REP. OF TURKEY

TED UNIVERSITY

GRADUATE SCHOOL

MIGRATION STUDIES

THE RIGHT TO HEALTHCARE UNDER CEDAW AND THE POSITION OF SYRIAN WOMEN REFUGEE

IŞILAY BORAN

ANKARA, 2021

THE RIGHT TO HEALTHCARE UNDER CEDAW AND THE POSITION OF SYRIAN WOMEN REFUGEE

A Thesis Submitted To
The Graduate School
Of
TED University

by

Işılay Boran

In Partial Fulfilment of The Requirements
For
The Degree of Master of Arts
In
Migration Studies

ANKARA,2021

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

Name, Last name: ISILAY BORAN

Signature: 

ABSTRACT

"THE RIGHT TO HEALTHCARE UNDER CEDAW AND THE POSITION OF SYRIAN WOMEN REFUGEE"

Işılay Boran

Master of Arts, Migration Studies

Supervisor: Prof. Dr. Şebnem Akipek Öcal

November, 2021

This study examined the right to health care and access to the healthcare facilities for Syrian women refugees living in Ankara within the scope of The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The issue of migration gains even more importance in the context of human rights. One of the most affected groups by the migration process is women. One of the main reasons for this is that women suffer a lot more during the migration process as they encounter more problems both as women and refugees. As a result of this, the health care problems they experience constitute one of the important issues which needs to be addressed. Refugee women face serious health problems that stem from insufficient language knowledge, environmental factors, lack of health insurance and economic reasons. These factors prevent refugee women from accessing reproductive, psychological, and physical health services. Furthermore, violence, sexual harassment and sexually transmitted infections are other problems faced by women refugees. In this study, qualitative research techniques were deployed and to be able to obtain data semi-structured interviews were conducted with Syrian female refugees living in Ankara.

CEDAW stated that women can benefit from the field of health on equal terms with men and without discrimination. The aim of this study thesis is to reveal the health problems of Syrian women refugees living in Ankara and how they experience problems in accessing the right to health, and how the CEDAW Convention shapes the right to health. The research question of this thesis is "How effective CEDAW in protecting the right to health care of Syrian women refugees in Ankara is."

This study showed that it is necessary to implement more effective policies to protect the right to health of Syrian women refugees. The study has also revealed that the health policies for refugees should be applied more efficiently by raising awareness about the implementation of human rights.

Keywords: Syrian women, refugees, health, CEDAW, women human rights

ÖZ

"CEDAW SÖZLEŞMESİ KAPSAMINDA SAĞLIK HİZMETİ ALMA HAKKI VE SURİYELİ KADIN MÜLTECİLERİN DURUMU"

Işılay Boran

Yüksek Lisans, Göç Çalışmaları

Tez Yöneticisi: Prof. Dr. Şebnem Akipek Öcal

Kasım, 2021

Bu çalışma, CEDAW Sözleşmesi kapsamında sağlık hizmeti alma hakkını ve Ankara'da yaşayan Suriyeli kadın mültecilerin sağlık faaliyetlerine erişimini incelemektedir. Göç konusu insan hakları bağlamında daha da önem kazanmaktadır. Göç sürecinden en çok etkilenen gruplardan biri de kadınlardır. Bunun temel sebeplerinden biri kadınların göç sürecini hem kadın hem de göçmen olarak daha ağır yaşamalarıdır. Bu nedenle insan haklarının en önemli parçalarından biri olan sağlık hakkına erişimlerinde birçok problem yaşanmaktadır. Dil sorunu, çevresel faktörler, sağlık güvencesine sahip olmama ve ekonomik nedenlerden dolayı mülteci kadınlar ciddi sorunlar yaşamaktadır. Bu faktörler mülteci kadınların üreme sağlığı, psikolojik ve fiziksel sağlık hizmetlerine ulaşmasını engellemektedir. Ayrıca; şiddet, cinsel taciz ve cinsel yolla bulaşan enfeksiyonlar kadın mültecilerin çoğunlukla karşılaştığı diğer sorunlardandır. Çalışmada Ankara'da yaşayan Suriyeli kadın mültecilerle yarı yapılandırılmış mülakat yapılmıştır. Kadına Karşı Her Türlü Ayrımcılığın Ortadan Kaldırılması Sözleşmesi (CEDAW), kadının sağlık alanında erkek ile eşit koşullarda ve ayrımcılığa maruz kalmaksızın yararlanabilmesini düzenlemiştir. Bu çalışmanın amacı; Ankara'da yaşayan Suriyeli kadın mültecilerin sağlık problemlerini ve sağlık hakkına erişmede nasıl sorunlar yaşadığını ortaya çıkarmak ve CEDAW Sözleşmesinin sağlık hakkını nasıl şekillendirdiğini ortaya koymaktır. Araştırma sorusu şu şekildedir: "CEDAW Sözleşmesi Ankara'daki Suriyeli kadın mültecilerin sağlık hakkını korumada ne kadar etkilidir?"

Bu çalışma; Suriyeli kadın mültecilerin sağlık hakkını korumada daha etkili politikalar yapılması ve uygulanması gerektiğini; özellikle de insan haklarının uygulanması konusunda farkındalık yaratıp mülteciler için izlenen sağlık politikalarının daha verimli hale getirilmesi gerektiğini ortaya koymuştur.

Anahtar Kelimeler: Suriyeli kadın, mülteci, CEDAW, sağlık, kadının insan hakları

To My Dear Family

ACKNOWLEDGEMENTS

I have learned many things during my thesis process. In this process, the support of my professors, my family and friends are great. I would like to take this opportunity to express my thanks to these people who were with me during this process. First and foremost, I would like to express my deepest gratitude to my advisor Prof. Şebnem Akipek Öcal for her support, suggestions, and guidance throughout my thesis. She supported me from the beginning to the end. The completion of this study could not have been possible without the expertise of her. I would also like to thank Assistant Professor Selin Akyüz for her valuable comments and support. She was the one who always encouraged me in my academic life at Bilkent University.

I would also like to thank my family, my mother Cemile Boran and my father Mehmet Ercan Boran. Getting through the long and difficult process of writing and completing my dissertation would not have been possible without their help and support. I am also very grateful to my uncle Mehmet Veysi Boran, who always encourages me and guides me with his general knowledge and ideas.

Last but not least, I am also thankful to my colleague Gizem Gönay Akbaş for her contribution to my thesis by finding interviewees.

TABLE OF CONTENTS

PLAGIARISM....iii
ABSTRACT.... iv
DEDICATION vi
ACKNOWLEDGEMENTS vii
TABLE OF CONTENTS viii
CHAPTERS
CHAPTER 1.... 1
INTRODUCTION.... 1
1.1 Conceptualizing and Literature Review 1
1.2 Methodology 3
CHAPTER 2.... 8
CONCEPT OF REFUGEE.... 8
2.1 Concept of Refugee 8
2.2 International Protection & Refugee Status Determination in Turkey 11
2.3 Rights of Refugees 14
CHAPTER 3.... 16
WOMEN'S HUMAN RIGHTS 16
3.1 Concept of Women's Human Rights.... 16
3.2 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).... 17
3.3 The Reporting Procedure.... 18
3.4 The State Parties Reservations 19
CHAPTER 4.... 23
INTERSECTIONALITY AND REFUGEE WOMEN 23
4.1 The Concept of Intersectionality 23
4.2 Discrimination and Equality.... 24
4.3 Intersectional Discrimination in CEDAW.... 26
CHAPTER 5.... 29
SYRIAN WOMEN REFUGEES IN TURKEY AND HEALTHCARE.... 29
5.1 The Right to Health 29

5.2 Refugee Health 30
5.3 Access to Healthcare for Syrian Women Refugee 34
5.4 CEDAW and Women's Health 37
5.5 CEDAW Country Reports 38
CHAPTER 6 41
ANALYSIS OF INTERVIEWS IN LINE WITH CEDAW 41
6.1 Analysis 41
6.1.1 Gender Roles and Expectations 41
6.1.2 Experiences in Receiving Healthcare Services 43
6.1.3 Social or Religious Preferences in Receiving Healthcare 49
6.2 Policy Suggestions 51
CHAPTER 7 54
CONCLUSION 54
REFERENCES 59
APPENDICES 73
Appendix A. Ethical Permission 73
Appendix B. Informed Consent 77
Appendix C. Semi Structured Interview Questions 79
Appendix D. Tez Fotokopisi İzin Formu 80

CHAPTER 1

INTRODUCTION

1.1 Conceptualizing and Literature Review

The concept of migration has become one of the most significant topics all around the world and in Turkey. Migration is an extremely important field for states. It can be a determining factor for their policy making system in such different walks of life as economy, education. health so on and so forth. After the Syrian war in 2011, a massive influx of Syrian refugees appeared as the circumstances in their country forced them to flee from their own country to many other countries. Syrians have been displaced and these circumstances have forced Syrian people to flee to the other countries.

The multiple effects of migration on the Syrians and host communities can be observed. While hospitality towards refugees is mostly practiced, many of them may encounter discrimination and exploitation. Syrian refugees lack fundamental human rights in terms of international legal norms. Relevant human rights treaties have concentrated on awareness raising about the problems faced by specific groups of marginalized people such as refugee women and children resulting from specific contemptible acts like discrimination, or persecution.

Marginalized groups' rights are reflected on the international migration law, but these rights have become invisible in practice. The right to an acceptable standard of life consists of many other rights such as, the right to food and nutrition, the right to work, and the right to health. It is obvious that protection of migrants' health is a fundamental human right. Meeting specific health requirements is the issue of states through policies and international organizations. Although health policies' aim is to provide both men and women to access health care services equally, refugee women mostly face more difficulties while receiving these services.

Numerous refugee women encounter many barriers in the field of healthcare services. It is crucial to raise awareness about the problems of refugee women against discrimination in health care services. One of the primary documents safeguarding the rights of women refugees is "The Convention on the Elimination of All Forms of Discrimination against Women" (CEDAW). CEDAW is a special instrument within the existing human rights treaties, since CEDAW primarily deals with the promotion and protection of women's human rights. It questions multidimensional gender inequality all around the world. The main essential of CEDAW is the

protection of the right to health care which is a basic human need. Many refugee women face discrimination based on their sex and gender and this is inseparably connected with other identities like race, ethnic, or poverty.

It is significant to examine CEDAW in terms of the concept of intersectionality. This concept reflects that people can encounter discrimination on account of various and intersecting identities. Syrian women refugees confront a double disadvantage due to both their nationality and gender. Intersectionality is visible in the life period of Syrian women refugees. Discrimination can be observed in many fields of life such as education, health, or work.

International human rights provide respect to the right to health. However, provision of healthcare facilities to Syrian refugee women are mostly inadequate in Turkey (Alawa, Zarei, & Khoshnood). The right to the healthcare for Syrian women refugee intersects with multiple identities, which causes discrimination. A large influx of Syrian refugees fleeing from conflict has caused difficulties in the healthcare system in Turkey. Moreover, because of the severe situation in their own country, Syrian women refugees have to endure many types of conflicts which have created problems related to their physical and mental health. Even though Turkey provides Syrian women refugees with health care facilities, these services are not adequate to cater for the needs of Syrian women refugees. This inadequacy needs intervention.

When tension and instability occur, gender-based violence also tends to increase dramatically. Programs for gender-based violence victims do not exist, or they are considerably insufficient in some areas. Victims are unwilling to report gender-based violence because of shame, anxiety, and distress. Syrian women claim that domestic violence has grown because of displacement and war. Many women and girls have restricted to their homes because of the fear of sexual abuse and assault. Gender-based violence has severe short- and long-term effects on the sexual, psychological, and physical health of Syrian women refugee victims. They develop some health problems like undesired pregnancy, complications from illegal abortions, and sexual transmitted diseases. Depression, suicide, anxiety, and post-traumatic stress disorder are also the result of gender-based violence (Raistick & Maglietti, 2014). Victims are both economically and socially harmed since they are excluded from their family and society. Gender- based violence is a matter of human rights issue and it breaks the right to life, safety of the people, health, and equal treatment under the law (Raistick & Maglietti, 2014).

This thesis aims to examine the right to Syrian women refugees' accessing healthcare services taking CEDAW into consideration. One of the most affected groups of the migration process is

women since they are likely to encounter more problems in their journey to another country both as a woman and a refugee. Latest studies have also demonstrated that the risk of mortality rates at the borders are higher for women compared to men and more women die during illegalized travel (Pickering & Cochrane, 2013). Women transiting alone or with their children are unguarded against the attacks by smugglers and they were vulnerable to rapes and sexual assaults (Freedman, 2017).

