).** Insufficiency of bathing and toilet facilities are reported by many surveys **(TTB, 2014).** According to the same AFAD survey mentioned above almost 40% of Syrian refugees can hardly find soap while over 40% can hardly reach other cleaning materials **(AFAD, 2014).**Further, one in every two Syrian can hardly get diapers for children and other consumables needed by women **(AFAD, 2014).** For Syrians living out of camps, limited access to safe and hot water and associated difficulties in taking bath constitute environments conducive to the emergence and spread of infectious diseases.

Suggestions:

- There is a need to diversify employment opportunities for Syrians to find ways in which they can market their home-based products.
- Rent increases in urban centres must be controlled. In each neighbourhood a maximum rental must be set with respect to given environments and housing quality.
- Local authorities must identify unhealthy and insanitary dwellings for necessary improvements or, if not possible, provide other housing opportunities to their dwellers.
- Assuming that many refugees will not be able to return, the right to education must be guaranteed together with necessary curriculum adaptations.

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AN EVALUATION RELATING TO REFUGEES LIVING OUT OF CAMPS:
Health Status of Syrian Refugees Living in Streets in İzmir

Zeynep Sedef Varol, Cem Terzi, Zeynep Altın

Objective: As of the end of November 2015, there are 2,181,000 Syrian refugees in Turkey. 90% of refugees in Turkey live out of camps provided by the state and they either totally lack or have limited access to some fundamental rights as nutrition, housing, safe water, education and health. Of Syrians living out of camps, some temporarily stay in İzmir and other neighbouring provinces to cross the sea to reach Europe. The objective of this study is to assess the health status of these Syrian refugees in the context of social determinants of health and basic health services as they wait in İzmir for their expected transportation to Greek islands by human traffickers.

Methodology: This descriptive survey was conducted with 41 families staying in the yard of Çorakkapı Mosque in Basmane Square-İzmir who accepted to be interviewed, and information thus collected covers 207 persons. Qualitative and quantitative information was collected on 16 August 2015, during a public health survey by Bridging Peoples' Association by a team of 20 persons including health professionals, translators and reporters on the basis of a refugee household questionnaire form.

Findings: The survey covered 22 infants at age 0 to1, 55 children in the age interval 1-5 and 42 women in the age interval 15-49. Their origins include Aleppo, Idlib, Damascus, Daraa, Deir ez-Zor, Al-Raqqah and Kobani in Syria and their presence in Turkey range from 1 to 75 days, majority having arrived 7 to 15 days ago. The majority wants to head for Greece first and then to some European countries preferably Germany, Switzerland and the Netherlands.

They have their drinking water from marketed bottles or taps from municipal water supply network. Depending on individual means, food is from nearby restaurants or markets. Nights are spent on cardboards laid on streets with blankets, quilts and pillows which have limited availability. They use the toilet of the mosque by paying 1 TL(0.3 cents) in each visit and the toilet is in bad condition in hygienic terms. Thousands of refugees around use the same single toilet. Since it is not free, some refugees use open spaces. There is no facility for bathing and they do not take bath.

No infant immunization has taken place while they are in Turkey and there is no regular infant monitoring. According to oral statements made during the survey there are 6 pregnant women in their 2^{nd} to 8^{th} months of pregnancy. There has been no pregnancy check-up while in Turkey. There is no monitoring of women in the age interval 15-49 and no registry with the Family Doctor. There is no access to medicine except for those who can afford buying them from pharmacies.

Conclusion: It is a serious public health problem that conditions in the surveyed area are quite unhygienic. The condition of the toilet used as well as open defecation and urination constitute a risk of faecal-oral transmission of diseases. As far as sheltering is concerned, the fact is that refugees have to sleep on hard and cold ground which may lead to musculoskeletal system problems.

Since Syrian refugees are not covered by family medicine system they cannot benefit from infant, pregnancy and women (age 15-49) monitoring services. Syrians having no identity document fall into unlawful status.

In the context of social determinants of health (i.e. nutrition, sheltering, hygiene, education, etc.) there is need for a comprehensive intervention to the health status of Syrian refugees. Given the importance of preventive and first step health services in public health, Syrian population must be immediately provided access to these services. As to conditions of Syrians waiting for the next step in seeking asylum there is also need for some urgent and special interventions and measures. Firstly, decent toilets and baths need to be provided. In order to overcome concerns about security and absence of registration as the main barrier in accessing health services, mobile health services in the field should be delivered without need to declare identity documents. Steps should be taken to provide nutrition, including safe water and sheltering through mechanisms developed by governments, including provincial governorates and local municipalities.

REFUGEES AND SUMMARY OF THEIR WORK EXPERIENCE

Kuvvet Lordoğlu

For citizens of Syria who have been coming in since 2011 and mostly referred to as "guest", "asylum seeker" or "refugee", the word "migrant" is more appropriate. Mainly fleeing conflicts in their own country and seeking security, these people's participation to working life differs from that of irregular migrants. Findings we are going to present here are not related to other regular or irregular migrants but only to Syrians and they describe the status of Syrian citizens who at present stand as over 2 million in Turkey. To summarize briefly:

1. Syrian migrants entering Turkey in various ways mostly take part in labour force in provinces that they mostly concentrate in, a swell as other large cities. The leading provinces in this context include İstanbul, Adana, Mersin, Kahramanmaraş, Konya, Bursa, İzmir and Ankara. (**AFAD 2013**).Syrian migrants are lured by these provinces due to various factors including the following: Relatively greater employment generation capacity than other provinces in industry and services sectors; less visible state of those participating to labour force; easier and less visible ways of informal employment and relatively higher wages **(Akdeniz E, 2014)**.[1]
2. Syrians arriving Turkey at different dates join labour force shortly after their arrival. [2] The basic motive for having a job is their low income status and low wages they used to receive back in their homeland.[3]
3. In provinces where they are found in high numbers, Syrians join working life mainly through three different ways (**Lordoğlu K, Aslan M, 2015**):
    a. The first is being an employer by launching an independent enterprise. Participation may vary depending on the level of development of the province concerned. In such provinces as Mersin and Gaziantep, for example, there are many commercial and industrial enterprises started by Syrians. Also, there are quite a few Syrian migrants employed in these enterprises (**Ekovizyon 2014**).
    b. The second group of economically active Syrians are those engaged in crafts and shop keeping in their independent enterprises. This is mainly retail trade in foodstuffs accompanied by others including running coffee houses, barber shops, restaurants and jewelleries with some small capital they had brought along.
    c. Possibly the widest area of engagement for Syrian migrants is wage employment in enterprises. In this case they work not independently but under some authority in construction, agriculture, trade and industry.

[1]A study on this topic collects media news in the period 2013-2014. Akdeniz E., "Mülteci İşçiler", Evrensel Kültür Kitaplığı, 2014 pp. 105-140

[2] Outcomes of unpublished studies on Syrian workers and various interviews.

[3]At this point, low wage rate seems realistic relative to the types of work performed. It is stated that there is either no or only small wage differentials when skilled jobs are concerned.

4. For this last group, the basic problem for Syrian migrants is that they are paid about 50 per cent less than Turkish nationals, on average, varying by types of work performed. Still, the problem is not only low pay; there are cases where enterprises decline to pay anything in return for their work.
5. There are some Syrian migrants engaged in wage work especially in Şanlıurfa, Hatay, Antalya, Denizli and Polatlı (Ankara) as temporary seasonal agricultural workers and it is reported that they are paid 25 to 50 per cent less than Turkish nationals doing the same work **(Çağatay S, 2014).**
6. Their informal employment means they are not covered by any social protection scheme.
7. A regulation issued on 15.01.2016 arranges for "work permits for foreigners who are under temporary protection" (**2016/8375 No. regulation**). This regulation legally formalizes the employment of Syrian citizens in Turkey by having their work permits and thus prevents any payment lower than minimum wage. However, those engaged in farming and animal husbandry are left out of the scope of this legislation.

In conclusion:

Syrians in Turkey make up the largest group among all migrants in Turkey. Their labour force participation is largely manifested in informal and low-paid jobs. Agriculture, construction and services are the leading sectors in their employment. The presence of large numbers of Syrian citizens with no social protection and consisting mostly younger people including women and children and their status as the lowest paid group of mostly is perceived as a serious threat to working Turkish citizens as well.

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CASE STUDY: CHILD LABOUR IN REFUGEES

Yücel Demiral, Ergun Demir

In Işıkkent shoemakers' industrial site in İzmir, serious medical entities were observed among Syrian workers including children employed by some enterprises at the site. These workers were involved in using adhesives in shoemaking and cases were associated with these adhesives. There were some patients diagnosed as having polyneuropathy. However, although informed, and notified there was no intervention by competent health authorities. Applications by Syrian refugees with their complaints have been going on since then.

CASE

In the period June-July 2015, there were many consultations with the Syrian polyclinic of Public Health Centre in Bornova. These persons, that included child workers as well, complained about feeling exhausted, numbness in arms, fatigue and difficulty in walking that emerged within the last 2-3 months. This first cohort added that their workmates had similar complaints too.

The case was associated with adhesives used in shoemaking workshops, further aggravated by the fact that these indoor workshops had no ventilation systems. Workers said they work 12 to 14 hours daily at the site for about a year without any work safety and health service and they were not given medical check-up while being recruited. They gave the address of their workplace as a centre located at the shoemakers' site where small size enterprises employed 5 to 10 workers including many children.

Syrian refugees applied to the polyclinic were referred to various hospitals and 12 of them were diagnosed as having toxic polyneuropathy. It is quite a dangerous disease that may cause severe damage to nervous system and may result in irreversible sequels in some cases. Polyneuropathy is a disease causing loss of function in nerves and varying neurologic damages depending on this loss of function. In cases of polyneuropathy, weakness in arms and legs, numbness, burn and pain are typical symptoms; however there may also be some other effects including constipation, problems in urination and double vision. Urine analysis of some patients revealed 2, 5 Hexandion which is a metabolite of "n-hexane and methyl n-butyl ketone" used as adhesive. Methyl n-butyl ketone (CAS 591-78-6) is a substance well defined as a cause of peripheral motor polyneuropathy. Its intake is through inhalation and acute exposure in high doses lead to dizziness, sleepiness, narcosis and irritation in upper respiratory tract. In chronic exposure there may be polyneuropathy and compression in cranial nerves. Other signs include weakness in legs in particular, hyposthenia and loss of reflex in achilles tendon. The progress of the disease is slow and symptoms may persist for two years after exposure. Yet, some symptoms may be persistent.

However, these patients were not referred to specialized occupational health facilities to be examined in the context of occupational diseases. In spite of written and oral reports to authorities, no further step was taken except medical treatment. Health treatment costs of Syrian refugees under temporary protection are covered by the Provincial AFAD (Disaster and Emergency Management) Directorates. However, health is not limited to "medical care" in its wider sense. Social and economic status of individuals, housing condi-

tions, physical environments and their working conditions are all important determinants of health. Especially, working conditions have their direct bearing on health and well-being of individuals.

Ages of patients vary from 14 to 36. Without any kind of social protection, these refugees try to get a hold on life, in conditions of unemployment, exploitation, hunger and poverty, in addition to their traumatic experiences of conflict and process of migration. Children, adolescents, adults, Syrians from all ages are employed informally as if slaves in sweatshops without any safety measure and social protection, which leaves them prone to health problems. Since Syrians in Turkey yet have no official permit to work, they are employed illicitly and thus have no official recourse in case of violations.

As understood from patients covered so far, Syrian refugees also face the problem of child labour, which is prohibited by national and international legislation and conventions, hence, the adoption of relevant measures is essential in terms of both avoiding serious occupational diseases, bonded labour and eliminating child labour. Without such measures, sweatshops exploiting cheap labour, will continue their activities, causing further ill health and disability in workers.

HEALTH PROBLEMS OF REFUGEES

EFFECTS OF CONFLICT IN SYRIA, TURKEY AND IRAQ ON COMMUNICABLE DISEASES IN THE REGION

Muzaffer Eskiocak, Bahar Marangoz, Nilay Etiler

This essay focuses on eradication and elimination programmes implemented at international level and measles, poliomyelitis and cholera that are particularly visible due to importance attached under the International Health Regulations. Although there is increased morbidity and mortality as a result of devastation brought along by armed conflict, acute respiratory infections (ARI) and such infectious diseases as diarrhoea and TB will not be addressed since they are not monitored in the same context and there is absence of relevant data, To what extent data presented here reflect the reality of countries experiencing conflict and violence visible is a matter of serious debate.

Table 1: Change in Protective Health Services and its Outcomes in the Conflict Zone

	Change in Protective Health Services		Outcomes of Insufficiency		
	Immunization Coverage	Sanitation, safe water	Vaccine-Preventable Diseases (Total)	Waterborne Diseases (cases of)	Vector-borne Diseases (cases of)
Period covered	2012-2014	2010-2015	2012-2014	2015	2012-2014 for malaria 2011-2013 for Leishmaniasis
Turkey	Measles from 96% to 94% Polio3 from 97% to 96%	Sanitation: from 93% to 95% Safe water: from 99% to 100%	Measles: 8319 Polio: 0	Cholera [unknown]	Malaria: from 374 to 249 C.Leishmaniasis: from1803 to 2618 V.Leishmaniasis: from 30 to 33
Syria	Measles from 78% to 71% Polio3 68%	Sanitation: from 95% to 96% Safe water : from 90%	Measles: 1347 Polio: 35	Cholera 1 mortality (26 October 2015)	Malaria: from 42 to 21 C.Leishmaniasis: from 58156 to 71996 V.Leishmaniasis: from 18 to 30
Iraq	Measles from 83% to 71% Polio3 from 79% to 76%	Sanitation: from 83% to 86% Safe water: from 85% to 87%	Measles: 2001 Polio: 2	Cholera 2810 (15 September-22 November 2015)	Malaria: from 8 to 2 C.Leishmaniasis: from 2978 to 1648 V.Leishmaniasis: from 1167 to 575

Poliomyelitis

While the last case of polio was registered in Syria back in 1999, 35 cases were detected after importation of the virus from Pakistan (**EMRO 2016a**). In Iraq, where the last polio case was spotted in 2000, two new cases emerged as associated with the outbreak in Syria in 2014 (**EMRO 2016b**).

Table 2: Distribution of Poliomyelitis immunization and cases of polio in the conflict zone

	No. of Cases)			Pol3 Immunization Coverage (%)		
	Turkey	Syria	Iraq	Turkey	Syria	Iraq
2003	0	0	0	69	99	58
2004	0	0	0	85	99	80
2005	0	0	0	90	99	83
2006	0	0	0	90	99	76
2007	0	0	0	96	99	85
2008	0	0	0	96	99	80
2009	0	0	0	96	99	86
2010	0	0	0	97	99	83
2011	***0***	***0***	***0***	***97***	***91***	***89***
2012	***0***	***0***	***0***	***97***	***68***	***79***
2013	***0***	***35***	***0***	***98***	***80***	***79***
2014	***0***	***0***	***2***	***96***	***68***	***76***

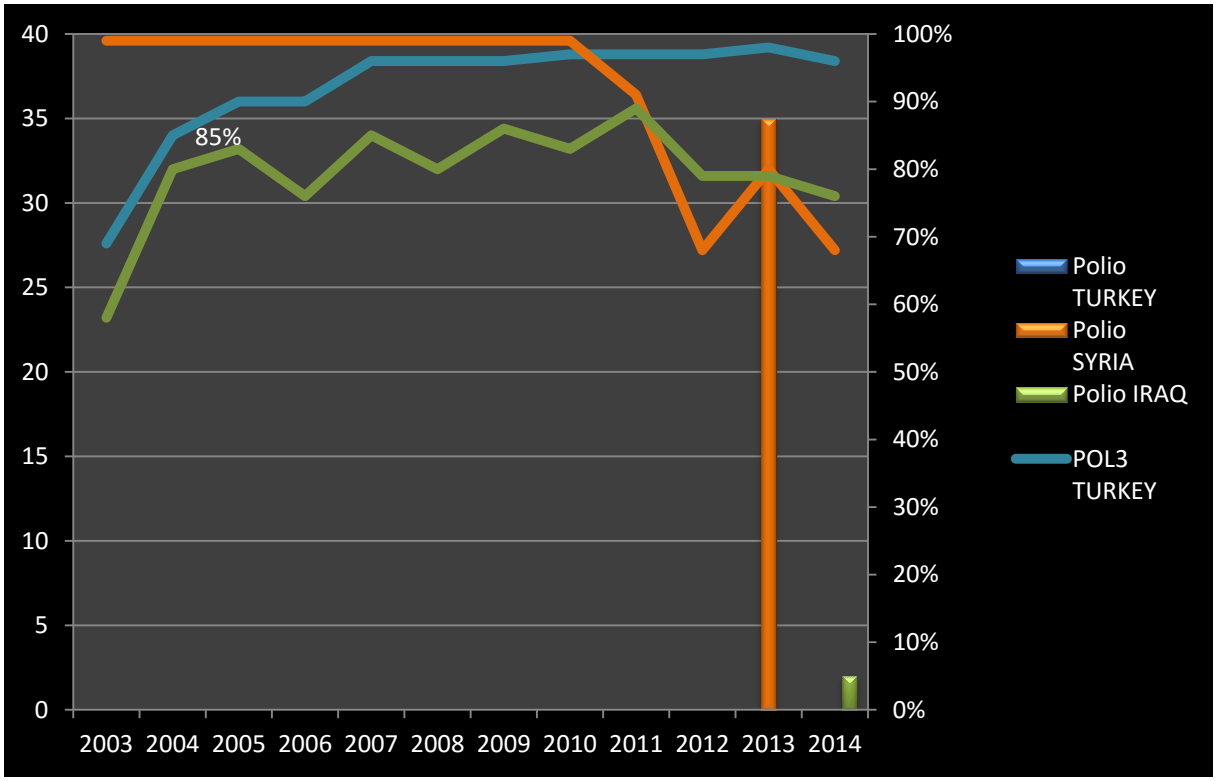

Figure 1: Primary immunization for **Poliomyelitis** and distribution of polio cases in the conflict zone

Measles

The number of measles cases in Turkey had fallen down to one-digit figures in the period 2007-2010 as a result of Measles Elimination Programme and compulsory lab evidence in defining standard cases. However, starting from 2011, that is before the start of civil war in Syria, measles cases started to rise again turning into an almost incessant outbreak. The reason of this rise is considered as Turkey's shift in the model of first level health services (transition to family doctors model) and abandonment of community based health service delivery which led to reduced prevention and response capacity. Following the fall in rates of immunization in 2012, there were outbreaks in Syria and Iraq in 2013.

Due to its high morbidity and mortality, measles is a real concern particularly in emergencies and extraordinary situations. Yet, we do not have detailed information concerning the outcomes of measles outbreaks (in refugee camps and in refugees out of camps).

Table 3: Distribution of measles immunization and cases of measles in the conflict zone

	Number of Cases			Measles (MCV1) Immunization Coverage (%)		
	Turkey	Syria	Iraq	Turkey	Syria	Iraq
2003	5844	801		75	98	68
2004	8927	189	9081	81	98	93
2005	6200	375	908	91	98	85
2006	34	517	474	98	98	78
2007	3	403	230	96	98	80
2008	0	19	5494	97	98	91
2009	4	22	30328	97	99	97
2010	7	26	492	97	99	89
2011	111	13	15	98	97	91
2012	***349***	***13***	***15***	***96***	***78***	***83***
2013	***7405***	***740***	***669***	***98***	***83***	***77***
2014	***565***	***594***	***1317***	***94***	***71***	***71***

Here, it must be noted that the rate of immunization for Measles and Polio given as 98% by WHO is not consistent with the findings of Turkish Demographic and Health Survey carried out every five years over a representative sample (Table 4)

Table 4: Immunization status of 15-26 months old children by source of information, TDHS 2013

Source	DaBT-IPV-Hib			*MMR*	No immunization	Fully immunized
	1	2	3			
Immunization Card	74	74	73	***69***	0	63,6
Self-reporting	20	15	14	***21***	2,9	10,5
Both	94	89	86	***90***	2,9	74,1
Immunized when < 15 months	94	89	**84**	***90***	**3.0**	70,0