CEDAW regulates women's access to healthcare on an equal basis with men and without discrimination. The purpose of this study is to identify the needs and the problems of Syrian refugee women living in Ankara in accessing healthcare services. It also tries to evaluate how CEDAW shapes the right to health, which is a significant issue as it can cause serious results if it lacks. The research question of this dissertation is "How effective CEDAW in protecting the right to health care of Syrian women refugees in Ankara is"

1.2 Methodology

Interviews are one of the most common methods used in qualitative research. They are used to obtain data about the experiences, perceptions, and beliefs of respondents regarding on the area that the researcher is interested in (Lambert & Loisella, 2007). In terms of structure, interviews vary from the strictly formal style of structured survey interviews that are asked in the same structure to semi-structured interviews that the structure of the question is less strictly organized.

The aim of this thesis is to identify the difficulties of Syrian women refugees while accessing healthcare facilities and discuss to what extent CEDAW can be effective to deal with these problems in the field of health system with respect to these Syrian refugee women. To be able to reach this aim, a literature review was conducted, and interviews were administrated with 15 Syrian refugee women between March and May 2021. The participants of this study are Syrian women refugees living in Ankara over the age of 18. The interviews were carried out with Syrian women who could speak Turkish. In some parts, translation support for some of the answers and questions was received. Interviews were conducted at refugees' homes as it helped respondents feel comfortable at their homes. All of interviews were transcribed.

Semi-structured interviews were conducted with 15 Syrian women refugees. Analysis of experiences of women is a significant part of this research. By conducting interviews, information on the following issues were obtained: arrival processes of Syrian women refugees,

difficulties faced as a woman refugee during and after her migration, experiences in receiving healthcare services, whether there are social or religious preferences in receiving health care like choosing the doctor's gender and having information about whether they were informed regarding women's health. The name of participant was not given in the thesis because of confidentiality and ethical permission was also obtained. Nicknames were given to the interviewees like A, B, C, D, E, F, G, H, I, J, K, L, M, N, O.

Some questions were asked in order to identify the problems of Syrian women refugees living in Ankara while accessing the healthcare services and how CEDAW shapes the right to health. Open ended questions were asked to encourage conversation. Semi-structured interview and content analysis of CEDAW were used to find the answers to the questions. The main important reason for this is to analyse the effectiveness of CEDAW and examine its practical contributions to Syrian women refugees.

In this research, qualitative research methods were used as these methods are believed to describe, understand, and occasionally explain social circumstances in a variety of ways better. Despite some differences among some qualitative methods, there are common ways that can be found in qualitative studies to help the researcher to understand the social phenomena (Lambert & Loisella, 2007). Firstly, experiences of people are examined. Biographical life patterns or activities can be linked with experiences. These issues can be highlighted through the examination of general knowledge, stories, and records. Secondly, experiences and conversations are examined in the process of making. Thirdly, documents that reflect similar experiences are evaluated.

For this research, the semi-structured interview type was chosen. In this type of interview, the same subject shapes the framework of questioning and the order of questions is determined by the participants of the interview. Issues are specified by the participants. Since the interviewer may not have a pre-formatted interview guide, the conversation mostly looks like a daily speech. Researchers ask a series of questions to elicit open-ended discussions about study subjects that are driven by what participants must express. This type of qualitative interview is commonly used as a primary analysis tool across disciplines (Flick, 2017).

In this study, during this semi-structural interview the following questions were asked to the participants:

1. Can you briefly introduce yourself? (Age, marital status, educational status, do you have children etc.)

2. Can you describe your arrival in Turkey? How, with whom and when did you come?
3. Women and children make up most of the migration movement. What problems do you face during and after the migration process, especially as a refugee woman?
4. Have you ever experienced any health problems after coming to Turkey? Did you get service from a hospital or a doctor?
5. Are there any problems in getting health care, if so, what are they? (Language problem, lack of health insurance, etc.)
6. Have you requested health services from any institution (non-governmental organizations or the United Nations etc.)?
7. As a Syrian woman, did you encounter any negative situation in hospitals or any health centres?
8. Are there any social or religious preferences for Syrian refugee women to receive healthcare services? (Choosing the gender of the doctor, timidity, inability to express herself comfortably to a health worker of different gender)
9. Have you been informed by healthcare professionals about benefiting from services that protect women's health?

Before starting an interview, researchers describe to participants what the study is about, and obtain their informed consent to take part in the study. There could be differences in how informed consent is obtained like orally or written and how consent forms are organized, based on sample population, research design, and the criteria for written consent (Mertens, 2018). For this research, the consent forms which were designed following the university guidelines were obtained.

In this research, phenomenological interview and feminist interview were the approaches taken by the researcher. The first type of interview approach, phenomenological interviews are the ones which concentrate on the experiences of respondents and the sense of they have that experience (Seidman, 2006). In this approach, researchers try to determine interviewees' experiences, perceptions, and feelings regarding the topic area of the research by raising open-ended questions about their thoughts, beliefs, and interpretations. The answers given by the respondents provide a foundation for reconstructed descriptions for the research topic (Vagle, 2014).

The latter approach that is the feminist ones try to identify the personal backgrounds of the women through conducting a variety of interview formats such as unstructured, semi structured,

while doing so, the researchers also pay attention to fostering an equal relationship with the women interviewees (Reinharz & Chase, 2002).

What differentiate feminist interviews from other qualitative interviews is implementation of the technique. They originally describe feminist objectives that support equal rights for women. Researchers carrying out feminist interviews intend to cooperate with the participants in admiration and in an ethical manner to emphasize women's statements Since the aim is to highlight women's voices, along with the speech, the gestures, body language, and nuances are paid particular attention (DeVault & Gross, 2007). Feminist interviews reflect that gender expectations are observed in the language of women.

This research tries to unveil the difficulties that Syrian women experience while accessing the healthcare services during their migration process. Their experiences in accessing health care services both as a woman and a refugee were observed and policy recommendations were made. In the analysis of the interviews, qualitative methods were used as their reflections, perceptions and experiences constitute the foundation of this research.

This research examines what problems Syrian women encounter during migration and what kind of difficulties they face during their access to healthcare services. With the help of interviews, this study tries to reach this aim. By doing so, it tries to raise awareness of the relevant parties regarding healthcare problems of Syrian refugee women and make their voices heard. In this respect, this thesis is hoped to help Syrian refugee women have a powerful voice that can affect and strengthen their gender equality. That is why the interviews can be linked with phenomenological and feminist interviews. They reflect Syrian refugee women's feelings, perceptions, and experiences with respect to healthcare services. What is more, a phenomenological interview is associated with understanding person's view instead of a theoretical perspective. According to the phenomenological researcher Giorgi, questions are wide and open ended in order that topic has the adequate opportunity to declare a general point of view (Giorgi,1997).

Phenomenological method was used in this study to analyse Syrian women refugees' subjective experiences and semi structured individual interviews were administered to understand healthcare issues of Syrian women refugee living in Ankara. This kind of structure allowed the research to do an in-depth analysis. It gave the participants' the opportunity to reflect their experiences in an active voice. It was also quite effective in understanding these people's life experiences in a better way.

Some methods can be applied by qualitative researchers for sampling. Respondent-driven sampling is a structured type of snowball sampling, where participation starts with a limited number of researcher-identified focus group, which follows another group of participants until enough people have been taken part. The strength of this technique is that it expands the contact of people sampled on the other side of researcher driven and allows accessing beyond these participants (Semaan, 2010).

In qualitative research studies, snowball sampling technique is commonly seen. Snowball sampling enables researchers to guess about the social connection of invisible community. Snowball sampling technique is especially useful where the population of interest is difficult to access and gathering a sample of population causes problems for the researchers. Typical examples of the using snowball sampling method include sociological research into hidden groups which might be participated in sensitive topics or illegal issues like prostitution and drug (Etikan, Alkassim, & Abubakar, 2016).

In this thesis, snowball sampling is used to study healthcare experiences of Syrian women refugees living in Ankara. The first step in this research sampling was visits to Syrian refugee families who were the acquaintances of the researcher's social network. The aim of these visits was the introduction of the researcher to these women and establishment of connections with them. In this way, this first group members helped the researcher to access community, which means the involvement of more women into the study.

While establishing the connections and conducting the interview all ethical requirements were followed strictly. Since the participants specifically requested that their identity information be confidential, they were assured for confidentiality and anonymity was guaranteed to the participants.

CHAPTER 2

CONCEPT OF REFUGEE

2.1 Concept of Refugee

'Refugee crisis' reported in the last years have been associated with conflicts (the current war in Syria), ethnic persecution (Rohingya genocide in Myanmar), an act of aggression because of political and economic turmoil (Paraskevas, Brookes, & Altinay, 2019).

A refugee is defined as 'someone who has been forced to flee his or her country because of persecution, war, or violence' in the United Nations (Article 2 of the 1951 UN Convention relating to the status of Refugees). While refugees came from a lot of different places and they had different perceptions of conflict, oppression, and flight, they still have common experiences regardless of where they had originally come. Since there is not a concept of volunteerism in the migration process, refugees encounter the discomfort of having to abandoning their homeland, and not being able to return their countries, hence not seeing their relatives and friends again.

As a result, refugees became displaced and troubled, and worried about political atmosphere in their countries. Refugees have established common basis of getting actual experience of living through conflicts or escaping violence. Such experiences influenced their capacity to settle down (Phillimore, 2011).

Accepting refugee is not only a humanitarian responsibility but a legitimacy restore system in the structure of international state (Owen, 2016). General duty is required by all states. It appears natural to expect that states should accept responsibility for the provision of security and integration for refugees. Conversely, international law is likely to have deficiencies in reflecting responsibilities of states when a large influx of refugees has appeared. These two responsibilities can become compatible if they follow each other in a successive order. Non refoulment regarding regions where the lives and freedom of refugees are at risk of threats, the acceptance of asylum seekers and assessing the refugee position are the responsibilities of the neighbouring states those expected to comply with the Refugee Convention. This is also the explanation of why the countries in the proxy of humanitarian crisis leading to refugees should have an obligation to host or assist them. The refugees want to stay close to their homeland, hoping that one day they might be acle to go back to their country (Bauböck, 2018).

The first responsibility of states is not to generate refugees. If states do not fulfil this duty due to persecution and they cannot preserve their citizens from conflict, deprivation and catastrophe, other states have second responsibility to accept people as refugees. Refugee status can be offered to a person who has been threatened by violent police officers or local forces. If a state has an ability to provide defence but become unsuccessful at its attempts, it would explicitly or tacitly be deceiving in the persecution. The key issue is that the people who seek refugee status is unable to return to their own country to safeguard their human rights since their state has a deliberate confrontational style towards them and it is eager to permit these violations taking place under its guidance.

States that accept their responsibilities toward human rights would usually prefer to perform those responsibilities by supplying assistance externally rather than by accepting people whose rights are at danger. It is a reason for limiting refugee status to people who cannot be supported except by admitting them (Miller, 2016). The criteria of refugees to be accepted or returned chosen by the state is questioned. There are four possible reasons for accepting.

Firstly, the refugees demand for long-lasting settlement. The areas to which refugees are moved should be human rights compliant which implies that they afford all opportunities that are required to lead a virtuous life, not only food, accommodation but also other urgent needs (Carens, 2013).

The second one is due to the correlational role performed by the receiving state in generating the conditions the refugee is escaping from. Sometimes states have a duty to accept refugees since acts of the state have triggered the conditions in a country where refugees are not secure anymore. Americans acknowledge this in aftermath of the Vietnam War and accept large numbers of refugees from Cambodia, Laos, and Vietnam (Carens, 2013).

The United States has the same kind of responsibility for Afghan and Iraqi refugees, particularly individuals who are forced to leave because their lives have been endangered due to because of their collaboration with American soldiers. The general argument states that causal relations can create ethical responsibilities.

The third one is when the refugees have the potential to contribute to the economic welfare of the receiving country. Many countries accept immigrants by evaluating whether they have special ability which will support to the economy. However, can this measure be used lawfully when choosing which asylum seeker to accept? The evaluation of the refugees' status should

be focused on the risk to his human rights, not on their possible contributions. Otherwise, giving them priority on the basis of their contributions may seem arbitrary.

The fourth one is the level of cultural connection between refugees and receiving country's political climate. According to Carens, state's eagerness to accept refugees is based on the fact that whether the existing population recognizes with the refugees and their struggle. If the more refugees looked like the current population regarding cultural kin, heritage, language, religion etc., it would be easier for refugees to embrace the new community and for the host society as well to accept them (Carens, 2013).

To illustrate, the conflicts in Syria and Iraq that happened in 2014 caused in some areas for Christian countries like the United Kingdom to prioritize Christian refugees fleeing from these countries. It was justified on the surface that Christian families were subjected to extremely devastating persecution but also on the basis that Christian states had important responsibilities to people who have common national religion. In the case of Iraq and Syria, Muslim refugees would probably be given shelter to nearby Islamic states like Jordan (Carens, 2013).

Generally, states are willing to give priority to people who experience their citizen's traditional or religious values. However, without considering the essence of the responsibility toward refugees, cultural criterion does not appear justifiable.

The receiving state has taken precaution to block refugees from arriving their coast so that they avoid fulfilling their duty of non-refoulment. This behaviour is harshly criticized as a violation of human rights. Conversely, supporters will assert that this can be self-defence in a circumstance that some countries are reluctant to handle their fair division of the refugee burden. It is an alternative obligation that if other states did not breach human rights of people living their territory actively or passively, there would not be any refugee issue at first (Carens, 2013).

Currently, democratic states accept refugees in two forms: asylum and resettlement. Resettlement happens when a state chooses refugees who have discovered a safe place, generally under advocacy of United Nations, and provides them a permanent place. Many of the states with important resettlement plans are conventional immigration countries. There are two important issues regarding resettlement which has been practiced currently.

Firstly, the total number of resettled people is really small compared to demands of refugees. To illustrate, there were more than ten million refugees under care of the UN High

Commissioner for Refugees (UNHCR), more than half of people had been faced deportation for many years. However, nearly 80.000 places were accessible for resettlement. Thus, resettlement presently assists some refugees, but it becomes pointless to most of them. Secondly, there is no commonly accepted obligation to accept refugees for resettlement. States which take refugees for resettlement can be perceived as thoughtful, but states that ignore to do this breach no commonly accepted rules. For this reason, resettlement, as today practiced, is not recognized as an ethical duty which restricts the state's discretionary power in the issue of immigration. Another way that democratic states accept refugees is through giving them asylum. In accordance with the Geneva Convention on Refugees, states are not likely to transfer refugees to their own country or transmit them to other countries in which their lives or freedoms would be endangered. This means the principle of non-refoulement. Each state has implemented policies to block people from coming and asserting refugee status in North America and Europe. One of the significant methods was to enforce more strict visa controls on countries that their citizens appeared possibly ask to apply for asylum on their arrival. People were expected to arrange required documents about their circumstances which would persuade immigration authorities that they would intend to go back home and thus would not seek for asylum.

What is more, states implement other regulations to limit the filing of asylum requests. One influent tactic is to call for any asylum claim to be filled up in the first secure state in which a claimant had come after decamping from his homeland. In the wealthy democratic states, this had the potential of restricting assertions because most of the refugees mostly move on land and most refugee-producing countries do not borderline the United States or Western Europe (Carens, 2013).

2.2 International Protection & Refugee Status Determination in Turkey

The 1951 Convention provides an essential basis for the protection of refugees by establishing basic values that is necessary for construction for international protection of refugees. These principles reported the principle of non-refoulment, and protection must be expanded to all refugees against discrimination. The refugee issue is essentially social and humane; thus, perception of refugee should not be the causes of strain between states (Feller, 2001).

The 1951 Convention does not identify how to decide if a person meets the concept of refugee by the State Parties. Instead, each state party is allowed to create proceedings for the establishment for refugee status determination and asylum procedures. This has caused

differences among states since the governments of these states make asylum laws depending on their distinct resources, national security, and experiences of their forced migration movements. Despite differences among the countries, the ultimate aim of the contemporary refugee system is to offer security to people who have felt compelled to leave their homeland since their countries are reluctant or incapable of safeguarding their citizens (Jovanovski, 2019).

The concept of non-refoulement means prohibition of returning which has appeared as necessity in history in the practice of international communities of international attorneys. This principle has clearly become visible in an increasing variety of international conventions which require that refugees must not force to send to home countries. The non-refoulment has offered comprehensive security, achieved widely acceptance, and provided positive legitimate implementation at the universal level by means of Article 33 (Molnár, 2016).

It pertains to a wide range of individuals, covering those pursuing asylums and those already accepted asylum, without looking whether the individual gets in the host state legitimately (Farmer, 2008).

The refugee status is not granted when refugee status is not demanded or expected any more. In addition to this, when a person is regarded as a danger to the security of the country or constitutes a danger to the community of that country (Article 33(2) of the 1951 Geneva Convention) in order to protect the community from serious danger, the refugee status could be revoked.

Refugee law in Turkey confirms that it is legitimately impractical to settle 'non-European refugees' in the long term. International protection strictly is given temporarily in Turkey (Koçak, 2020). In October 2008, "The Migration and Asylum Bureau" and "The Bureau for Border Management" were founded. The UNCHR and the IOM have developed managerial support for the operations of bureaus. The initiation of the two institutions is a reflection of the regularization of the migration administration. The fundamental objective of the Migration and Asylum Bureau was to draw up the "*Law on Foreigners and International Protection*" (LFIP) (Üstübici, 2019). LFIP offers significant changes so that Turkey can deal with refugee issues with a better efficient and fair administration in accordance with the international laws and at European standards (İçduygu, 2015).

The LFIP can be regarded as a pillar of Turkey's migration policy in long term. However, Turkey imposes the geographical restrictions which indicate that Turkey does not admit non-European people as refugees. This position causes uncertainty in the matter of refugee

protection. When the precarious status of non-European refugees is evaluated, international protection has vital importance to the current asylum mechanism. Hence, international protection is controlled by the third section of the LFIP. Four main definitions have been adopted. These includes refugees, subsidiary refugees, conditional refugees, and temporary protection. Even though concept of refugee is used for European refugees, the concept of conditional refugees was defined for non-European refugees because of protection of geographical limits. Furthermore, Article 62 in the LFIP reflects "*Conditional refugees shall be allowed to reside in Turkey temporarily until they are resettled to a third country*." Therefore, it can be stated that non-European refugees are required to leave Turkey just after the termination of the process of resettlement. From this perspective, it can be said that for non-European refugees, local integration is not possible (Dalkıran, 2016).

What is more, "*Regulation on Temporary Protection" (TP)* was adopted in 2014 that enabled humanitarian assistance by granting access to education and health services, social welfare, communication. Article 20 in the Regulation on Temporary emphasized that urgent health services will be offered as a first concern to foreign people who arrive at health facilities are assessed to have urgent health needs. Article 27 indicates provision of health care services in a detailed way. Health services which are provided under the supervision of Ministry of Health listed above.

a) Health services need to be set up. If there are already established healthcare facilities, adequate ambulances and medical staff should be provided.
b) In the emergency and primary situations, patient payment costs must not be charged.
c) The payment of health services should not exceed the payment in the "Health Budget Law".
d) People who have opportunity to benefit from Temporary Protection cannot get health care services in the private health facilities if emergency situations happen.
e) All necessary precautions should be taken, and analysis and immunizations practices should be controlled against the possibility of infectious problems.
f) Qualified staff should provide knowledge and regulate tasks regarding reproductive health (Özcürümez & Yıldırım, 2017).

What is more, Turkish government enhances the opportunities of healthcare services of the Syrian population by means of SIHHAT programme. With this purpose, organizations are prepared in the concept of improvement health care facilities for Syrians and enhancing health awareness. SIHHAT project was carried out by means of the European Union (Egici, 2019).

In this context, whereas healthcare workers can practice their job by learning the Turkish health system, Syrian individuals can benefit from health services in their native language and traditions. The Ministry of Health planned and applied adaptation education for Syrian health professionals such as doctors, healthcare interpreters, nurses, mental health, and psychosocial staff to enhance accessibility of the effective and equal services, especially services which are sensitive traditionally and linguistically.

Adaptation trainings are implemented for Syrian health workers under SIHHAT project. Syrian health professionals started to work in the Turkish healthcare system. Arabic and Turkish translators employed as a patient guide by the Ministry of Health. Adaptation Trainings includes information about adaptation to Turkish health service. Patient guides organize communication and negotiation between healthcare staff and foreign people, as well as directing them to the relevant departments. While doing so, in addition to translation they may need to make interpretations, which needs extra training.

The composition of training is limited to four key components, which contains Turkish Healthcare System, conversation, general concept of medical terminology and patient protection and privacy. In this system, theoretical trainings have been aimed to adjust them to Turkish health structure and health terminology in healthcare facilities (Toker, 2019).

2.3 Rights of Refugees

The human rights issues of non-nationals are widely discussed but still there is incompletion in terms of international legal agreement. The human rights issues of non-nationals have been widely discussed but there is still incompletion in terms of international legal agreement. In history the prejudice against foreigners can be seen in early Greeks. They used to differentiate the foreigners from their citizens by addressing them with the terms like “barbarians” or “nonbelievers” (Nafziger, 1983). In Hindu, Roman, and Greek societies, these “nonbelievers” did not acquire rights as the law was shaped by religion and the concept of citizen was specified as a person who follows rituals of the religion of the city (Tiburcio, 2001).

The common problem faced by human right treaties in evaluating reports is some constitutions just grant rights to nationals while international human rights regulation is likely to afford rights for all people. Some constitutions improperly discerning between rights have offered to individuals who have acquired their nationality through birth and people who have not. The only addressed of the common principle of non-discrimination in constitution is not an adequate

answer to provision of equality in the human rights law. States are required to have comprehensive regulation to challenge all types of discrimination and efficient solutions to make restitution for a breach of such law as well (Weissbrodt & Divine, 2012).

Nowadays, millions of refugees are escaping from inequality, brutality, and conflicts in the world (UNHCR, 2015). Any country can really be capable of accommodating many displaced individuals. The international community acknowledges this when community is gathered and adopted conventions to safeguard refugees. Origin countries have demonstrated lacking the provision of the basic needs of the government. Refugees mostly absence of right to education, documentation, and sense of well-being (Karas, 2015).

CHAPTER 3

WOMEN'S HUMAN RIGHTS

3.1 Concept of Women's Human Rights

The UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) tackles the aspects of women in poverty situation and financial needs emphasizing the importance of gender equality in terms of caregiving, types of credits and lending and promoting the fundamental rights of poor women concerning accommodation, food, or other basic needs (Grabe, 2018). Feminist scholars from most of the world have expressed that gendered public field which can be linked with strength, advantages, opportunities, and richness restricts and manages women's access to services and inhibit ability of women to govern laws that defend their rights (Tamale, 2004). The theory of gender and power assumes that inequalities based on gender are prevalent social features which culminated with men's excessive power in community (Connell, 1987).

The rising concern regarding women's human rights frequently includes global language related to that used formerly which expresses women and men in the homogenizing concepts. Firstly, the main principle underlying universal human rights is that these rights are provided autonomous persons who are free from social and historical circumstances like deprivation, discrimination based on gender etc. An apparent result of this is that in many situations women's suppression not only is a subject of gender but also affected by variables that may encompass race, gender, sexual identity, and economic exploitation which their male equivalent already suffers.

Thus, intersectional perspectives emphasize different sources of power which constitute threats to women unlike homogenous and universal feminism. These two approaches place importance on solely the power imbalances between men and women. Another concern is related to definitions of the rights by the West, which means the evaluation of the rights are done with the standards of white women, straight women, and Western feminists (Lal, McGuire, Stewart, Zaborowska, & Pas, 2010).

To illustrate, criteria of human rights based on Western principles can be perceived as another example of oppression and restriction on women who are able to describe their own standards

of rights and justice (Phillips, 2002). However, many views of the majority of people as well as, the rights of women were not well reflected in universal declarations (Lykes, 2000, 2001).

That is why, women around the world have tried to extend the current human rights agreements by announcing the United Nation's Convention on the Elimination of Discrimination Against Women (CEDAW), which aims to identify places where women are rejected deprived of equality with men (UN,1979). Commonly accepted as the international treaty of women's right, CEDAW clearly recognizes that immense discrimination persists to exist against women and that discrimination damages norms of equality of rights and esteem honour of human.

Even though 189 countries have ratified the CEDAW, there is a wide gap between the equal rights defined in the CEDAW and those are reflected in the lives of women. A report documented by the UN in 2011 outlined that many infractions of women have become unrelieved, partially since justice system have strengthened unequal distribution of power between men and women and they are discriminatory towards the rights and well-being of women (UN, 2011).

The key point of transnational feminism includes discussion of how structures of global power reinforce or maintain gender oppression. It is important to concentrate on societal structures and mechanisms of power to recognize the violations of women's rights and social justice. To illustrate, one of the most common group-based inequalities is based on gender around the countries and cultures by which men and women have different roles that articulate the prejudice of male structural and social influence (Pratto, Sidanius, Stallworth, & Malle, 1994). A brief look at international facts instantly reveals that nearly without exception women all over the world are weakened by power differences and are in more subordinate situation than men (Acosta- Belen & Bose, 1990).