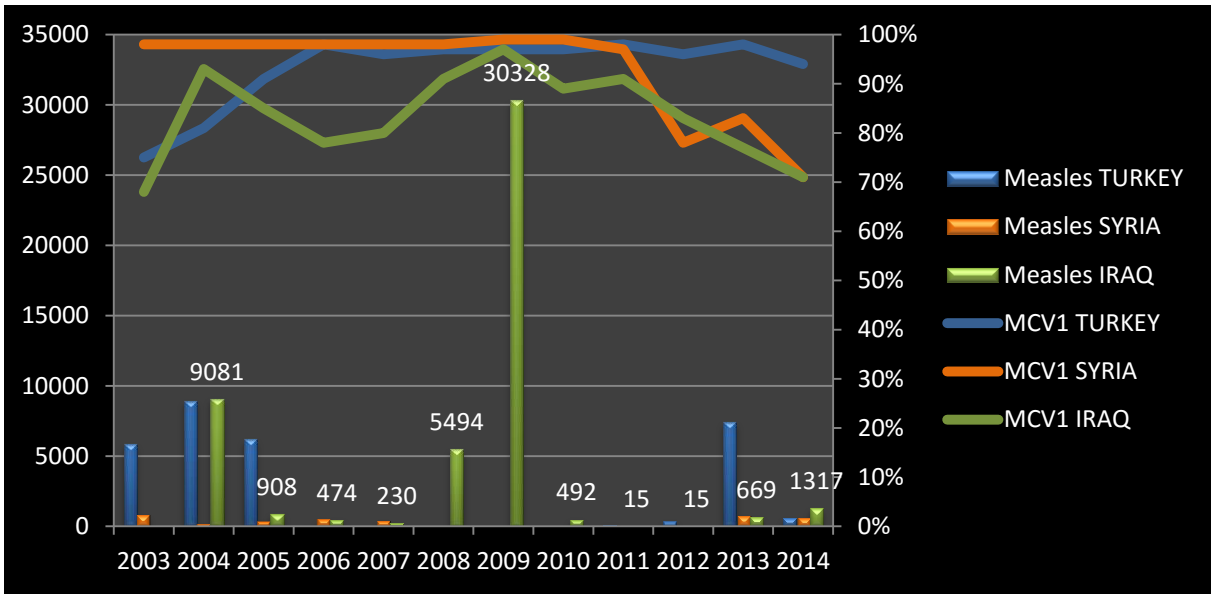

Figure 2: Distribution of measles immunization (MCV1) and measles cases in the conflict zone.

From the onset of the outbreak, the Turkish Ministry of Health claimed that cases of measles were "imported" (Table 5) while the Turkish Medical Association (TTB) kept making its critical and constructive suggestions (**TTB 2011; TTB 2012; TTB 2013**).

Table 5: Distribution of cases of measles in Turkey according as reported by the Ministry of Health and WHO European Region

	2015		2014		2013		2012		2011		2010	
	MoH	**CISID**	MoH	**CISID**	MoH	**CISID**	MoH	**CISID**	MoH	**CISID**	MoH	**CISID**
Measles		**342**	**-**	**531**	**6731**	**7406**	**318**	**349**	**0**	**105**	**0**	**15**
Imported Measles			**-**	**0**	**674**	**0**	**31**	**0**	**111**	**11**	**7**	**8**

MoH: Ministry of Health, Yearbook of Health Statistics

CISID: Centralized Information System for Infectious Diseases

Cholera

The outbreak starting in Iraq on 15 September 2015 reached 2,810 cases as of 22 November 2015. Given mass population movements from Syria-Iraq to Turkey, vulnerability of displaced persons, collapse of water supply and sanitation networks, excessively crowded living environments and further weakened health services, wider spread of the disease in the conflict zone may be expected.

In the region where the culture of warfare reigns at present, the lack of political will for life and health poses a great problem also in terms of health threats other than what is addressed above (**Independent 2015b; AA 2015**).

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PROBLEMS OF WOMEN

Nuray Özgülnar

The visibility of women in the context of problems related to refugees has increased as more women are involved in irregular migration processes. Children and women constitute the most vulnerable group in times of armed conflict and migration and negative effects of these processes are felt most heavily by this group. Hence, women and children have special protection needs relative to adult male refugees. They must be protected, in particular, from sexual and physical abuse, exploitation and discrimination in the distribution of relief materials and services. While the status of women may be low in countries of origin, gender-based problems start to come to the fore in countries of destination.

Particularly in the age group 15-49, women may face risks of morbidity and mortality due to their gender as they become pregnant and give birth, which are in fact normal physiological and social processes. This means they are in need of special health care. Health care that women receive especially in this period and quality of this care has its bearings on their life and their future state of health. The situation of female refugees is even more critical since satisfaction of their health needs are at a much lesser level than the indigenous population.They often have much lower access to such protective health services as family planning and immunization. Unwanted pregnancies, delivery in unfavourable environments without qualified care and maternal mortality are more common in these women **(Carbolla & Nerukar, 2001).**

Access to reproductive health services:

We have limited, in fact quite insufficient data about the health status of female refugees in Turkey (especially those from Syria which constitute a much larger group) including information on reproductive health. As it is the AFAD that funds health services, we have information only about the number of births. We find, in this context, from the relevant website that there are daily 128 births adding up to 70,728 **(AFAD, 2015).** However, there is no information as to how and where these deliveries take place and their consequences. Still, we can find more detailed information from the regional monthly reports of the UNFPA on the Syrian crisis. According to this source, out of 2,154,826 Syrian refugees in Turkey 538,707 are women at their reproductive ages and 34,320 of them are pregnant **(UNFPA, 2015a; UNFPA 2015b).**

The 2014 report by the Disaster and Emergency Management Authority (AFAD) on Syrian women in Turkey is important in that it is the result of a survey conducted among women and it provides some implications. It is interesting, in this report, that 78% of women replied negative to the question *"Do you have food enough for the next 7 days or money to buy this food?"* It must be noted, however, that the report is based upon the "satisfaction of refugees for being able to get all health services they need" instead of women's statements about their poverty and difficulties of subsistence.

There is presently no information about the status and needs of Syrian refugees with respect to reproductive health, family planning, ante and postnatal care, vitamin and micronutrient deficiencies, miscarriage, unwanted pregnancies and birth complications **(AFAD, 2014).** This AFAD report, however, mentions some problems related to the

status of women and problems they face as confirmed by some other surveys. The leading problems in this context include early marriages and pregnancies as young as 13-14 years of age. According to the TMA (Turkish Medical Association) report "Syrian Refugees and Health Services" refugee women say they have received no assistance in these aspects while they were in Turkey. They further state that they are told "no such services are delivered" when they consult community health centres and public hospitals **(TMA, 2014).** As the stay of Syrian refugees in Turkey gets longer and longer it is possible to say that this problem will continue and even get worse.

A study on Syrian women staying in Şanlıurfa found that 26.7% of women never cosulted any healthcare facility or staff while pregnant, 47.7% experienced miscarriage or stillbirth while in Turkey and that 36,4% of responding women had unmet family planning needs **(Şimşek et. al., 2015a)**. According to the same study 50% of women suffer iron, 45.6% B12 and 10.5% folic acid deficiencies; 78.4% of women have deficiency in any one of these **(Şimşek et. al., 2015b)**.

In countries of destination, refugee women frequently face almost all forms of sexual violence (i.e. sexual assault, harassment, forced marriage, polygamy, etc.)

UNFPA reports state that so far 2,667 women have been given counselling services in reproductive health and 571 in gender-based violence while there are 17 women who have suffered sexual violence (**UNFPA 2015a; UNFPA 2015b**). Another finding is that polygamy with Syrian women and marriage brokerage turn out as a way of seeking material gain. Males who want to get married resort to middlemen and pay them for it. Having their daughters married is regarded both as a way of making money and guaranteeing the future of their daughters by some Syrian families. But another dimension of the problem is the abuse of female children since there are children among Syrian refugees who were given as brides (**Orhan and Gündoğar, 2015**).

Another report by MAZLUMDER points out that the spread of short-term marriages and prostitution bring along the risk of sexually transmitted diseases. Another form of abuse that Syrian women are exposed to is that they are forced or find no other way but becoming a part of polygamy practices even at early ages. While Syrian women are forcibly employed in prostitution sector at much lower pay in all provinces they live in, there are also serious reports, assertions and judicial cases showing that they are made subject to excessively abusive practices including being used as sex slaves by human traffickers (**MAZLUMDER, 2014**). While organizing and delivering counselling services to Syrian refugees including women who have experienced torture, assault and all forms of abuse utmost attention must be paid to their safety and privacy.

Another aspect of the issue is internally displaced persons who are considered in the context of internal migration. Since internally displaced persons are often mixed with settled populations in urban centres and other places it is quite difficult to obtain information about their numbers and violations they encounter. Still, it can be safely said that such factors as social fragmentation, temporary sheltering, limited resources and lack of security further increase risks especially for women and female children and expose them to gender-based violence (**IDMC, 2015**).

Ensuring full, equal and quality access to health services that refugee women need/may need is essential for the realization of women's human rights.

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SEXUAL VIOLENCE

Şevkat Bahar Özvarış

Gender-based violence, particularly sexual violence as its most dangerous form is one of the most important problems threatening the safety and lives of women and young female children especially in environments of armed conflict and acute crisis. In this context, prevention of and intervention to gender-based violence is directly associated with the protection of human rights (1). Gender-based violence is a form of violence used against a person on the basis of roles attributed to males and females by the society and stereotypes (gender stereotypes) or sexuality (2,3). Gender-based violence comprises acts that are physically, emotionally or sexually harmful and painful for another person as well as other related situations where persons are threatened, pressured or deprived of their freedom (2). There are different types and forms of violence including physical, emotional, sexual, economical and harmful traditional practices.

Sexual violence is defined as "any sexual act, attempt of a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (2,3). Sexual violence may assume many forms among which there is assault, sexual slavery and/or prostitution, sexual harassment, sexual abuse and forced miscarriage (2,3).

Worldwide, sexual violence is used as an instrument of war in almost all conflict zones. This form of violence often manifests itself as assaulting or attempting to assault women and forcing women for sexual intercourse. Beyond physical outcomes, sexual violence has its adverse effects on emotional health and well-being of victims (4).

Since the start of conflict in Syria, it is estimated that some 6,000 women have been assaulted (4). It is publicly known today that ISIS bands in northern parts of Syria and Iraq abducts many women, sell or force them into marriage, and that there are many women and girls who have been raped. It is reported that the incidence of victimization of women by harassment, assault or sexual violence is as high as 30% in conflict zones. It is added that in these zones women suffer more than one form of violence. Besides suffering violence, it is also observed that there are some women who resort to violence and take part in armed groups though not as combatants.

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PROBLEM OF NON-COMMUNICABLE DISEASES IN SYRIAN REFUGEES

Emel İrgil

Irregular and suddenly emerging migration movements often bring communicable diseases to the fore as a major problem. However, as we witness in the case of Syrian refugees, many non-communicable diseases including diabetes that they had earlier and anaemia which is associated with their living conditions turn out as problems, as refugees start to settle though temporarily, in terms of diagnosis, treatment and monitoring. Further, difficult living and unfavourable environmental conditions lay the ground for the emergence of new non-communicable diseases. It is a fact that non-communicable diseases are often neglected though they constitute a serious economic burden if they go untreated.

Hypertension, diabetes mellitus, ischemic heart disease, MS, kidney failure, cancer, anaemia, depression, schizophrenia, etc. are worldwide examples of non-communicable diseases and Syria as well as Syrian refugees in Turkey are no exception to this. According to data provided by the World Health Organization (WHO) age-standardized mortality rates (per 100,000 population in Syria were as follows in 2012: For all non-communicable diseases together: 572.7 (467.7 in females, 682.2 in males); cardiovascular diseases: 375.6 (299.2 in females, 455.0 in males), all types of cancer: 111.8 (99.0 in females, 125.4 in males), chronic obstructive pulmonary disease: 23.7 (17.2 in females, 30.6 in males) and diabetes mellitus: 9.9 (9.6 in females, 10.3 in males) **(WHO, 2012)**. According to WHO estimates, 6% of Syrian refugees in Jordan have diabetes **(WHO, 2016)**.

There is no data on non-communicable diseases among refugees in Turkey. Leaving aside a few small-scale ones, there is yet no screening programme developed. The survey conducted by Şimşek and colleagues in February-March 2014 in Urfa found that three out of each four women had iron, B12 or folate deficiencies **(Şimşek Z ve Ark, 2015)**. Such states caused by migration-related malnutrition are true not only for women but for children and adult males as well.

30 to 40% of capacity of hospitals located in our border provinces is used for extending services to Syrians. In some provinces other than those along the border, units extending polyclinic services have been launched as "Refugee Polyclinic" within Community Health Centres. While majority of consultations to these facilities is for communicable diseases, there are also others calling at for non-communicable diseases and pills.

While care and medicine needs used to be met in Syria through the programme for preventing non-communicable diseases which was integrated with first level services prior to civil war, now the treatment of persons having these diseases neglected and related complications may emerge. Since they are in constant need of medication and care, refugees having such problems must be provided urgent access to health services.

In general, preventive health services to refugees are delivered by Public Health Directorates. Family doctors have the duty of examining persons with "Foreigner Identification Cards" and the status of "temporary protection". Doctors may prescribe for these persons. But the cost is covered only for registered refugees. Registered refugees are entitled

to benefit free health services and can take their medicines from contracted pharmacies. When there is full compliance with the referral chain 80% of the cost of medicine is covered by the Disaster and Emergency Management Authority (AFAD) while the patient pays for the remaining 20%. Otherwise, all costs have to be borne by the patient. To ensure the smooth working of the mechanism, the AFAD and the Chamber of Pharmacists are engaged in a protocol. Under this protocol; the cost of prescribed medicine is billed to the AFAD.

In case of inpatient care, all costs including diagnosis, medicine and surgery are covered by the state.

Problems and suggestions for solution:

- Translation services: In each hospital or polyclinic, there must be a person on duty speaking Arabic/Kurdish.
- Absence of official registration: Registration is a must to be able to benefit from all rights and services that refugees are entitled to.
- Failure in using family doctors effectively: Refugees must be informed about health services that they can benefit from.
- Family doctors' failure in registering refugees: In order to avoid any discriminatory attitude, family doctors too must be informed about services that can be delivered, rights and responsibilities.
- Not covering the cost of medicine (prior to the latest circular, the implementation of AFAD articles related to medicines provision had varied by provinces): Reimbursement of costs of medicines must be made uniformly according to the AFAD Regulation in all provinces.
- Changes in residence: For registered refugees to benefit from the AFAD Regulation there must be re-registry with the Provincial Directorate of Migration Management in a newly settled province.
- Social support: Episodes of health service delivery alone may not be sufficient. In order to avoid malnutrition related disorders like anaemia, vitamins must be included in urgent health aid deliveries particularly for women and children.

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HUMANITARIAN CRISES, REFUGEE PROBLEM and PRIORITIES IN NUTRITION

Dilek Aslan

Humanitarian crises denote a complex situation where basic needs essential for life can hardly be met. Mass displacements as well as migrations, epidemics, natural disasters such as earthquakes and floods, armed conflict, drought and famine are the leading humanitarian crises observed in recent decades **(Huber and Reid, 2015).** In each of these situations, normal life course of people is interrupted and there emerge difficulties in meeting such basic needs as food and shelter. It is reported that in 2015 there are 795 million people worldwide fighting hunger. In other words, hunger is a problem for one in every 9 in the world **(WFP, 2015b).** Hunger means simply food intake that is below the calorie level required for normal activity of an individual **(WFP, 2015a).**

What is the daily calorie and protein needs of an individual?

Though daily calorie and protein need of an individual varies by such factors as age, sex, body structure, physical activities engaged in, climate and seasonal conditions, normally a daily calorie intake of 2,100 kcal, on average, is necessary for a normal life **(WFP, 2015b).**

Which nutrition problems come to the fore in refugee crises?

The problem related to the influx of Syrian refugees which closely affects Turkey must be addressed in the context humanitarian crisis mentioned above. Among numerous problems that refugees are confronted, those related to nutrition have their specific importance. There is mention of food insecurity when basic nutrition needs are not or cannot be satisfied. In contrast, the term "food security" is defined at the 1996 World Food Summit as "when all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life" **(Ghattas et. al. , 2015; WHO, 2012).**

Hence, food insecurity is a problem having priority during humanitarian crises including those related to refugees. Other nutritional problems emerging during similar situations are outlined below **(Hadley and Sellen, 2006; Rondinelli et. al., 2011; UNHCR, 2014)**:

1. Lack of food security (food insecurity)
2. Lack of access to safe water and emergence of associated diseases
3. Problems related to food safety
4. Malnutrition (micronutrient deficiencies, anaemia, etc.)
5. Unbalanced nutrition
6. Failure to provide appropriate feeding in case of chronic diseases

The most important risk factors with respect to food insecurity include unemployment and low socio-economic status **(Abdollahi, M., et. al., 2015).**

As far as nutrition is concerned, all refugees are under risk. Still, **infants, children, elderly persons, pregnant women** and **women** in general make up especially vulnerable groups needing specific attention. For instance, acute malnutrition was observed most frequently in under five children living in camps in 2012. This is also associated closely with high mortality **(UNHCR, 2014).** There are two basic reasons for high prevalence of acute malnutrition in refugees. The first is lack of access to sufficient amount of safe food (food insecurity). The second is the disruption of nutrition/diet routine due to environmental problems or other health problems (i.e. communicable diseases, diarrhoeal diseases) **(Hanquet, 1997).**

Recent studies conducted in Turkey highlight that nutrition problems among displaced populations deserve special attention. According to the cross-sectional study by Şimşek et. al. covering 458 Syrian women in the age group 15-49, 93.4% of respondents stated that their primary problem is nutrition related **(Şimsek et. al., 2015a).** The same study found that 50% of women had iron, 45.6% had vitamin B_{12} and10.5% had folic acid deficiency and the incidence of deficiency of any of these is 78.4% **(Şimşek et. al., 2015b).** Özkahraman and colleagues examined the prevalence of acute and chronic malnutrition in children aged 6 to 10 living in a tent camp. According to this cross-sectional study in which weight for age index was calculated 7.9% of male children are underweight, 5.3% are extremely underweight and 3.5% are overweight. Figures for female children are, respectively, 21.9%, 2.3% and 3.8%. As to height for age, 10.6% of males are stunted and 2.2% are extremely stunted while corresponding figures for females are 20% and 2.4% **(Özkahraman et. al., 2015).**

What should be done?

- The state of health must be checked regularly and updated. Assessments related to acute malnutrition (weight for height) have special importance in cases of displacement. Checking for anaemia has also priority in such situations **(Bilukha et. al., 2014).**
- There is need to develop urgent intervention programmes to respond to immediate needs. There are two important priorities in this context:
    - There must be food supply sufficient to ensure that individuals have intake of 2,100 kcal/day at minimum.
    - Treatment programmes must be implemented to prevent malnutrition and malnutrition related complications and mortality.
- Food security must be provided.
- There must be continuous training and advocacy work to ensure that children are breastfed.
- Information building in issues related to food security.
- It is also important that trainings are tailored to the dominant culture **(Fabio, 2014).**

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CONCEPT OF DISABILITY and DISPLACEMENT

Dilek Aslan

In its definition, the term disability is a general framework covering impairment, activity limitation and participation limitation. "Limited participation" refers to poor socialization and social participation. It would be a flawed approach if this concept is regarded exclusively as a health problem. Instead, the concept should be perceived as a complex state of affairs embracing interaction between an individual and society **(WHO, 2015; Barker, 2008; ICF, 2004; Aslan, 2015).**

It is reported that there are over 1 billion persons with disabilities in the world. This means people with disabilities constitute 15% of the world population. Further, 2 to 4% of this group has serious dysfunction **(WHO, 2011).**

When it comes to displacements experienced by individuals and communities due to human made situations (war, hunger, famine) and/or natural disasters there are some priority groups. Referred to as "vulnerable" in some sources, these groups include persons with disabilities as well **(Wu et. al., 2015; Lima et. al., 2009).**

There are persons with disabilities among Syrian refugees in Turkey **(Baş et. al., 2015).** A cross-sectional community-based survey conducted in Bursa in 2014 found the share of persons in total population is 1.1%. The same survey found that in 1.6% of household there is one bedbound member **(Kalkan et. al., 2014).**

Disability may deem it more difficult for persons to adapt to extraordinary circumstances while they face some specific problems associated with their disability. Yet, the Convention on the Rights of Persons with Disabilities (2006) establishes in its Article 25 that these persons have the same rights as other persons in access to health and other services **(UN, 2006).**

In case of emergency or extraordinary situations, persons with disabilities may face some special risks **(Tanabe et. al., 2015; Bogenschutz, 2014):**

1. Lack of access to health services
2. Lack of access to correct information on health facilities and relevant services
3. Violence (sexual, physical, etc.)
4. Neglect and abuse
5. Not being able to use means of transportation
6. Lack of access to rehabilitation technology
7. Situations threatening psychological health
8. Problems in cultural adaptation

In extraordinary circumstances health persons too may face newly emerging disabilities and stand in a specific category in the spectrum of disabilities. For instance, while persons wounded in armed conflict are expected mainly to have some physical problems, there may also be mental/psychological disabilities (**Palic et. al., 2014).** It is known that people experiencing/exposed to armed conflict, refugees and internally displaced

persons frequently develop such psychological problems as anxiety, post-traumatic stress syndrome and depression which increase the frequency of disabilities **(Makhashvili et. al., 2014).**

An individual's right to health should be ensured at highest possible level regardless of whether disability emerges as a result of extraordinary circumstances or existing prior to such circumstances. In this context, the UN Convention (2006) is a fundamental document all of whose requirements need to be met. **(UN, 2006).** Reserving for this, advocacy efforts in the context of public health should focus on the elimination of factors causing displacement of people. If the case is that, some disabilities may emerge in armed conflict, there is need to ensure that there is no war and to eliminate all factors that may lead to it. It must be borne in mind that other solutions can be only temporary and palliative unless this base is ensured. Nevertheless, it is necessary that short, medium and longer term solutions are needed and should be developed for persons with disabilities.