3.2 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) is women's rights treaty which was adopted in 1979. It exists in the form of a multilateral treaty that sole binds countries that agree to ratify it (Merry, 2011). CEDAW is accepted as universal identification of women's rights as human rights and their integration into human rights framework of the United Nations. CEDAW implements two significant concepts in the antidiscrimination law. Firstly, it addresses instrument for safeguard of women against all types of overt and indirect discrimination in different aspects of life. Secondly, it obliges for state

Parties to take all proper measures to authorize women or to advance women. CEDAW formed the CEDAW Committee which consists of twenty-three experts. State Parties have responsibility to submit a report to indicate provision of CEDAW (Šimonovic´, 2014).

The members of the Committee are selected for four-year term and members can be elected several times. The member of the Committee has predominantly women and members have a wide range of professional profiles such as politics, public health, education, law, diplomacy. All members are selected as independent experts for performing their duties rather than government representatives and members are not subject to the directives of the government that chose members. Due to requirement in the convention, membership needs to come from different parts of the world, representing the diverse views in legal systems despite overrepresentation of some parts of the globe.

State Parties are required to submit a preliminary report within one year after their entry and following this initial report, they need to submit their report every four years afterwards. The submission and analysis enable State Parties to get an opportunity to see their progress with the help of an objective evaluation by an external specialist thus enabling the country to provide its citizens the joy of rights guaranteed by CEDAW. Even though many State Parties overstate their success mainly legislative changes, they mostly pay less attention to failures to act for looking for fulfilment of equality for women. The purpose of the CEDAW Committee's assessing report is to recognize factual conditions in the country as well as drawbacks and progress that need to be addressed.

The main function of the Committee involves evaluating the scope of its implementation of the Convention in practice in nearly all the countries in the world, which requires. an application of a universal standard for equality and non-discrimination. Therefore, it needs to take a diverse sense of legal, religious conventional and cultural systems into account ranging from - the small nations to the biggest in the world. It should reflect all these systems varying from advanced democracies to unstable ones (Byrnes, 2010).

3.3 The Reporting Procedure

Each State Parties, both ratifying or accession to the Convention, submit their first initial report on legal, legislative, administrative, or other measures taken by the country to be effective with respect to the Convention. Following this, the other reports can be submitted every four years or whenever the Committee asks for. This report is the first attempt for the State Party to report

to the Committee its policies and procedures conform with the Convention that has ratified. Firstly, the report should constitute administrative, legal, and constitutional structure for the enforcement of the Convention. Secondly, the report should describe the legal and functional steps implemented to make effective for provision of the Convention. Thirdly, the report should exhibit the progress made in ensuring that persons within the State party and subject to its jurisdiction enjoy the provisions of the Convention. In the content of the report, State Party should focus on the factual circumstances and the practical accessibility and impact as well as solutions for violations of the Convention with explanations and examples.

What is more, the report should state if the Convention is relevant under domestic law on confirmation and whether a constitution or other legislation guarantees the provision of the Convention. The report also should explain how Article 2 of the Convention is implemented and indicate the legal steps that the State Party has affected to implement Convention rights (UN, 2007).

3.4 The State Parties Reservations

Reservations are a significant issue around the international legal system. A few of the reservations to CEDAW are specially challenging, reaching to the centre of core issues like nationality, equality in the family relations, and legal capacity. Even though joining a reservation would appear to prevent consideration of the reserved requirement(s), many reservations emphasize that whereas the States Parties are still not ambiguously dedicated to the international requirements set out in the Convention, they want to maintain dialogue. In some situations, with the help of these reservations, the states can foster their dialogues with both CEDAW and the society as they focus on the resolving of the identified issues and when CEDAW withdraws these reservations, this gives these states promote themselves in the international area.

The Committee implemented new regulations for State Party reports in 2008. According to reservations, the Committee clearly marked the necessity to clarify reservations and their continued maintenance should be explained. What is more, the Committee identified Articles 2, 7, 9 and 16 as especially important. The State Parties that have made general reservations which do not point to article or are referred to Articles 2 and/or 7, 9, 16 should review influence and interpretation of these reservations. State Parties should provide details about any reservations or statements they may have similar requirements in similar human rights treaties (CEDAW Committee, 2008).

Many of the CEDAW reservations discuss comparatively technical issues like customary title and jurisdictional matters. The most reserved clause is Article 29, connecting to negotiation of conflicts over the implementation of treaty clauses. Neither of the Latin American states have made significant reservations, but many of them failed to enforce women's human rights, especially linked to reproductive rights and violence. European states made no reservations or restricted reservations, but wage disparities and violence against women continue. States make reservations on specific articles to show the fields in which they accept deficiencies and aim to fix, and many of the states have withdrawn these reservations since their cultural and political frameworks have shifted. Reservations show spheres in which situation of women is of matter to the reserving State Parties regardless of the reason.

In its evaluations, the CEDAW Committee routinely approaches States parties in a useful dialogue on the prospect of reconsideration laws, religious principles, and traditional exercise to decide whether reservations may be revoked. The experts concentrate on the results of the reservations for women, community, and families. They give support to limit reservations if State Party cannot be fully withdrawn, and they advise State Parties' reservations which have modified their laws to remove the relevant reservations. It is significant to withdraw reservations beyond an administrative and legitimate motion.

The withdrawal of reservation offers confirmation to local civil society groups and motivation to supporters in other countries, this also means that other State Parties can reconsider their reservations. More importantly, this implies the state party's commitment to improve the status of women and the responsibility taken over by the state to be able to do this (Freeman, 2009).

The main constructive reservations are to CEDAW Articles 2, 5, 7, 9, 15, and 16. Reservations to Article 2 are especially arguable since Article 2 sets out basic condition to conform with all clauses of the Convention in the constitution, laws, and regulations of the State Party. States are expected to be effective in implementing laws and regulations to eradicate discrimination towards women and trying to change and eliminate discriminatory customs and values. All or some parts of Article 2 have been reserved by twenty-two states.

A reservation to Article 5 implies that a State Party does not desire to investigate carefully and approach the basic attitudinal problems that motivate sex discrimination. The enforcement of Article 5 involves a significant effort to control public behaviours towards women, take steps to eradicate traditional attitudes that damage or undermine women and foster innovative thoughts regarding gender roles. This can be absolutely considered as complicated, but it is not

difficult and impractical. It is a basic principle of international human rights law that rights should not be perceived as contradictory to one another because all of them have been originated from the Universal Declaration of Human Rights. States have a responsibility to create the balance which treats all human rights in an equal way and to overcome sex discrimination by means of legal methods.

Reservations to Article 7 generally are linked with laws or traditions that preclude women from working as judges or as high standing officials of government. Thus, women are discouraged from directing policy and legal decisions that have a significant effect on the lives of women and the fulfilment of their human rights. Article 7 has been reserved by four states.

Reservations to Article 9 are mostly to 9(2) which grants women to transmit nationality to their children. The failure of women to transmit their nationality to children leads to considerable difficulties for children, household, and mothers. Absence of nationality may block children from educational resources, the right to health care, the ability to move with other members of the family, and chances for military or national service that can constitute an important career path.

In several states, women cannot make a journey outside of the country with a child if women have not verified that there is an approval from the father. Furthermore, many countries that restrict the nationality of women in this way do not permit children to be supported by the passport of their mother. Now, Article 9 has been reserved by nineteen states.

Reservations to Article 15 is linked with the legal capacity of women, the identification of their rights to make decisions and implementing these decisions for both themselves and their families, to receive inheritance and to own and manage their property. The absence of legal power causes women in a vulnerable position. Article 15(4) grants freedom of motion and equity in the decision of dwelling and many states reserved Article 15(4). The preference of residence depends on husband or male in many states. Article 15 have been reserved by thirteen states and majority part of reservations are to Article 15(4).

Article 16 completely incorporates equality in marriage and divorce. All its clauses are vital to women's capability to maintain their lives as equal partners in the family and to take care of themselves and their children. An identified reservation to Article 16 brings into question the State Party's obligation to cope with child marriages with all detrimental results for women and girls.

CEDAW Article 16 (1) indicates basic steps of equality in marriage, probably between two people who have openly agreed. Reservations to any clause of Article 16(1) demonstrate unwillingness to accept the full adequacy of women as individuals in the family. If women do not have equal access to ownership and property rights, women are hindered in decision making in marriage and can be left needy after the death or divorce of the husband. It should be noticed that the CEDAW Committee determined that polygamy is a breach of the human rights of women through Article 16 in 1994. Article 16 is reserved by thirty-four states and all or section of Article 16 have been reserved by many countries.

Turkey is a noteworthy example since it is secular state with a greater part Muslim population that accepted and subsequently removed reservations to many significant clauses of the CEDAW Convention. When Turkey had access to Convention in 1985, it applied reservations to Article 15 (2) which supports equal legal power and rights to control ownership and Articles 15 (4) linking with residence.

Turkey also reserved Article 16 (1) (c) equal rights during marriage and divorce, (d) equal rights and obligations as parents, (f) equal rights as executors, adoptive parents, guardians, and (g) rights to surname and to preference of profession. The “Law on Protection of the Family” was implemented in 1988 to provide orders for protection in domestic violence incidents. In 1999, Turkey removed its reservations to Articles 15 and 16 because many attempts were maintained to change the Civil Code.

In 2001, the Civil Code was modified to support for equality in marriage and dissolution especially divorce, keeping the marriageable age at 18 both men and women, equal split of property on divorce, attribution of economic importance and power to the non-financial contributions of women and enabling opportunity for single parents to adopt children. The constitution was modified to redefine the family unit, underlying the importance of the equal powers of the spouses as depend on spousal equality in 2001. It is apparent that the removal of Turkey’s reservations corresponds with political developments especially increasing power of women's advocacy. In 1999, the reservations to Articles 15 and 16 were removed and existing substantive reservation relating to Article 9 (1) was removed in 2008 (Freeman, 2009).

CHAPTER 4

INTERSECTIONALITY AND REFUGEE WOMEN

4.1 The Concept of Intersectionality

The concept of "intersectionality" deals with the aspects of numerous inequalities because it supports the idea that the interaction of these inequalities keeps the characteristic dynamics together at their multidimensional interface (MacKinnon,2013).

In 1989, Crenshaw proposed the concept of intersectionality in the legal framework. The concept that components of identity like gender and race do not manage separately but are interconnected with experiences of people (Chang & Culp Jr, 2002)

Intersectionality is a representation of the collaboration between structures of oppression. The definition formed attempts to identify how political and social life were influenced by race and gender relations. As an idea, intersectionality is objected to monism, the notion that it is possible to properly examine or understand each type of social interactions (gender, race, class) independently from each other as a single subject.

The notion of intersectionality also emphasizes the boundaries of the concept that social structures are piled on top of each other to produce a double or threefold or triple or a fourfold burden or double repression. Intersectionality has been very significant in identifying the constraints on current theoretical perspective to gender analysis. In particular, the principle of intersectionality has been useful to show how thinking in terms of gender plus race is insufficient and makes women's experiences at the intersections of these social relationships difficult to understand (Weldon, 2008).

Intersectionality has been originated from the idea that social formation intersects to form social situation. It supposes that social situation, and related social groups are shaped and described by social structures (constellations of rules, norms, institutions, customs) (Collins, 1997; Young, 1994). Intersectionality provides us insights as to how to implement human rights so that we can promote equality and participation by diverse groups while designing implementing and monitoring laws, policies budgets and programmes (Truscan & Martignoni, 1995).

While analysing the differentiation processes which have created relegations of groups, suppression, and economic exploitation, it is highly important to perceive intersectionality as a concept that does not only include social categories but also its formations and epistemological

basis. Intersectionality enables us to comprehend how power works through the construction of categorization systems and social segmentation that cause inequality and make it invisible but at the same time make it seem necessary (de Los Reyes & Mulinari, 2020)

The lack of intersectional approach exacerbates the problem of not seeing the main causes that condemn racialized migrant female workers to violence, over exploitation and injustice. (Stasiulis, Jinnah & Rutherford, 2020).

Social justice is closely connected with intersectionality and migration. Both include procedures of classification which are strongly integrated in social science and policy, and they serve as a significant tool for us in comprehending and constructing the social circumstances. Both also support political goals and interests and are related with hierarchic categorization of goodness and accessibility of constrained structure of rights (Crawley & Skleparis, 2018).