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PROBLEMS OF CHILDREN

Mehtap Türkay

Introduction

Migration movements to Turkey have increased in recent decades due to political and military strife in the region and especially armed conflicts surging after 1980. These movements can be described in two ways:

1. Regular or legal movements of people: This is movement with the permission of the state concerned where migrants are registered for purposes of employment, education and so on.
2. Movements that are "illegal" or "irregular" (**Şahin İ, Düzgün O; 2015**).

There are refugees-asylum seekers in Turkey coming from many countries; but presently Syrians constitute the largest group. According to the statement of Deputy Prime Minister Akdoğan there are 2,541,000 Syrian refugees in Turkey (**Sol; 2016**). According to different sources, however, there are about 4.5 million Syrians either staying in Turkey or moved to other countries via Turkey. This means that about 1.5 million Syrians are not registered. Assuming that the age composition of Syrian population is similar to that in Turkey, there must be at least 1,125,000 Syrian children in Turkey in the age group 0-14. Further, there may be refugee children separated from their parents or moving as unaccompanied. This makes it difficult to give figures for migrant children (**Atasü-Topçuoğlu R; 2014**).

There are many studies confirming that the process of migration may have its effects on the fundamental determinants of health and that migrating groups have high incidence of risky behaviour including smoking, consumption of alcohol and high calorie feeding habits (**Hyman, I., Guruge, S;2002**). Migration affects adults, children, males, females and elderly people experiencing this process at varying levels and degrees.

The present paper will discuss the effects of migration on child health and try to suggest some solutions.

Effects of Migration on Child Health

Communicable Diseases

Communicable diseases constitute one of the most frequently observed health problems among refugees. Absence of such basic health services like immunization among irregular migrants may lead to epidemics in their destination countries as well. A study conducted in İstanbul interviewed 51 Syrian families (248 persons) and found that 50% of this group is children in the age group 0-9. Other findings are as follows: 99.6% of migrants have no passport and identity documents and consequently no health insurance; none of school-aged children are enrolled to school; there are 4 children presently employed and only 8.5% of children in the age group 0-15 have their vaccination cards (**Esin N.M et. al., 2014**).

Another study on cases of measles observed in Batman in January-May (**Yetiz P; 2013**) examined samples from 401 children of whom 141 were diagnosed as having measles. 26% of these children (48 children) were from Syria. While the rate of seropositivity is

39.2% for Turkish children it is 88.8% for refugee children from Syria. Refugee children having no registry with family medicine services make up a pool of non-immunized.

Child Labour and Child Abuse

The Police Academy Centre of Criminology Researches (SAMER) organized a symposium in Antalya on 11-13 December 2015 to discuss the issue of "sexual abuse of Syrian refugee girls in Turkey". It is stated in this symposium that Syrian women and girls in camps fall prey to traffickers and there is widespread practice of having Syrians girls as second wife through religious marriage where the age of girls could be as small as 11-12. It is further stated that there is prostitution and trade in women and girls as young as 12 under the cover of official marriage (**SAMER, 2015**).

Child labour is in rise in provinces where the number of Syrian refugees is high. Due to deep poverty, Syrian children suffer severe violations of their rights. The sectors where child labour is observed more frequently include textiles, construction, services, seasonal agricultural works and sheep herding. Without any job security or social protection these children are open to exploitation by their employers (**Atasü-Topçuoğlu R; 2015**).

Lack of Access to Health Services

According to a study conducted in Bursa only 17.1% of refugees consult health facilities when they have any health problem. The reasons for not using health facilities include lack of money (31.6%) and problems in communication due to language (26.3%). 25.2% of infants and children aged 0 to 5 in households are followed for their health status, but 40.4% of these children have missed their vaccinations. (**Kalkan O et. al., 2015**). According to another study in Konya the leading cause of not having access to health services is language problems and the attitude of family doctors not registering refugees (**Kara F, Akgün N; 2015**).

Though there are problems varying by provinces and districts they presently live in, refugee children still have common problems of adequate shelter, food and health. There are further problems including cultural adaptation, social exclusion and exclusion from education opportunities. There is no social support and protection mechanism for children living out of camps. Their rights to health and education are presently violated.

In sum, the problem areas identified in relation to refugee children are:

1. A large proportion of children living out of camps is not registered and thus cannot benefit from health services.
2. There are serious problems in access to health services.
3. No immunization can be made since they have no immunization cards.
4. There is serious risk of communicable diseases for refugee children in unfavourable housing conditions.
5. Child labour is spreading among refugee children.
6. Child abuse and child marriages are also becoming more common. There is sale and trafficking of Syrian girls.

Suggestions for Solution

There is need to keep the record of children living out of camps in Turkey. Their registry with family medicine system is important in terms of health monitoring and immunization.

Barriers to benefiting from health services must be removed. Also, for the realization of the right to education, 12-years long compulsory education system must be restructured so as to cover Syrian children as well.

Refugee children must be included in programmes targeting the elimination of child labour. Child labour is a problem of Turkish children as well. As child labour is a problem getting more serious for refugees, there must be measures to limit flexibility and deregulation in labour markets.

In particular, sexual abuse of girls and gender based discrimination must be prevented. No girls must be traded as a commodity. This requires joint work by the security, social services and health sector.

Language is one of the most pressing problems confronted by refugee children and their families. Hence, it is important to appoint public servants who can speak their language for Syrians living out of camps.

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HEALTH SERVICES DELIVERED TO REFUGEES AND PROBLEMS FACED

LEGISLATIVE ARRANGEMENTS IN THE FIELD OF RIGHT TO HEALTH

Mehmet Gülay

Clashes that started in Syria in March 2011 rapidly spread to the country assuming the form of civil war and consequently millions of Syrians had to leave their homes and even their country. An important part of this outflow of Syrians headed for Turkey which had to take measures for the protection of these refugees. Following these migration movements some legislative arrangements had to be made relating to the rights of refugees. One of them is the right to health which, in line with the definition made by the World Health Organization (WHO) in its Constitution of 1946, cannot be demarcated from arrangements in other spheres of life: "A complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity" (**World Health Organization, 2006**)." This paper addresses legislative arrangements pertaining to the right of Syrian refugees with respect to both protective and curative health services.

The UN Convention on the Legal Status of Refugees was opened to signing in 1951. Since Turkey acceded to this Convention with some geographical reservations only persons coming from European countries can be given refugee status **(Yavuz, 2015**). Hence, refugees from Syria cannot apply for this status. Nevertheless, these refugees were taken under "temporary protection" starting from 28 April 2011 in line with the Temporary Protection Regulation issued in the official Gazette no. 29153, dated 22 October 2014, which finds it basis in Article 91 of the Law no. 6458 on Foreigners and International Protection. According to the Regulation, "services to persons under temporary protection" organized by relevant ministries and agencies are to be delivered under the coordination of the Prime Ministry Disaster and Emergency Management Administration (AFAD) The primary responsibility in service delivery in provinces rests with provincial governors (**Council of Ministers, 2014**).

On the basis of the Regulation mentioned above, health services to persons under temporary protection are arranged for by two official documents: The AFAD Communique no. 2014/4 dated 18 December 2014 on Services to Foreigners under Temporary Protection, and Directives by the Ministry of Health on Principles Governing Health Services to Persons under Temporary Protection issued upon approval no. 2875 and updated on 4 November 2015.

General Principles

On the basis of these documents, general principles relating to services to be extended to persons under temporary protection are as follows (**Prime Ministry Disaster and Emergency Management Authority, 2014**) (**Ministry of Health, 2015**) (**Council of Ministers, 2014**).

1. Health services: Persons under temporary protection owning identity cards, others under temporary protection who are yet not registered with the General Direc-

torate of Migration Management and persons who have been brought from the other side of the border as wounded and assumed as under temporary protection benefit from health services at varying levels. For those who are wounded and assumed as under temporary protection must be biometrically registred by the Migration Authority after having been treated and discharged from health facilities.

2. Under the present legislation, persons under temporary protection with their identity cards but without any provision from the Social Security Agency (SGK) and unregistered persons can only benefit from emergency services and from first level health services in cases of epidemics and communicable diseases threatening public health.
3. Foreigners under temporary protection can benefit from health services only in provinces that they are registered. They may be referred to health facilities in other provinces under routine procedures, but they cannot consult facilities in other provinces without referral. They can benefit from health services in other provinces only in case of communicable diseases and if there is an emergency.
4. Except emergencies and cases of referral, foreigners under temporary protection cannot benefit from the services of university hospitals and private health facilities unless they are ready to pay for it. In referrals from second and third level hospitals under the Ministry to university and private hospitals costs have to be covered by the referring facility.
5. No services other than those offered to persons covered by the General Health Insurance Scheme can be delivered to persons under temporary protection.
6. Patient cost-sharing is not applicable to basic and urgent health services including treatment and medicine prescriptions.
7. While, under the legislation, foreigners registered with the Migration Management are placed in their temporary camps, priority must be given to unemployed persons, those without any means of subsistence, persons with disability and to children. Locations of these temporary shelters are identified by AFAD. But temporary health centres set up in these places are operated in line with directives and procedures established by the Ministry of Health. Addresses of person who could not be placed in or have left these places must be updated in the registration system. For preventive health services to be delivered effectively records have to be updated and the Ministry of Health must be informed about relevant population movements.
8. It is established that the cost of services delivered under the Regulation is covered by the budget of the relevant public agency. If this cost is too high to be covered this way then amounts prescribed by the Health Implementation Communique (SUT) can be requested from AFAD (**Council of Ministers, 2011**) (**Prime Ministry Disaster and Emergency Management Authority, 2014**)
9. Cost of individual reports not covered by the SUT (reports to be issued by individual doctors or health facilities for any disability, admission to a job, licence etc.) is to be borne by the applicant.
10. Translation services must be provided free since communication with foreigners in matters covered by the Regulation is otherwise problematic.
11. Data related to health services delivered to persons under temporary protection must be reported to the AFAD fortnightly and monthly.

Preventive Health Services

Preventive health services are delivered by facilities operating under Public Health Directorates (i.e. Community Health Centres and Family Health Services). Moreover, first level health services can also be provided by Voluntary Health Institutions with permissions from the Ministry of Health. Some services delivered by Provincial Directorates of Family and Social Policies are closely related to health. Under the relevant legislation, preventive health services are delivered as described below (**Council of Ministers, 2014**) (**Prime Ministry Disaster and Emergency Management Authority, 2014**) (**Ministry of Health, 2015**):

All services (immunization, screening and monitoring) offered to infants, children and adolescents in Turkey must be available for people under temporary protection as well. Best interest of the child must be the primary consideration in all cases and provisions of the Child Protection Law must be observed.

1. Female and pregnancy monitoring and family planning services offered to all fertile women must also be available for women under temporary protection. Necessary measures must be taken under the existing legislation for female victims of violence and victims of trafficking in human beings.
2. Foreigners entering the country and referred to dispatching centres must be given health examination and necessary measures must be taken in case there is risk of communicable diseases.
3. It is under the responsibility of the Ministry of Health to check the environmental health conditions of temporary protection centres and supervise centres that deliver health services.
4. Reports of communicable diseases and other acute public health problems must be regularly collected and follow up of identified cases must be made by Provincial Health Directorates. Screening and vaccination activities must be carried on against the risk of outbreaks.
5. It is under the responsibility of Provincial Health Directorates to take such protective measures as prophylaxis, isolation and quarantine in case there is potential public health risk emanating from people under temporary protection.
6. Necessary measures must also be taken for those among persons under temporary protection identified as involved in substance abuse or having psychological problems. Their referrals and follow up must be handled in line with rules set by the Public Health Institution of Turkey (THSK).
7. In psychosocial support services to people under temporary protection, it is under the responsibility of the Ministry of Family and Social Policies identify and to take care of persons with special needs including unaccompanied children and persons with disabilities. Under the relevant legislation, vulnerable groups may be accorded access to such facilities as child care institutions and shelters for women.

Curative Health Services

Curative services may be delivered by all facilities in the first, second and third levels. Emergency health services are delivered in temporary shelters and 112 ambulances are kept for service in these places if found necessary by local health directorates. Emergency health services must be available to those under temporary protection living out of temporary shelters, as is applicable to Turkish citizens and in line with the Regulation on Emergency Health Services. Persons under temporary protection must be able to benefit

from all services available under the SUT. The rules are outlined below: (**Council of Ministers, 2014**) (**Prime Ministry Disaster and Emergency Management Authority, 2014**) (**Ministry of Health, 2015**):

In delivering health services, priority must be given to foreigners arriving at referral centres who are identified as in need of urgent health services. Persons under temporary protection may consult second and third level health institutions under the Ministry without need for referral. However, they cannot directly consult health facilities managed by universities or by private sector enterprises. There can be no referral to these facilities except for cases of urgency and intensive care. Referral to university hospitals first and then, if this is not possible, to private hospitals can only be made in emergencies, for intensive care or burn and cancer treatment. Furthermore, in case there is no vacant bed at facilities of the Ministry when there is entry of wounded persons from borders, these persons may be referred to university hospitals and private health facilities. Wounded persons entering the country with loss of organs may be provided simple and mechanic orthesis and prosthesis free. However, the cost of services to those who suffered these losses long before entering the country is not covered (**Council of Ministers, 2014**) (**Prime Ministry Disaster and Emergency Management Authority, 2014**) (**Ministry of Health, 2015**) (**Council of Ministers, 2014**).

In conclusion it can be said that persons under temporary protection can benefit from services provided to Turkish citizens covered by the General Health Insurance on equal footing with them given that the following conditions are satisfied: availability of technical infrastructure and sufficient personnel; health personnel sufficiently informed about the relevant legislation; orderly maintainance the records of persons under temporary protection; and solution of communication problems with volunteer translators. Nevertheless there may be problems in all phases of service delivery which may need further research and observations. Some relevant indicators are addressed in other parts of the present report.

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PRESENT STATE, PROBLEMS AND OBSTACLES ENCOUNTERED IN THE USE OF HEALTH SERVICES BY REFUGEES/PEOPLE UNDER TEMPORARY PROTECTION

Ergun Demir, Işıl Ergin, A.Öner Kurt, Nilay Etiler

The civil war in Syria forced millions of people to leave their country and move to other countries where they think they could be safe. The number of Syrian refugees in Turkey reached 2.5 million and for many of them, their chance of returning back to Syria is meagre. Hence, the problems of these refugees in Turkey have to be addressed in this context, regarding their stay as permanent. While trying to survive in conditions of hunger, unemployment, poverty and exploitation, refugees in Turkey also face a range of health problems. Their health status has been seriously affected by both circumstances back in their points of departure and their troublesome journey. Thus, in their destination, it is important to respond to their needs including shelter, nutrition and safety and to ensure their access to comprehensive health services. Migrants and refugees are considered as a **risk group** with respect to health services and they have their special health problems. These problems require a special attention and approach beyond the routine delivery of health services.

"Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices"and States are obliged to identify and implement activities that guarantee this right (**EU Charter of Fundamental Rights, 2000**). Further, under international conventions, states are obliged to internalize in their domestic legislation those rights that migrants/refugees are entitled to by these conventions. It is compulsory to observe such universal rules and principles as extending health services to all equally and without any discrimination and delivering special services to groups under risk.

Looking at the present status of refugees in Turkey with respect to health services, it can be said that those who are accorded the status of "foreigners under temporary protection" with their registration and identity, can benefit from services including health, education, temporary housing and social assistance. However, this formality of "being registered" may give rise to some concerns in refugees that they might be sent back to their countries. Being registered is a precondition for receiving health services and for unregistered refugees it is impossible to benefit from public health services except for emergencies and contagious diseases (**Orhan O, 2015**). Further, for registered refugees it is determined by regulations what kind of services can be sought, in which facilities and there are algorithms developed for this purpose. The algorithm has been revised by the Public Hospitals Financial Analysis Department of the Ministry of Health on 11 September 2015 (**AFAD circular 2015, S.B algorithm 2015**).

The legislation on health services delivered to persons under temporary protection consists of the following:

- Law on Foreigners and International Protection
- Circular no. 2013/8
- Circular no. 2013/12

- Temporary Protection Regulations
- Circular no. 2014/4
- Protocol Dated 1.7.2015
- Circular no. 2015/8

Except for emergency services, for refugees staying out of the camps, the access to curative services and medicines remained very limited until 2014. They mostly relied on their own means for these services. After 2014, refugees started to benefit from regular public health services.

Syrians living in temporary shelters as well as others out of camps can benefit from 112 emergency services, preventive, diagnostic and curative services at, second and t levels. These services are delivered on the basis of provision from the citizens' registration system. Unless such provision is taken, refugees can benefit only from emergency services and other services related to contagious diseases and epidemics. By principle, refugees receive health services only in their registration addresses. Refugees may consult to second and third level health institutions under the Ministry of Health without need for referral. However, they cannot directly use health facilities managed by universities or by private sector enterprises. Refugees may use these facilities only upon referral and there can be no referral to these facilities except for cases of emergency, intensive care, and treatment for cancer and burns.

The scope of available services is determined by the SUT (Health Implementation Communique) and relevant protocol provisions. To be effective starting from 15 October 2015, the cost of medicine, medical equipment and products is covered by the AFAD in line with rules of reimbursement. SUT provisions establish that health services whose cost cannot be reimbursed are not delivered at all and that the scope of health services can be narrowed down. But there is no clarity as to which services can be subject to this narrowing and thus excluded.

The payment of reimbursable health care costs is made under the *"Protocol for procurement of health services"* acted by AFAD and Ministry of Health which is effective from 1 July 2015 to 31 December 2015. It is stated that the AFAD would make an annual lump sum payment of 375,000,000 TL to the Ministry of Health and monthly sums of 31,250,000 TL would be deposited to the revolving fund account of the Ministry.

This sum includes the cost medicines and medical equipment used in inpatient services given by hospitals of the Ministry and also medical examinations related to inpatient and outpatient services. Costs of referrals made to university hospitals and private health facilities are to be paid to these facilities by the referring institutions (**Protocol dated 1 July 2015**).

It is stated that first level preventive, diagnostic and rehabilitative services are delivered by community health centres (TSM) in camps and by migrant health centres under TSM, family health centres (ASM) and voluntary health organizations out of camps. Health services presently delivered include outpatient examination and treatment, immunization, control of communicable diseases, TB control, environmental health services, reproductive health services and child and adolescent health services **(AFAD Communique or health services to be delivered)**

Migrant health centres (Syrian polyclinics) under TSMs in provinces where Syrian refugees concentrate, started to operate during the last months of 2014. These units are supposed have physical and technical endowment and medical fixtures complying with relevant minimum standards of ASM. Yet, there are many units lacking endowment necessary for extending quality health services. The system of hospital referral was lifted as of December 2015. However, since the system of referral chain had to be observed in referrals to second and third level services before that date, an overwhelming majority (80-90%) of consultations to these units was for referral to hospitals. The majority of referrals were for obstetrics, dental problems, child health, internal medicine and surgery. The most significant work by migrant/Syrian polyclinics was related to immunization and, though limited, family planning services. Meanwhile such problems as TB, measles, chicken pox, cutaneous leishmaniasis and parasitic diseases were found among patients and necessary interventions were made.