The concept of intersectionality for dealing with fairness issue of migrants, and unfair issues shaped through the migration process, is embedded in its arrangement with numerous power relations. Intersectionality has been associated with concerns of social justice and has involved in significant place in evaluation of national, localized, and international inequalities, especially in the framework of international human rights of feminist politics, rules, and law (Cho, Crenshaw & McCall, 2013).

At the centre of intersectionality perspective, there is a growing part of migration analysis. The lack of intersectional analysis is more visible in legal changes of areas of living circumstances, labour, and health policies. What is more, violence and danger penetrate the migrants' sources of income in non-safe parts of the state borders. Implementing an intersectional approach for methods of sufferer that oppressed racially and migrant women have formulated to overcome various forms of violence in their lives is significant (Stasiulis, Jinnah, & Rutherford, 2020).

4.2 Discrimination and Equality

The concept of equality and non-discrimination against individuals was ignored before the Charter of United Nations and these principles remained connected with the idea of state equality. Although the concepts of equality and non-discrimination are well formulated in international law, their application in international jurisdiction has become more challenging. In theory and human rights framework, there is a variety of terminology used to refer to equality and discrimination. These include transformative, formal, and substantive equality and structural, indirect, and direct discrimination (Charlesworth, 2002).

However, it is very simple to say that direct discrimination is just intentional discrimination. Lippert-Rasmussen rightly points out that there may be cases of direct discrimination that does not involve the intent to disadvantage anyone because of group membership (Lippert-Rasmussen, 2013). Indirect discrimination distinguishes from the direct type in that actors do not target disadvantage persons for being part of a certain community (Altman, 2011).

Structural discrimination analyses the regulations that implement and govern the key sectors of life including the family dynamics, ownership, political powers, and responsibilities (Pogge, 2008).

These regulations and rules are discriminatory, and they are mostly explicit product of common and individual representatives like a legislative branch or executive authority. Structural discrimination means that rights and resources are available to one group while another group has limited or inaccessible rights due to the legal and social policies, perceptions and actions of organizations and other social systems (Altman, 2011).

Structural discrimination reflects the principles of majority institutions and attitudes of people who enforce and regulate these institutions which are neutral in terms of race but have distinct or negative effects on minority groups. The main aspect of structural discrimination is not to aim but the impact of maintaining minority groups in a subordinate position (Pincus & Ehrlich, 2019). The concept of structural discrimination may help to explain the circumstances under international human rights law (Schutter, 2010).

In order to provide illustration of CEDAW, Article 5 involves the concept of structural discrimination which demands contracting parties to remove social structures like traditions and biases and all other behaviours which focus on principle of inferiority or superiority and roles which are given by society for women and men (Holtmaat, 2012).

A structural analysis has been applied by the CEDAW Committee. The obligations of the States parties are to tackle with the violations of women's rights including structural sex and gender-based discrimination that can constitute the basis of these violations (Holtmaat, 2004).

Sexism, racism, and other forms of discrimination are different from individual prejudices in that they go beyond these individual ones as they are implanted in a larger structure of a society (Fredman, 2016).

The CEDAW Committee has internalized the concept of transformative equality (Henn, 2019). To establish transformative equality as a target, it opens a way to focus on challenging social and institutional systems and eliminating the factors of embedded types of discrimination (Biholar, 2014).

4.3 Intersectional Discrimination in CEDAW

The CEDAW Committee provides an inclusive and dynamic approach to intersectional discrimination. In the Recommendation No.25, the CEDAW Committee, it is emphasised that in addition to being discriminated as women, some groups of women may also face various forms of discrimination based on additional grounds such as race, ethnic or religious identity, disability, age, class, caste, or other factors. Such discrimination may affect these groups of women primarily or to a different degree or in different ways than men. States parties may be required to take certain temporary special measures to eliminate such a wide variety of discrimination against women and its combined negative impact on them (CEDAW Committee, 2004).

The CEDAW Committee argues that gender and sex-based discrimination against women is inseparably associated with other factors which influence women like status, age, religion, sexual orientation, and health (CEDAW Committee, 2010). The discrimination faced by older women is mostly multidimensional, considering with age dimension of gender-based violence in particular migrant status, marriage or parental status, ethnic and minority groups (CEDAW Committee, 2010).

The CEDAW text and the CEDAW Committee have developed a sophisticated understanding of intersectional discrimination. Sex and gender discrimination are not isolated and inseparable from other forms of discrimination. In the General Recommendations, CEDAW and the CEDAW Committee take an integrated perspective to the detriment of cross-cutting discrimination based on eliminating discrimination and achieving equality (Campell, 2015).

The CEDAW Committee emphasizes that types of discrimination and their intensive detrimental effect on women must be acknowledged and forbidden, and policies and strategies must be implemented (Truscan & Martignoni, 1995). The Committee has continued to use intersectionality language in several other recent General Recommendations, including Recommendation 30, expressing women and conflict prevention, conflict, and post-conflict situations in 2013 (CEDAW Committee, 2013).

Furthermore, the rights of rural women are reviewed by the Committee Recommendations (CEDAW Committee, 2016). Access to justice for women is included in the Recommendations. Notably, General Recommendations state that discrimination against women is exacerbated by intersecting causes which influence some women to a degree or in a way that are different from those that affect men or other women (CEDAW Committee, 2015).

The Committee states that laws should identify the underlying causes of attitudes, particularly sex-gender based discrimination, discrimination based on age or intersecting elements and give importance to human rights. In addition, social standards are linked with each other. Harmful applications need rights-based approach which acknowledges the unification and interconnection of rights (CEDAW Committee, 2014).

Ideological structures formed by extreme fundamentalism and nationalism which conceptualize women as carrier of the traditions and values have caused sexual harassment against women as political representation of violence. These acts of sexual violence are mostly driven by propaganda depending on race and gender (UN, 2000).

Numerous refugee women are systematically discriminated against based on race and gender. Due to this racial discrimination, women become more vulnerable. Attackers disrespected the women due to their gender creating and observant gender discrimination along with racial discrimination. This conditions double discriminate women, making them more vulnerable to rapes, systematic rape, and sexual torture to shame the men of their community (Charlesworth & Chinkin, 2000).

Sexual harassment and rape have been used to abuse women of specific ethnic groups and as a tool of genocide in Rwanda, East Timor, Bosnia, and Sierra Leone were linked with ethnic-based conflicts (Linke, 1997).

Refugee women are often classified as second-class citizens in the place of destination as numerous migrant workers. The abuse of refugees and migrant women is the consequence of discriminatory state policies of host countries in the West and Asia-Pacific, especially about labour and immigration. Many refugee women have encountered discrimination in the matter of wages, working circumstances, security, employee training and the right to join union. They are mostly exposed to physical abuse and sexual harassment, and they have no protection under labour law when they work illegally. Employment opportunities are generally restricted to domestic jobs or the sex industry where the right to obtain, change or maintain nationality, the right to work, the right to health and other fundamental human rights are contravened. The

consequence is that refugee women and their families are in a more vulnerable position to race, religion, and gender discrimination (Pittaway & Bartolomei, 2001).

Furthermore, access to health services is very important for the life chances of refugees fleeing conflict zones. Access to health services is a basic human right, regardless of migration, and refugees face greater health risks compared to the general population (Fine, 2018). According to physicians based on studies, refugees should have the same rights as the citizens of host countries. If there is a disproportion in rights, social discrimination might emerge. Health inequality can lead to discrimination towards refugees and discrimination is one of the factors that affect health and can be associated with the exacerbation of the health and well-being problems (Priebe et al., 2011).

CHAPTER 5

SYRIAN WOMEN REFUGEES IN TURKEY AND HEALTHCARE

5.1 The Right to Health

The human right to health was first publicly declared in July 1946 as one of the fundamental principles of the World Health Organization. The minimum pillar of the human right to health comprises of delivery basic health services, secure drinking water, sufficient food and hygiene, essential health education, reproductive and child health services, and necessary medicines. As determined by the World Health Organization, required medicines are those medications that meet primary health care necessities of the community, thus it should be always accessible in sufficient amounts, in the proper forms, with guaranteed quality, and the cost that person and society can acquire (Hayden, 2012).

The international right to health is embedded in significant international agreements and smaller treaties about human rights, providing protection depending on age, gender, and race. The Universal Declaration of Human Rights affords "everyone. . . has the right to a standard of living adequate for the health and well-being of himself and of his family, including . . .medical care and necessary social services". Numerous states have the right to health integrated in domestic laws. More than 100 state constitutions embody the right to health covering above 50 % member of the United Nations. These constitutions assure or strive to preserve a right to health, especially prophylactic or a right to health care services (Dittrich, Cubillos, Gostin, Chalkidou & Li, 2016).

Under international law, states that are party to various treaties undertake three folded obligations. The first one is related to health rights. The states have to show respect the right to health by avoiding direct violations in the healthcare system. Secondly, they have to sustain the rights of the people from the intervention of third parties. The third one is that they have to satisfy the rights by taking steps to ensure not only universal access to care but also preconditions for health. Human rights structure concomitantly accepts health as innately political which is closely connected with social situations, principles, and power arrangements.

Also, human rights framework eliminates health policy resolution from being subject of political control by putting them directly into the law. Application and implementation of the right to health is seriously based on parliamentary and judicial review at the domestic level.

The right to health is accepted by over than 70 state constitutions, and much more countries legislate different dimension of the right to health. Domestic courts and local bodies which have discussed what minimum requirements governments should be expected to follow. Firstly, states have commitment not to implement reactionary measures. Secondly, there must not be discriminative strategies and polices. Thirdly, states must try to control actions of third parties that intervene the right to health. Fourthly, governments can need to advance national policies and actions to overcome health problems (Yamin, 2005).

5.2 Refugee Health

War produces a growing militarization and masculinization of community. Militarism is described as the prevalence of symbols, principles and discourses that justify military strength and readiness for war (Turshen, 1998). Militarism does not generate but aggravates the discrimination against women which is also performed in patriarchal societies (Ashford & Huet-Vaughn, 1997).

The disproportionate emphasis on military force influences the health of public, especially women's health. Health institutions might be bombed, and health care facilities could be destroyed, and health standards fall in war. Deficiency of food and drug lead to insufficient natal treatment care with increased numbers of unplanned abortions and higher mortality rates of mothers and infants. There is a direct discrimination against women's access to health care in some countries like Afghanistan. Religious restrictions require that only women have to treat women despite the few female doctors (Gardam & Jarvis, 2001).

A study conducted within the framework of the IRCT (International Council for the Rehabilitation of Torture Victims) humanitarian project revealed that Bosnian refugee women with gynaecological problems due to rape or hormonal difficulties did not receive medical care for three years after fleeing to Croatia as they could not afford these health services (Arcel & Kastrup, 2004). Due to war, violence, and conflicts, in addition to many illnesses that are caused by the stress of these, many African women have been diagnosed with diffuse malaria alongside with nervousness', fatigue and pains, which have no treatment (Turshen, 1998).

Emergency assistance to refugees and displaced people mostly requires enormous logistical operations, especially when there are large-scale population movements. Clean water, hygiene, food, and health facilities should be arranged as soon as possible to save lives and the needs of the refugee society should be explored. These essential needs should be addressed without

considering the individual social and cultural context of diverse refugee groups (Frontières, 1997).

Many refugees are lacking regular healthcare and encounter problems in receiving health facilities. Even though majority of the refugees are shifting to a new life and efficiently incorporate into the community, many refugees have been confronting with healthcare problems owing to existing and happening healthcare facilities. Extreme and repetitive government initiatives and policies and changes in identification of refugees and their authorization led to difficulties in receiving healthcare. Many refugees are at the threat of severe mental, physical, and social challenges which lead to poor health results and hinder effective social inclusion. Many refugees encounter ongoing challenges and are isolated in their new destination (Khan, Fary, & Amatya, 2017).

Studies that have been carried out in the United Kingdom revealed that one in six refugees have suffered from physical health problems severely which influence their lives and two third have encountered depression or anxiety (Burnett & Peel, 2001). The frequent health problems of refugees consist of injuries, infection, inadequate immunization in children and under managed chronic disease like diabetes, chronic pain, and hypertension (Amara & Aljunid, 2014).

Various type of traumas such as major depressive disorder, posttraumatic stress disorder is accepted as mental health disorders amongst refugees (Guajardo, Slewa-Younan, Smith, Eagar & Stone, 2016). There are variety of reasons why refugees mostly encounter with accessing health facilities. These cover language problems, financial restrictions, lack of confidence, and inexperience with national health service. Health professionals are likely to have inadequate proficiency and ability to sufficiently cope with persecution or unfamiliarity linked with health situation (Smith, 2003).

Many refugees acquire psychological symptoms and behavioural disorders to escape from stimuli which trigger past experiences of refugees. When physical assessment is required, sensitivity is mostly expected regarding gender of the sufferer and doctor. This may stem from traditional or religious considerations, or past sexual harassment (Harris & Zwar, 2005).

Some refugee women are likely to need their gynaecological health examined and they are also likely to suffer from female genital mutilation or sexual abuse. Worries have been escalated because of sexual and gender-based violence while many refugees are removed from their families and have little security and social support (Milosevic, Cheng & Smith, 2012).

In all due consideration, it can be stated that Turkey has taken significant steps to ensure Syrian refugees benefitting from public health services within the given extent of refugee's access to health facilities and healthcare services. Syrian refugees are subject to temporary protection under *"Regulation No. 29153 on Temporary Protection (2014)"* that is secondary regulations descended from Article 91 of *"Law No. 6458 on Foreigners and International Protection (2013)."* The healthcare facilities offered to Syrian refugees under temporary protection is explained in Article 27 of the Temporary Protection Regulation (2014).

The Ministry of Health launched a directive that gives comprehensive details about governance of health facilities provided to the needy of temporary protection in 2015. It explains comprehensive clarifications of eligible requirements for free health care facilities, obligations of health care organizations, extent of health care, issues concerning emergency medical services, billing, and fees for health care services (Diker, 2018). Syrians can access basic health services under the temporary protection.

What is more, Article 91 of the Law of Foreigners and International Protection states that all cooperation regarding addressing the needs of this large influx are determined by the regulations proposed by the Cabinet (Özcürümez & Yıldırım, 2017). Access to health care facilities generally demands legitimate Turkish ID card (LFIP, 2013) allows registered migrants to have equal rights. State and non-state organizations provide relevant services to refugees, but these services are contingent on governmental approval (Özcürümez & Yıldırım, 2017).

The Health Ministry of Turkey has established additional institutions to deal with the refugee health problems. One of them is the Migration Health Services Head Office (Ministry of Health, 2014). It has been operating under the Public Health Institution of Turkey. The international organizations and non-governmental organizations are cooperating with this institution for health care service delivery needs of the Syrians. Furthermore, the Ministry of Health published "The Fundamentals of Health Services to be delivered to those under Temporary Protection" for the management of health services to be offered to Syrians under Temporary Protection (SuTP) (Ministry of Health, 2014). Health care service provision is significantly better in temporary housing areas where government officials are mostly more active, than out of temporary housing areas owing to various barriers such as language difficulties (Turkish Medical Association, 2014).

Syrians under Temporary Protection have significantly made different demands for health facilities based on ethnicity, age, gender, and socioeconomic factors. Many civil society organizations are providing health care services. However, there are some limits for their actions because of the need for getting permission from government officials (IGAM, 2013).

As a result, the NGOs are required to deal mainly with the diverse Ministries and local governors. Also, NGOs work with municipalities, particularly in the border regions. The essence of this cooperation differs among different cities. Most NGOs claim that there is a significant lack of coordination and communication among various Civil society organizations (CSOs). NGOs carry out an intermediary task between state agencies and Syrians under Temporary Protection (SuTP) for the delivery of service. One major issue that has been recognized is the challenge of continuity of services and extension of services to a larger group of people (MEDAK, 2016). The attitudes of governmental institutions and NGOs mainly concentrate on urgent problem-solving instead of long-term preparation and expenditures in mostly all facilities like health services. However, there is a significant deficiency of social and financial assets.

Two NGOs that attach importance to delivering health care services to SuTP are "Turkish Medical Association" (TMA) and "The Association for Solidarity with Asylum Seekers and Migrants" (ASAM). TMA is a qualified organization which does not accept financial support from government, so it is independent from government bodies. As a professional organization, TMA aims to promote the interests and benefits of physicians with their counterparts in decision makers and government agencies. TMA also seeks to preserve and improve public health, as well as delivering high quality services to the public at an affordable cost (TMA, 2017).

TMA previously published a study named 'War, Migration and Health'. This research is one of the most comprehensive studies about social factors affecting health and health conditions of SuTP in Turkey, concentrating on those residing both inside and outside the camps.

In the Turkish Constitution, the right to health is not based on citizenship, but is accepted as a right for all living. *"Social Insurance and Universal Health Insurance Law (2006)"* describes the health facilities, the circumstances of access, and cost of health care. Article 60 states that everyone has universal health insurance and therefore refugees, stateless people, asylum seekers are included into general health insurance by means of "*The Law on Foreigners and International Protection."* Having a health insurance does not imply that all health facilities are free. Health care services are generally covered by health insurance and contribution payment

is paid by sick person. This is also placed in Article 60 and 69 of "*Social Insurance and Universal Health Insurance Law."* Therefore, people can reach basic health services which includes mother and child wellbeing, counselling facilities, migrant clinics, and family health care facilities.

In Turkey, According to UNCHR, over than 63.3% of Syrian refugees have registration (Fine, 2018). However, numerous people were forced to go to bigger cities where they lack registration. Although health care services must be free under health insurance, mobility to big cities creates problems when people need to access health care particularly in emergency situations. The healthcare insurance and health care services should not be limited because of moving to other cities. This can worsen health situation of people when they are afraid to benefit from health facilities since they do not have registration in that region. As a result, the content of health insurance should be expanded all locations and cities whether they have registration or not (Mardin, 2017).

5.3 Access to Healthcare for Syrian Women Refugee

Turkey implemented an open-door policy for its geographical, cultural and neighbourhood relations for Syrian refugees after the beginning of the conflict in March 2011. As a result, a major public health issue has been faced (Demirtaş & Özden, 2015).

In the sense of disease prevention and preventive health facilities, vaccinations rates for polio and measles are 98 %. Thus, there have been no reported cases of diseases prior to 2011. Disease prevention and preventive health facilities are essential for provision of health for both Turkish residents and international refugees and more important needs to be give not this crucial subject (Köse, Bora Başara, Güler, & Yentür, 2014).

Refugee health centres are set up to reduce this burden. These centres work in cooperation with community health centres to provide fundamental health facilities to Syrian refugees. In addition to normal health personnel, physiologists, social workers, and interpreters are working in refugee health centres to fulfil the specific needs of refugees. Reproductive health services need special importance. Pregnant and postnatal refugee women are given a supplement of iron and vitamin D throughout their pregnancy.

Furthermore, supply of contraceptives and reproductive health services are delivered without having to pay. Brochures about safe maternity, postnatal care, good nutrition during pregnancy and safe sex attitudes are planned in Arabic through United Nations Population Fund (UNFPA),

and distributed to refugees (Ekmekçi, 2017). While reproductive health services are supplied to refugee women in destination countries, just one in three women is informed about these facilities (Masterson, Usta, Gupta, & Ettinger, 2014a).

Understanding the increasing vulnerability of women and girls in conflict settings prompted the creation of the Minimum Initial Service Package (MISP), designed by the Inter-Agency Working Group on reproductive health in 1996 (Schreck, 2000).

The purpose of MISP is to establish the basis for an extensive reproductive health care and address the question of how to prevent women girls and new-borns from illnesses (United Nations Population Fund, 2015). A memorandum of understanding was signed by the Ministry of Health in Turkey with United Nations Population Fund (UNFPA) to manage the provision of health services for women in 2014 (Samari, 2017). UNFPA operates to set up reproductive health counselling services for Syrian refugees that include three reproductive health centres or mobile teams (Saadallah & Baker, 2016).

Turkish government claims that healthcare system is provided to 96 percent of pregnant women. (Oktay, 2013). Main problems for receiving reproductive health care in Turkey are the ongoing conflict and insecurity, postponed implementation of extensive reproductive health services, increasing gender-based violence and the absence of scheduling for urban refugees. The reasons that lead to weak reproductive healthcare are women's inadequate equipment for basic hygiene such as absence of drinking water, accessibility of hygiene products, shower, and bathing facilities (Masterson, Usta, Gupta, & Ettinger, 2014b).

Turkish women do not desire to have a choice of the gender of gynaecologist, whereas Syrian women would prefer female obstetrician or gynaecologist (Bal, Yılmaz, Beji, & Uludağ, 2014). Most of the Syrian women do not seek a gynaecologist unless they are pregnant due to shame, anxiety, and lack of awareness about reproductive health. Just a quarter of women documented receiving a gynaecological treatment in the previous 6 months and just a third considered that reproductive health services were readily available. Even though nearly % 60 of the overall population of Syrian women noted using contraceptives before the conflict, merely % 34.5 documented utilizing family planning throughout displacement (Masterson, 2014a).

The Ministry of Health started to set up Migrant Health Centres in the framework of the project negotiated by the Ministry of Health and the EU Commission. The project will be funded via a direct donation from the EU. These centres are being concentrated in areas with highest number of Syrians. To illustrate, the first centres was constructed in Kilis in 2017 and 750 Syrian doctors

and nurses were intended to be trained until the end of the year. The goal is to support efficient and inclusive healthcare services to people under the temporary protection (Bilecen & Yurtseven, 2017).

The objectives of The Minimum Initial Service Package (MISP) can be listed as followings: preventing the maternal morbidity rate as well as new-borns, decreasing the death rates from HIV, planning for RH services, and increasing the accessibility rate of these services, preventing gender violence and its consequences.

The MISP encompasses implementing the requirement of important provisions like family planning services, analysis of sexually transmitted infections (STIs), avoidance transmission from mother to child, guaranteeing accessibility of antiretroviral drugs, and division of available menstrual hygiene products. These are considered as the basic provision, but it is highly vital for addressing the sexual and reproductive needs of refugee women. Despite reported health problems in the literature, there is still a gap in literature in terms of reproductive health of Syrian refugees.

Despite the existence of sufficient family planning infrastructure in Turkey, the access rate of these services for refugees is low. Language, sociocultural factors, and traditional beliefs constitute the barriers for the family planning. In Turkey, the proportion of using conventional contraceptive technique is 47% (Çöl, Aykut, Mut, Koçak, Uzun, Akın, Say & Kobeissi, 2020). Although the birth control rate in Turkey is good, its use is not very common among refugees.

Because of excessive conflict and violence linked with dispute and displacement, refugees are increasingly confronted with a rising risk for experience in risky sexual relations and increased risk of getting sexually transmitted infections. Research reflects very restricted information about condition of sexually transmitted infections and HIV precluding in the group of Syrian refugees in Turkey. In Arab communities, women do not have multiple spouses. That is why, the high recorded sexually transmitted infections pervasiveness can be related to sexual abuse and survival sex (Silveira,2017). The ratio of condom use was limited and awareness about how to benefit from HIV counselling centres was weak (Ördek, 2017).

In Turkey, it should be indicated that the registered Syrian refugees have access to the same health care systems as Turkish individuals. Nevertheless, the increased mobility of refugees between regions, concerns about registration, the desire to take refugee status from European countries are significant details influencing Syrian refugees' benefiting from health care services (Gümüş, Kaya, Yılmaz, Özdemir, Başıbüyük & Coşkun, 2017). The level of

satisfaction for health system were strong (AFAD, 2014). Because of the practical barriers, ensuring complete access to health care services by means of legal procedures does not mean equality of access (Norredam, Mygind, & Krasnik, 2007).

5.4 CEDAW and Women's Health

The right to health is a human right that is acknowledged by a whole set of international conventions and treaties. It means that everyone has the right to the highest standard of health that can be achieved. The Article 12.1 guarantees equal access to health care facilities for men and women, like those linked with family planning. In the Article 12.2, state parties also take some measures for women to make use of health care services equally, provide services with regards to pregnancy, confinement, and postpartum period and make sure that women have sufficient nutrition throughout pregnancy and lactation.

Article 14.2b reflects that State parties meet the requirements to acquire health care services comprising knowledge, counselling, and family planning. The Article 10.h states that State parties ensure them to receive essential educational information to support the health and welfare of families, as well as information and guidance on family planning (Janssens, Bosmans &Temmerman, 2005). As claimed in the Article 10 h, women should be informed about contraceptive interventions. Also, sex education and family planning programs should be ensured (CEDAW Committee, 1994).

CEDAW is distinctive as it aims at diminishing the gender inequality, which is deeply embedded and deep-rooted and multifaceted by focusing on the rights in both in public and private emphasizing both public- and private spaces. It particularly highlights the difference between de jure and de facto equality of women (Samet, Yoon & WHO, 2010).

In 1999, the CEDAW Committee also acknowledged that there are social variables that are affecting the health of women. Therefore, it drew the attention on the health conditions of vulnerable women groups such as refugee, migrant, or internally displaced women. The Committee suggested that authorities of the State parties enforcing a comprehensive national policy to support the health of women during their lives. This will cover initiatives including both the precaution and treatment of illnesses and conditions influencing women, also reactions to violence towards women. These initiatives will guarantee that all women have universal access to a wide range of qualified and accessible health care consisting sexual and reproductive health facilities.