Problems Faced in First Level Health Services (Baş D, 2015), (Kara F, 2015), (İkinci S, 2015), (Bahadır H, 2015), (Adana Seyhan Report, 2015), (Syrian Women in Turkey, 2014), (Girit S, 2015), (Kutlu Z, 2015), (Zencir M, 2014), (The Problem of Syrians in Turkey from Mersin to the Country: Health Workshop Report, 2015)

- In provinces where there is a high number of refugees, capacity problems emerge including lack or shortage of equipment and personnel including translators and psychologists. While "migrant health centres" were opened to implement the referral system mentioned in the communique, there are yet gaps in terms of physical and technical endowment.
- It is observed that communication problems and cultural differences may stand as barriers in accessing health services. This may lead to some problems in ways of medical examination and diagnosing and also delay some procedures. Patient privacy is also undermined when health services are not delivered in the native language of patients or when there is no translator.
- Diagnosis, treatment and rehabilitation of trauma caused by the experience of armed conflict is given by NGOs, since public health services do not include this dimension. Public health services do not cover preventive services in this context as well.
- As a result of their traumatic experiences, refugees may adopt negative attitudes, develop fear of being discriminated against, not examined well and given proper treatment. Support and in-service training for health workers are important for them to understand such refugee behaviour.
- It is an important problem for health workers that they have no information about the medical files of refugees and thus their medical histories.
- Records of health services delivered are kept not in data processing systems but in outpatient registeries.
- Problems in provision procedures persist due to lack of timely updating of identity numbers by the migration management authority.
- There are still gaps in services related immunization, pregnancy monitoring, maternal and child nutrition, antenatal and postnatal care and sexually transmitted diseases and health education in these topics.

- The important place of maternal and child health and family planning centres which were defunctionalised after transition to family medicine system is now better understood. In fact, the majority of cunsultations are related to needs in the field of reproductive health.
- Syrians living out of temporary camps frequently change their places and live in dispersed groups which make service delivery more difficult and also pose risks to health of the public. This mobility of refugees particularly interrups preventive health services.
- Given this mobility, identification through field visits and updating of health needs becomes almost impossible. So health services can be delivered on regular basis only upon personal consultations and in immunization campaigns.
- Health service providers have to cope up with such facts as extremely unfavourable living conditions, residence in desolate buildings, malnutrition and lack of hygiene.
- Adolescent pregnancies, child mothers, child labour and malnutrition are important problems in children and there is no record/data related to these issues.
- Syrians at all ages including children and adolescents are made to work like slaves at sweatshops and in heavy and hazardous works by greedy and opportunistic employers. These persons are exposed to various diseases and hazards.
- Family doctors have concerns about reaching and communicating with Syrian families, conducting pregnancy and child monitoring. So they are unwilling to record/add them to their patient lists because of worry about a decrease in their performance scores. Furthermore, many doctors have already reached the upper limit of 4,000 registered patients and do not want any more additions to their list. The existing number of family doctor positions is far from responding to the needs of expanding populations and their health problems.
- Syrian refugees are not adequately informed about health services available in Turkey. Adding the presently passive, consultation only oriented nature of the system to this, the right of refugees to health is under jeopardy.
- Important barriers in accessing health services include distance from living environments to health facilities, too many patients exerting pressure on the existing capacity and discriminatory attitude on the part of some health workers.

Suggestions

- Refugees dispersed in various parts of towns must be registered with family doctors in their area to benefit from first level health services. To ensure this, new positions for family doctors must be introduced and the system must be adapted to include health records of Syrian refugees as well.
- Health services must be improved in quality with necessary infrastructure, personnel and equipment and existing gaps in migrant health units (Syrian polyclinics) in terms of physical and technical endowment must be covered to ensure minimum standards.
- TSMs(community health centers) should ensure an assessment of the current situation in their area through mobile teams, collection of health data in service areas, necessary monitoring and evaluation, improvement in service quality and sharing of relevant information (i.e. with family doctors, etc.)

- Needs of TSMs in personnel and vehicles must be met.
- Health workers in these units must be given in-service training on issues related to migrant/refugee health and be assigned on the basis of volunteerism.
- Although it was declared that records related to health services would be shared in electronic environments, there is yet no such database. There is immediate need for having a database related to services in Syrian outpatient clinics.
- In settlements where there is a population concentration and easy access to services, a migrant health centre must be launched for every 10,000 Syrians.
- Centres extending reproductive health services must be supported in infrastructure and technical capability; their work in cooperation with migrant health centres must be ensured and necessary health education must be given start immediately.
- Establishment of temporary Family Health Units (FHU) in temporary settlement areas with population over 1500 will remove many barriers to access to health services.
- There must be interventions to address such problems as adolescent pregnancy, child mothers and child labour through the cooperation of relevant institutions.
- When children are employed in heavy and hazardous work without protective measures in some sweatshops, they are exposed to various risks and diseases. It is therefore important for health workers extending services to this special group to be well aware of possible occupational diseases and take special care in patient history and physical examination. They should be sensitised on what to do and whom to inform when they come across such a problem.
- It is particularly important to withdraw children from these forms of employment, refer them to schools and provide social support to their families.
- There is a need to ensure hygienic conditions and enhance sensitivity regarding access to immunization and other health services.
- If found necessary, problems must be addressed by province/district public health boards and plans must be developed for solving them through cooperation by respective sectors.

Problems Faced in the Delivery of 2nd and 3rd Level Health Services (Baş D, 2015), (Kara F, 2015), (Savaş N, 2015), (Bahadır H, 2015), (Adana Seyhan Report, 2015), (Syrian Women in Turkey, 2014,), (Girit S, 2015), (Kutlu Z, 2015), (Mardin D, 2015), (Orhan O, 2015), (Zencir M, 2014), (The Problem of Syrians in Turkey from Mersin to the Country: Health Workshop Report, 2015)

- State hospitals in border provinces face the problem of overcrowding which also arouses reaction of native citizens.
- Those who live out of camps and have no registration cannot have free access to health services and medicines except in cases of emergency and communicable diseases.
- Refugees have to pay from their pocket for health services other than those specified by the Ministry.

- Health workers at hospitals state that their work burden has increased after the refugees, working hours became longer and time allocated to each patient got shorter. It is also reported that there are problems regarding the number of health workers, patient beds and capacity for intensive care and in meeting needs in drugs, blood and blood products.
- There are gaps in hospitals for amputees in regard to psychosocial support and rehabilitation and equipment.
- Communication problems in diagnosis and treatment related to language lead to the violation of the principle of confidentiality and tensions between patients and health workers.
- One-third of health workers say they have suffered verbal violence by refugees and 6.7% have also experienced physical violence by refugees.
- Some health workers are involved in discriminatory behaviour, seeing refugees as "the other".
- Many health workers state that they have received no training in "health services during emergencies."
- Deliveries that must be attended at hospitals take place at home due to lack of access to these facilities.
- It is reported that patients with chronic diseases and those who have to take medicine periodically have problems in getting their medicines.
- It is reported that health workers from among Syrian refugees have started to give care asking for small charges to Syrian patients.

Suggestions

- Institutional capacity must be enhanced so as to respond to increase in persons entitled to health services. Gaps in services to refugees (i.e. in psychosocial support, rehabilitation and equipment support to amputees etc.) must be closed.
- There is need for pamphlets in different languages to inform refugees about the health system and their rights in this context.
- Health workers must complete their in-service training in the legal status of refugees, their right to health and health needs.
- There must be solutions to language problems that refugees face in service delivery. Volunteering must be the basis in appointments.

CONCLUSION

Ending of the tragedy of refugees trying to survive across borders depends, firstly upon putting an end to conflicts going on in Syria and in other parts of the region. The general tendency is to invoke curative services and medicines when there is any mention of health; but it must be borne in mind that the crucial determinants of health include sheltering conditions, nutrition, socio-economic status, physical environment and working conditions as well. Winter is coming, weather is getting cold and there are children going to bed hungry. What should we do to protect and treat these people who are trying to survive in extremely difficult circumstances? There is a single answer to this question: There must be a firm stance against systematic exploitation, deprivation from fundamen-

tal rights, hate speech and discrimination against refugees; and act as advocators for the delivery of quality health services immune from any discrimination or segregation on the basis of nationality, race, religion or class.

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NON-GOVERNMENT ORGANIZATIONS DELIVERING HEALTH SERVICES AND REFUGEES

Yeşim Yasin

The most distinguishing characteristics of neoliberalism relative to earlier forms of capitalism consist of radical market orientation, flexible employment and ruling out the concept of "social state". Starting with the 80s, the Keynesian welfare state model started to dissolve, accompanied by narrowing domain of social benefits and more difficult access to the remaining ones. Now, the main function of the state is to ensure the smooth working of mechanisms geared to safeguarding the "health" of markets rather than health of the society (**Schrecker and Bambra, 2015**). In this context, the state gradually withdrew from certain sectors and even totally abandoned some. It is now the task of civil society replacing the state in vacated areas and/or mitigating the negative effects of this withdrawal.

Civil society encompasses enormous diversity in terms of constituencies, institutional forms, capacities, goals, tactics and objectives. According to Scholte, this diversity incorporates three categories in terms of objectives: conformists, reformists and radicals. These categories are of significance insofar as they are conceptual tools. In practice, however, they are more fluid rather than being clear-cut and generalizable. Conformists seek to uphold and maintain existing norms instead of trying to alter them. Reformists aim at correcting the flaws they confront in the existing system while leaving the underlying structural problems intact whereas radicals intend to change the social order comprehensively. Radicals are often referred to as "social movements" (**Scholte, 1999**). It would be wiser to use this categorization as a tool to understand the organizational structures and/or modalities of work rather than a ranking that implies a hierarchical order among non-governmental organizations (NGOs). Humanitarian aid in general and healthcare in particular include myriad of NGOs that fall into each of these categories.

The governance concept of neoliberalism, on its part, opens a domain for civil societies. It is actually a fragmented, multi-component and mainly informal structure around a decentralized state apparatus. Civil society organizations come to the fore in this design as a new component,as one of the leading actors. Relief work in particular brings along a kind of privilege and autonomy. And healthcare is an important component of humanitarian relief work. This work which mostly revolves around doctors puts health at the centre. The objective is, in fact, mitigating pain through medical case rather than improving the overall situation. The priority is shifted from citizen to patient (**Ticktin, 2011**). This refers particularly to patients from "disadvantaged/vulnerable" groups and refugees are exactly one of these groups.

Health Services Delivered to Refugees in Europe

Turkey is in the European Region of the World Health Organization. It is reported that about 700,000 refugees and migrants entered the European union (EU) countries in 2015 and it is estimated that this will exceed 3 million by the end of 2016 (**WHO, 2015**). It is a query that a population of this size leads to some "concerns" in the EU while Turkey along rooms in close to 3 million refugees. But the core issue is to mobilize

funds and human resources needed to extend services to this population. Of course, health is one of the most critical of these services.