The duty to safeguard women's health-related rights includes States Parties, their officials, and representatives to take steps to avoid and enforce penalties for exploitations of rights by individuals and organizations. To illustrate, since gender-based violence is a serious health problem for women, States Parties should guarantee effective implementation of law and establishment of policies to overcome violence towards women such as sexual harassment of girls and assurance of health facilities. The Committee puts emphasis on gender-based approach in health policies. Therefore, it requests state parties to adopt policies, develop programmes and conduct research with a gender-based approach, which recognizes the importance of biological and social factors as determinants for the health of women and men (CEDAW Committee, 1999).

5.5 CEDAW Country Reports

The article 18 of the Convention reflects that State parties are required to present preliminary report within one year of the implementation of the Convention for the individual State Party and every four years afterwards (OHCHR, n.d.). The submission and analysis of a report offers an opportunity for a State Party to evaluate steps taken in the enforcement of the Convention. Many states tend to exaggerate their successes, especially in their initial reports while giving less importance to their weaknesses. The Committee bases its own expertise on the Report of the State Party, the material supplied by the Secretariat and other organizations. The Committee also obtains information from other UN human rights structures, human rights policies and numerous professional organizations, programs of UN. However, the basic source of information for them is NGOs. Despite late submissions, initial reports have submitted by most of the states. Many of states have also submitted one or more reports periodically (Pillay, 2012).

Turkey submitted seventh periodic report to the CEDAW Committee. The Committee expects the State Parties written answers to the list of concerns and questions and as well as the additional explanations made in response to questions raised verbally by the Committee. The Committee appreciates the attempts of the State Party to strengthen its institutional and policy structure aimed at enhancing the removal of discrimination against women and enhancing gender equality like the implementation of the “National employment strategy (2014 - 2023), XX, National action plan on the empowerment of rural women (2012 - 2016).”

The Committee is likely to worry about ambiguous and insecure living standards of women refugees who are frequently lacking essential necessities, economic opportunities, health care, hygiene and refugee women are at the centre of sexual and other types of violence. The Committee recommends that Turkey needs to construct a hotline with providers who also speak Arabic and Kurdish to control gender-based violence towards women. The crucial increase of prostitution in the places with high number of Syrian refugees is the concern of the CEDAW Committee. Syrian women refugees, especially girls and young women between the age groups of 15 and 20, commence to prostitution to meet their and children's basic needs (UN, 2016). Some Syrian women also started to sex work because of increased economic inequalities (Demirtaş & Özden, 2015). The Committee is anxious about that the marriages of Syrian women refugees and girls is mostly polygamous marriage because of socioeconomic reasons or protection reasons (UN, 2016). Many Syrian female refugees are forced into forced and polygamous marriages at a young age. Gender roles play an important role in the realization of these marriages.

In various research reports, Syrian girls who are as young as 12 and Syrian women marry Turkish nationals either the second or third wife (International Crisis Group, 2014). It was crucial that the average age of maternity in research of 452 women was just 19 years old (Masterson, Usta, Gupta, & Ettinger, 2014a). In 2020, Syrian brides ranked first among foreign brides in Turkey. 14.8 % of Syrian women married to Turkish men (Turkish Statistical Institute, 2020).

The concerns on access to the sexual and reproductive health facilities were expressed by CEDAW Committee in its seventh periodic report on Turkey Reproductive health facilities. Contraceptives are extremely inadequate, particularly for Kurdish women as well as other minority women, and women who live in rural areas. That is why, it led to many unwanted and early pregnancies. Furthermore, the legal framework about abortion and the plan of free contraceptives are seriously criticized.

Although the termination of pregnancy is allowed until the tenth week of pregnancy, most of the public hospital reject abortion which forces numerous women to turn to costly private clinics and risky abortion. Despite the growing rates of HIV infection, Turkey has deficiencies in epidemiological information of groups who are especially at risk for HIV/AIDS and needs clinical centres for sexually transmitted illnesses and HIV.

In the recommendation part, the CEDAW Committee suggests Turkey should provide fair and full acquisition of sexual and reproductive health facilities and information for all women consisting of Kurdish women and minority group of women. Moreover, the Committee

recommends that State Party take all appropriate steps to protect right to abortion and contraception, control hospitals and enable women to terminate their pregnancy which is the legal right until the tenth week (UN, 2016).

Turkey provided information about concluding observations on its seventh periodic report. In response to recommendations, Turkey states that meetings would be scheduled to increase consciousness of the Syrian women about gender-based violence and even early and forced marriage. Leaflets and handouts about early and forced marriage, trafficking, and application method in situation of violence would be designed in Turkish and Arabic and distributed to camps and regions heavily populated by Syrians.

What is more, "Workshop on International Refugee Law and Protection of Refugee Women" was prepared for women's shelter managers. The workshop addressed the legal structure for international protection, broad insight of international refugee law, defend mechanism towards trafficking and issues in Turkey. Under the Ministry of Family and Social Policies (MoFSP), 183 Hotline serves without costing in Turkish, Arabic and Kurdish. 183 Hotline offers legal, economic, and psychological advice to children and women victims of violence and give information about their rights and institutions (CEDAW, 2018).

CHAPTER 6

ANALYSIS OF INTERVIEWS IN LINE WITH CEDAW

6.1 Analysis

While analysing the interviews, the topics that Syrian refugee women mentioned regarding the questions were divided into various headings and comments were collected under these headings. My headings consist of "Gender Roles and Expectations", "Experiences in Receiving Healthcare Services", "Social or Religious Preferences in Receiving Healthcare".

6.1.1 Gender Roles and Expectations

Institutions may maintain practices and ideas of women's inferiority that perpetuates sex roles and gender expectations. The difficulties faced by women as both refugees and women stem from their gender roles. In the migration process, institutions trigger women to take part in these roles. In addition, the Committee explains that legal services may maintain to trigger gender roles and inequality (CEDAW General Recommendations, 2015). Intersectionality is an approach that emphasizes that categories such as gender, sexual orientation, class, race, nationality, disability, and age/generation cannot be considered independent categories. Intersections of gender, health and refugee status was observed in the interviews. Many respondents expressed gender expectations in the family.

In addition to CEDAW, "The Law on Foreigners and International Protection" and Regulation on Temporary Protection (TP) was adopted to improve safety of refugees and asylum seekers in Turkey. Even though there are numerous human rights treaties regarding the right to health care of refugees, contributions of these to the refugees are still limited.

This thesis is important for examining intersectional perspectives of gendered forced migration and question whether Syrian women's experiences have been gendered. The latest influx of refugees is being portrayed as extremely gendered in the media and policy discussions. When refugee women are mentioned in the different contexts of discourses, they are mainly depicted as defenceless and in need of protection. Women who move alone are considered vulnerable due to the absence of male protection (Freedman, 2017).

In CEDAW, it is expected that State Parties required to take necessary steps to apply the Convention in all areas. These steps encompass legislation guaranteeing the improvement and

growth of women to ensure their human rights and freedoms in accordance with equality of men. As a result, some articles of CEDAW review the right to health care of women, especially reproductive rights.

Article 12 of the Convention deals with women's health. According to this article State Parties have to take actions to eradicate women discrimination in health care services which include family planning. Moreover, States Parties have to provide services to women with regards to pregnancy, post-natal period and ensure women to have adequate nutrition during these periods. (Bustelo, 1994).

According to Interviewee D, "*Women do not work, and she does not go out too much. Women generally work at home and take care of their children. Men work and is the breadwinner*." Interviewee I said *"My husband died at war, and I was alone with my children. It is so difficult to raise a child as a woman alone. I do not have any education. We generally clean the house and cook. I have a hard time when I go to the hospital. My husband would help when I had things to do at outside."*

Interviewee N explained *"It's harder to be a woman in war. We are afraid of being harassed and we must protect our honour. I cannot trust anyone. It is our duty as a mother to protect our family, especially children. The whole burden is on me as a woman. This makes my life more difficult.*

Migration process has a crucial effect on women. Many Syrian women refugees have encountered dramatic difficulties throughout their lives. When they reach destination country, they suffer from human rights abuses because of lacking inadequate conditions in the host countries. These stem from difficulties in accessing existing services and lack of social support in the host countries. Many Syrian refugees cannot make use of facilities especially in terms of health. That is why, women are faced to gender discrimination in the field of health. Even though there are numerous human rights treaties which are related with health issues of refugees, there are still some problems in the provision of health care services. Violence against Syrian women may vary during the migration process and after arriving destination country.

These gender expectations make women more vulnerable in the migration process and difficult accession of basic health facilities in the destination country. If situations and special needs related to women's health are not determined and necessary measures are not taken, health problems of Syrian women refugee may become permanent. Health situations of refugee

women are affected by political instability, gender discrimination, racial and political reasons. These make accessibility of health care services difficult in the host countries.

6.1.2 Experiences in Receiving Healthcare Services

Syrian women's experiences of health care are the important part of the thesis. Conflicts frequently threaten for the delivery of health services. Lack of health services are likely to cause illnesses, mortality, and injuries for the refugee women.

In the interview analysis, Although Syrian women were satisfied with health services, they faced many problems. Discrimination against Syrian women refugees was emphasized in the interviews. Interviewees claim that doctors and hospitals helped to improve health conditions of Syrian women in Turkey. One of the interviewees expressed her satisfaction with these words: *"I got better health care in Turkey than Syria."* Only one interviewee expressed her dissatisfaction caused by doctors. She thought she was not taken care of in a good way because she was Syrian. Discrimination against Syrian women refugees was emphasized in the interviews.

Furthermore, financial constraints and different organizations of hospitals were emphasized as barriers. Cost of care was not affordable for the Syrian women refugees and many of these women do not know how to get health insurance. That is why, they forced to pay high cost of health services at hospitals. Literature reviewed showed that the most frequently reported obstacle to healthcare admission for Syrian refugees was cost inclusive of logistical costs like, transport, infrastructure, and medicine costs.

Within this context, this issue was pointed by Interviewee A. *"I had problems in the hospital. I was currently 3 months pregnant. I tried to go there every month. I was satisfied. However, I lost my baby when I was 3 months pregnant. I had to have an abortion. Doctors treated me well. It was difficult for me since I had a severe backache. Also, my husband got into the debt because we did not have health insurance."*

Interviewee B said *"We felt quite sick on the way because me and my family climbed the mountain. We were under the difficult conditions in the mountain and influenced psychologically. I felt lonely and helpless. Although I wanted to go to the doctor or hospital, I could not due to lack of money. Now, I made an appointment but when the doctors saw us, they*

did not care much and give importance to us as we were refugees. Some doctors act indifferent when they see that we are foreigners. Their morale is deteriorating, and they make a sour face"

Interviewee C stated *"It was very difficult for us to come to Turkey. We had a lot of trouble, and we came to Ankara through the Hejaz Road four years ago. My first child was born prematurely. It was very difficult for me. My baby was so small, so she spent twenty days in an incubator. My daughter died after twenty days. The hospital asked us to pay 24 thousand Turkish liras because we did not have an identity card. I went to the police station many times to get an identity card. It was very difficult to get an ID card, but the hospital said they could not do anything about payment. When we entered the hospital, we were informed that we need to have an identity card. I do not know how to pay this money. We are a family of fifteen people and only my husband works."*

Accessibility of health services was inadequate as reflected in the interviews. Semi structured interviews indicate that Syrian women face language difficulties, registration problems, lack of knowledge regarding Turkish health system.

Syrian migrants cannot not benefit from health service free of charge if they are not registered. Revised registration programs have remained as an obstacle for Syrian refugees receiving medical care. Syrian migrants should have identity card numbers to benefit from health facilities and services (Alawa, Zarei, & Khoshnood).

Interviewee D declared *"I came to Turkey six years ago and my husband died in Syria. I have four children. When I came to Turkey, my child got sick. The doctors welcomed and examined my children. However, I had some difficulties because I did not obtain health insurance. That is why, my children and I could not be treated in the hospital. I do not know how to have an insurance. This forced me to pay too much money for treatment. What is more, hospitals in Syria are very small, whereas hospitals in Turkey are very complex and big. My daughter fell and had an infection on her face. We stayed in the hospital and had difficulties in the big hospital. Registration process is difficult for us because we do not know hospital rules. Meeting with doctors was hard. The most important obstacles are in getting an appointment in the hospital system. Healthcare system in Turkey is different from the ones in Syria."*

Interviewee E noted *"We came to Turkey four years ago with my parents. When I came to Turkey, I became a diabetic patient because of being under a lot of stress and anxiety. I had high blood sugar and went to the emergency service. I started insulin to regulate blood sugar*

level. Doctors helped me and they informed me about the importance of insulin They took care of me but being sick in a foreign country has many difficulties.