The EU has no standard and holistic legislation guaranteeing health services for refugees. The practice is fragmented, varying with respect to individual member countries (**Yasin and Elbek, 2015**). There are also some legal restrictions barring access to health services. When refugees are concerned, health services are mostly limited to emergency in pregnancies, antenatal care, delivery and immunization (**Langlois et. al., 2016**). Moreover, even when there is no legal barrier or limitation, access to health services is still problematic for refugees due to a set of reasons including the following: uninformed status of many refugees regarding their rights, economic difficulties, insensitivity of health services provided to cultural differences, language barriers, shortness of information and experience on the part of health workers and overall administrative problems. Access of refugees to health services can be improved through highly disciplined teams, no cost or affordable services, covering the cost of transportation, more flexible working hours in clinics, advocacy for patient rights and gender sensitive service delivery (**Bradby et. al., 2015**). It is observed that NGOs come to the fore especially where the state falls short of service delivery. Yet, though NGOs may deliver complementary services in some respects, their competency is questionable in such fields as continuum of care, referral to second level services and mobilization of local human resources including practising doctors and nurses (**Bradby and ark. 2015**).

The legislation presently in effect in Turkey does not allow the recognition of migrants from neighboring countries as refugees.[1] Consequently, health services by the state in the "transition period", between the first application of foreigners and attaining legal status, are quite limited and with many problems in practice. In this context only Syrians who are accorded "temporary protection" constitute a "privileged" group in term of having access to health services; however, there are still some problems including frequent changes in legislation and absence of translators in medical issues. Few NGOs that extend health services to refugees try to eliminate or at least mitigate some practical problems. Below there is a brief account of the activities of few NGOs that extend health services to refugees directly in the field.

NGOs Delivering Health Services to Refugees in Turkey

Doctors without Borders

"Doctors without Borders" or MSF (Médecins Sans Frontières) is an international humanitarian aid organization established in 1971 to extend emergency health services in cases when routine services fall short of need due to such events as armed conflict, epidemics, and natural disasters.

Since the start of the crisis in Syria in 2011 the MSF has been engaged in many health projects covering Syrians both in the country and in neighbouring countries including Lebanon, Jordan and Iraq. In 2014, as a result of worsening safety and kidnapping of five MSF personnel, health related activities in Syria lost some momentum, but the organization still extends support to more than 150 health agencies in the country and delivers health services in Aleppo, Idlib, Hasiçi and Kobane (**MSF, 2015a**). The MSF is

[1]For a detailed assessment related to legislation see Kıvılcım, 2015.

also engaged in search, rescue and emergency health services at the Aegean and Mediterranean while also delivering health, relief materials, water, sanitation and transportation services to refugees along the borders of such countries as France, Italy, Greece, Croatia and Macedonia.

Since 1991, the MSF has engaged in short-term emergency service delivery in various humanitarian crises. In the period 2011-2013 the organization conducted Refugee Defence and Support Programme for refugees in Istanbul in partnership with Helsinki Citizens Association. Since 2012 it has been giving technical support to NGOs in Turkey engaged with refugees in the field of health including psychological health. As of June 2015, the MSF started to expand the scope of its activities in Turkey by launching programmes directly targeting refugees.

Existing health facilities and activities in the region include the following: Gaziantep Child and Women's Health Polyclinic with consultation capacity of 2,500 per month; Mental Health and Psychosocial Support Project conducted in Suruç-Şanlıurfa together with the Support to Life Association; Mental Health Project conducted in Akçakale together with International Blue Crescent Association and Basic and Psychological Health Project in Kilis in partnership with the Helsinki Cizitens Association (**MSF, 2015b**). A 20 bed capacity temporary Post-surgery Care and Rehabilitation Centre is planned for launching in 2016 in Kilis where 53,242 outpatient and 30,849 psychological support services were delivered in 2015[2].

"Peoples' Bridge" Association

Established in İzmir in 2015, the Peoples' Bridge Association (HKD) is a relief and solidarity NGO working along the principle of "promoting the solidarity of peoples in cases of social-political turmoil and natural events that turn into disaster." The association is active in the field in refugee related issues including direct delivery of health services. So far the association conducted health screening including dental health in refugee populated neighbours of İzmir such as Torbalı, Foça, Basmane, Konak and Kadifekale, delivered health services to those in need or intermediated for delivery. There is also organized work to respond to hygiene, dressing, food and fuel needs of the same refugee groups. The association is also engaged in advocacy work related to the fundamental rights and freedoms of refugees including sage border passing. Detailed activity reports documenting the work of the association can be reached at websites[3].

International Blue Crescent Relief and Development Foundation

The Foundation (IBC) is active longer than 13 years now to assist people trapped in disasters and difficult circumstances, particularly the most vulnerable and disadvantaged population groups and its main activity area in Turkey is Kilis. Its services concentrate mainly in such areas as psychological support to those who have lost their relatives, rehabilitation in programmes on post-trauma stress disorders, psychological support to children and provision of prosthesis, wheel chair, etc. to amputees. The IBC has its field hospital launched together with Malteser International. In September 2012 the facility was first planned as a temporary clinic containing 32 beds. Later, it became stable with a bed capacity of 58 and now is serving 86 patients a month on average. The facility ex-

[2]Information without any reference in this section is from Serap Öztürk, Co-Representative of MSF Turkey
[3]Information is obtained from the website of the organization: http://www.halklarinkoprusu.org (Accessed: 24.01.2016).

tends free second level health services to patients in coordination with Kilis State Hospital. Delivering medication and physical therapy services, the facility gives treatment to patients and wounded persons mainly through Syrian doctors and health workers (**İGAM, 2013; Kutlu, 2015**). Its meal services are capable of serving 300 patients and their companions. The plan of the Foundation for 2016 is to start first level services as well to refugees in Kilis[4].

International Medical Corps

Despite the difficulty of international CSOs in having official registry in Turkey, the International Medical Corps (IMC) managed to become the "first" in this area and in 2012 started to deliver services directly in Turkey. The organization initially gave weight to provinces of Kayseri and Nevşehir with their Iranian refugees and then, in 2013, moved to the northern part of the country where there were refugees from Iraq and Afghanistan. Today, the IMC continues its supporting activities through its Multi-Service centres in İstanbul, Sakarya and Gaziantep.

In 2012, an Urgent Response Team was created in Antakya for Syrian refugees. Through a holistic approach, the team is engaged in assistance and support activities in health, physical rehabilitation, nutrition, protection, gender-based violence, mental health and distribution of relief materials other than food.

The organization carried out many programmes in Gaziantep, İstanbul, Kayseri, Mersin, Kilis Nevşehir, Nizip, Sakarya, Şanlıurfa and Yalova.[5].

Doctors of the Earth

The organization started extending its services by setting up health stations in Yayladağı-Hatay and Suruç-Şanlıurfa. The organization distributes free medicines and implements a psychosocial support programme for Syrian children in Yayladağı in cooperation with the Life Foundation (**Kutlu, 2015**). Ensuring continuous supply of medical equipment and medicine to the region, the organization partnered with the EU ECHO Fund and IOM (International Organization for Migration) to deliver first level health and pharmacy services in Batman, Şırnak, Diyarbakır and İstanbul. The organization also undertakes the circumcision of Syrian children born in Turkey and supplies food to refugees.

The Doctors of the Earth provides free polyclinic services to Syrian refugees at the Fatih Polyclinic of Bezmialem University from 17:30 to 21:30 during working days. Activities planned for the future include delivery of first level health services to Syrian refugees in needy neighbours of Istanbul and İzmir[6].

Prospects and Suggestions for Solution

- Keeping the channels of dialogue between NGOs operating in the field and state institutions open; having the state delegate some services that it cannot extend through its facilities to NGOs working in these fields.
- Developing programmes to train medical translators particularly in Arabic, Kurdish and Persian.

[4]Information without any reference in this section is from IBC field coordinator Mehmet Akdemir.
[5]Information is obtained from the website of the organization:
.http://internationalmedicalcorps.org/page.aspx?pid=2136 (Accessed: 24.01.2016.
[6]Information without any reference in this section is from Tuba Fatma Küçük.

- In cooperation with NGOs, developing multi-language information booklets about health services that refugees can benefit.
- Regularly informing refugee population in cities and neighbourhoods where doctors and health workers serve about available services.
- Integrating first level health services extended to refugees with the system of family medicine in the country. Introducing the system of "positive performance" for doctors and health workers with respect to refugees in their service domain.
- Introducing "flexible working hours" for refugees in some polyclinics.
- In cooperation with NGOs, organizing in-service trainings for health workers in such themes as culturally sensitive health services, stigmatization and discrimination.
- Conducting joint work and scientific studies with NGOs in regard to the long-term health outcomes of refugee status.

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EPILOGUE

Necati Dedeoğlu, Dr Gamze Varol

Economic and political concerns constitute the root cause of all wars and armed conflict. The conflict in Syria which affects Turkey too is the result of imperialist assault. All countries in the Middle East are affected and all are used as pawns in the context of the "Greater Middle East Project" envisaged in line with the interests of imperialist powers. For a long time now, the countries of the Middle East have been undergoing a process which is difficult to reverse and which affects them profoundly in social, economic, demographic and political terms. In recent years, Syria is the country most adversely affected by the process. The people of Syria have lost their homes, homeland and fell prey to human traffickers. Blood, hunger and diseases occur as routine while civilians are killed while those who could survive suffer hardships of long journeys or get drowned while trying to cross from one country to another. It is a humanitarian crisis and tragedy taking place so close to us.

The on-going strife is meaningless and should be stopped immediately. All initiatives should be taken to make Syria a safe place for its citizens and to make return to the country possible for those who want to. Before all, however, there is urgent need to stop human traffickers. Negotiations between the European Union and Turkey suggest that a large part of Syrian refugees presently in Turkey will remain here for a long period. The recent legislation entitling work permit to Syrian refugees in Turkey is a reflection of this prospect in labour markets. While being a positive step forward, it should be carried further including citizenship and right to benefit from all available services.

Initiative should also be taken to solve the language problem faced by Syrian refugees. While setting up the infrastructure for Syrians to learn Turkish, there should also be brochures in their language providing information about the ways of accessing and benefiting from available services including health in the first place as well as their rights. The process may require the employment of translators in public institutions. Refugee children should continue their education in Arabic while also taking courses to learn Turkish.

Those in need should be provided support in terms of food and shelter. Also, there may be long-term loans with easy repayment conditions for Syrians to have their own homes. Refugees with education and occupation may be enabled to continue their professions in Turkey after equivalency comparisons. Vocational training courses may be launched for unskilled refugees. Presently existing problems such as child labour, informal employment and wage rate below minimum should be eliminated by strict supervision.

Lastly, considering the root cause stated at the beginning, struggle against imperialism should be the essential action to take.