In the migration process, many Syrian women face many health problems in their journey. They experienced health problems when they cross the borders. Syrian women expressed that they have mental health and psychological problems. They need psychosocial support services because fear of death, anxiety, and social isolation affect mental health of Syrian women refugees.

Interviewee F said *"I escape from the war and came to Turkey eight years ago. We were together with my husband and children. At first, we had a very difficult time in Turkey. My husband is working now, and we are trying to build a new life. I was pregnant and had a child when we came to Turkey. Process of pregnancy was very difficult for me because we did not have good conditions, safety, and adequate money. I could not go to the doctor regularly for the control. I have a concern regarding the birth of my child. Sometimes, I feel vulnerable, and I have worries about future."*

Many women emphasized that they face discriminatory attitudes during their migration journey. They lack basic human rights. It mostly causes mental health problems among Syrian women refugees. Anxiety, depression and other mental illness become visible in their lives and they feel depressed and hopeless about the future.

Interviewee G explained that *"I had a uterine cancer and underwent a surgery for a uterine problem two years ago. Chemotherapy was performed and I am better now. Doctors informed me about cancer, and I am satisfied with f treatment of doctors. There was no problem in the process of my illness."*

Interviewee I stated *"I came to Turkey five years ago. I was pregnant when I arrived in Turkey but did not realize it then. I gave birth to my child in a tent, so I was in bad condition. I cannot forget those days. After I moved to Ankara, I suffered from diabetes. The doctor said I had a lot of illnesses and for a diagnosis I needed to undergo a lot of tests. However, I had neither money nor time for a doctor's examination. My treatment remained incomplete."*

Interviewee M explained *"I and my husband escaped from the war four years ago. It was very difficult because we did not have enough money and I have two children. When we arrived in Turkey, we did not have an ID number. Registration process took time. This is a significant problem for us since we could not get treatment from health facilities. Also, doctors sometimes*

got angry with me for asking questions, but doctors generally gave importance to our health problems."

Interviewee N said *"I had an infection in my eye. It was really hard to make an appointment with a doctor. Since we are Syrian, we are not a priority during the appointment. Doctor gave me medical treatment. Communication with doctor was a little bit difficult.*

Interviewee O said *"My son witnessed a bomb explosion, and his psychology was broken. He had language disorder and was afraid of possible attacks. Unfortunately, he cannot speak fluently anymore. I do not know how to make an appointment with hospitals and doctors. Hospitals are very big in Turkey. Also, cost of health care services is very expensive. We cannot not pay this money. It is very difficult for us to survive here, so we cannot complete the treatment."*

Temporary Protection Regulation states that Syrians who live in Turkey have opportunity to access all kind of health services, involving mental health services at public health institutions without giving a contribution payment to the Social Security Institution (SSI).

However, it is necessary to be registered as temporary protected individual to get benefit from health insurance. Nonetheless, Syrians can take health care services without giving money in both public and private institutions in case of emergency situations or circumstances recognized as a possible threat to public health. Syrians living in camps take health services in primary and secondary healthcare institutions free of charge. A patient can be relocated from the camp to hospital (Ekmekçi,2016).

Interviews were conducted to acquire information regarding barriers and difficulties related to accessibility of healthcare for Syrian women refugees. Accessibility of health services is of great importance to lead a good life. However, difficulties may threaten and impede access to health care in case of a humanitarian crisis such as conflicts or wars. Difficulties to accessing healthcare involve language barriers, lack of health insurance, and not having information about how to access health care facilities. Syrian women should be informed about health services.

According to the information obtained from the interviews, many Syrian women refugees suffer from language barriers and lack of health insurance. Participants expressed that they are mostly concerned about language barriers in terms of accessing healthcare services. Syrian women have limited language ability to tell their symptoms and problems to health care professionals, so this may cause them to have less health information about themselves. Even though

translators are employed in some hospitals, interpretation services cannot be provided all the time at hospitals. Hospitals lack translators and Syrian women refugees need an interpreter at the hospital. What is more, lack of health insurance is another challenge for Syrian women refugees. As reflected in the interviews, most Syrian women do not know how to access health insurance and must pay for health services. Cost is the important obstacle to healthcare services since many Syrians face financial difficulties when making their healthcare payments.

Interviewee A stated *"Arabic–Turkish language interpreters should be provided. Doctors have difficulty in communicating with us at hospitals." According to Interviewee B, "It was very difficult to explain our problem. When there is a translator, communication becomes easier, but we cannot always find an interpreter. Now, we are better in speaking Turkish than we used to."* Interviewee C said *"We knew very little Turkish and speaking with doctors became difficult. The problem was my little knowledge in Turkish. I am striving to learn Turkish language. However, learning Turkish is so hard. There is limited opportunity to learn this new language in Turkey."*

Interviewee D stated *"When my children and I came to Turkey, we had a tough time. I was struggling to learn Turkish, but I could not understand some sentences. I am better now. That is why, I cannot answer sometimes. I am trying to read Turkish books or news. In addition, I could not benefit from health insurance because I do not know how to apply for health insurance. This prevents me from accessing free health care. I want to access health insurance for me and my children."*

Interviewee E said *"I did not really communicate with other people, but I have improved my Turkish. Interpretation assistance is necessary in hospitals for us because I have limited Turkish."*

Interviewee F said *"Learning a new language is very difficult for us. I started a Turkish course two months ago. Turkish course takes place in Mamak. I am trying to learn and speak Turkish. My children improve their Turkish at school."*

Interviewee G explain *"There was no language problem. I can communicate in English because I studied English Literature in Syria. However, not everyone knows English here. Interpreters are needed in many places. I cannot speak Turkish fluently. Turkish language courses generally focus on grammar, but it is not necessary for us at this stage. As a suggestion, I think that the courses in Turkey should be better. The courses focus on grammar. This is not important to us.*

We are at the beginner level. We want to introduce ourselves. Grammar is not necessary for us at this stage. Conversation is important to us.

Interviewee H stated *"We speak Arabic, but we are learning Turkish here. I gave birth to my child in Turkey. The doctors understood me, and they took care of my health. My five children are going to school. They have learned Turkish at school and help me to communicate with other people."*

Interviewee I said *"We need an interpreter, but we generally cannot find them. I translate the sentences from the phone application. I use the internet. It would be very difficult without the internet."*

Interviewee J explained *"There was a translator at the hospital. Sometimes I tried to speak and explain myself. Language problem restricts our lives, and we have to learn Turkish."* Interviewee K claimed, *"When translator was provided at hospital, our job became easier."*

Interviewee L said *"We could communicate with other people. I knew Kurdish and there were many Kurdish people. Thus, they helped us to express ourselves to doctors in the camp otherwise, it would be very difficult for me."*

The aim of this thesis is to examine the experiences of Syrian refugees in accessing health services in Ankara in the light of CEDAW and to review the health policies in accessing health services. Although there is a significant effort in providing health services to women refugees, the implementation of health policies in Turkey should be reconsidered. The officials of health care institutions are expected to set up free translation services. Some health care centres have Arabic-speaking personnel, but requirements cannot be completely met because of inadequate capacity (Tunaligil, Tuzgen, Ozdemir & Albayrak, 2019).

Interviewee M stated *"We went to the hospital for my child. They felt quite sick on the way. However, we had a hard time getting an appointment because hospitals were very crowded and big. It is difficult to communicate with officials and doctors. Our psychology is affected negatively. I do not feel happy. If everything becomes normal in Syria, I want to go back with my family."*

Interviewee N claimed *"We are not talking same language and we are trying to learn Turkish language. When translator is not provided, there is a communication problem. That is why, translator service is important for us. We must speak Turkish because translator is not always available for us."*

Interviewee O said *"It is not easy to live in a place where you do not speak the language. We had communication problems with doctors. Translators are not available all the time. We are trying to express ourselves by means of body language, but it become insufficient. That is why, we could not get professional treatment.*

Syrian women emphasized a lack of affordable and accessible health care services as significant problem. When it is evaluated in terms of migration and women's health, prioritizing special needs of Syrian women based on health is significant. As analysis of the interviews indicated, existing policies, institutions, human resources, and services are mostly insufficient for meeting health requirements of Syrian women refugees. Law on Foreigners and International Protection and Temporary Protection Regulation provides rights and access to services to the refugees who are under the protection of this law. In this framework, Syrians under the temporary protection has the right to benefit from primary and secondary health services offered to Turkish citizens with free of charge. However, language barriers, complexity of health system, registration process, preference of female doctor cause problems in terms of accessing to health services. Despite all difficulties, Syrian women refugees are mostly satisfied with health services in Turkey.

6.1.3 Social or Religious Preferences in Receiving Healthcare

According to the interviews, most of the Syrian women refugees feel unrelaxed when they must get appointment from a male doctor. Female doctor preference of Syrian women refugees has been observed. Most of the interviewees prefer a female doctor. Lacking a female doctor can be perceived as dissatisfaction with the health system. Female doctor choice is linked with religious or social background of Syrian women refugees.

Interviewee A said *"I would prefer a female doctor. When I had an abortion, doctor was male. I said I want a female doctor, but I did not have a choice. I did not feel comfortable.* Interviewee B noted *"I can go to a male doctor. If the doctor is a woman, it will be better, but it is not a big problem for us going to a male doctor."*

Interviewee C claimed *"I would prefer to go to a female doctor because it is difficult for me to undergo an examination by a male gynaecologist. If the doctor is female, I feel comfortable, especially if it is an ultrasound or gynaecological control. I have a hesitation about a male doctor."*

Interviewee D stated *"A female doctor would be better for examinations. Male or female doctor does not matter. There are successful male doctors in some branches as well as female doctors. However, for gynaecology examination I prefer a female one. I also get an appointment from a male dentist. I think, a male dentist is more qualified professionally. But for other branches I do not have any preferences"* Interviewee E said *"The gender of the doctor is not an important issue for me. The significant matter is whether the doctor is good at their jobs or not. Male doctors generally have a good attitude towards us."*

While some women want to visit women doctors, for some others it is not that important. They can be treated by male doctors. However, few Syrian women refugees think in this way. What is more, some Syrian women prefer to go to a male doctor according to the doctor's branch. They do not prefer male doctors in medical issues related with health of the female reproductive system.

Interviewee G said *"I do not have any problems, if doctor is male or female How the doctor treats the patients is important for me, but some women refuse to go to a male doctor because women may have a traditional approach. I think it is not related with religion because our religion does not say you have to be treated by a female doctor."*

Interviewee H noted *"I do not have such ideas. Being a doctor is a profession. I have no preference about the gender of the doctor."*

Interviewee I explained *"When I make an appointment, I don't go if the doctor is male. Once I had to visit a male doctor and the doctor wanted me to examine my chest. I was nervous and doctor was angry at me for refusing him. Going to a male doctor is a sin. This male doctor told me to pay extra if I want to be examined by a female one."*

Many women prefer female physicians because they can communicate with female doctor easily. They have higher satisfaction when Syrian women examined by female doctor. Many women complained about the lack of female doctors in health care services. It is important to provide female providers in health facilities.

Interviewee J stated *"I do not want to go to a male doctor because I am reluctant to speak my health problems with men. Male doctors are not welcomed by women in our culture and male doctor is a strange man. I had a gall bladder problem. I sold my gold earrings to go to a female doctor for an examination and this doctor did my operation."*

Interviewee K said *"I do not feel comfortable when I go to a male doctor because all women in our family do not go to a male doctor for an examination. It is difficult to visit a male doctor for women."* Interviewee L explained *"Some people make preferences depending on the gender of the doctors. But it does not matter for us. It was not important in Syria. Doctors are doing their jobs."*

Interviewee M claimed *"I prefer a female doctor because I feel more comfortable when I get an appointment from a female doctor. If I am in a difficult situation for my healthcare, then I go to a male doctor.*

Interviewee N stated *"I prefer to go to a female doctor for gynaecological problems and treatments, but male doctor can be better in some health issues. It depends on the health problems for us."*

Interviewee O explained *"I do not have any preference about whether the doctor is male or female. I can be examined by a male doctor. What is important for me is how the doctor treats the patients. I think treatment and behaviour of doctor is more important for me. When I go to hospital, I want to communicate with doctors easily since it is hard to live in a place where you do not know the language."*

This thesis aims to raise awareness about the experiences of refugees when they need healthcare. Even though Turkey takes precautions for Syrian refugees to provide them with healthcare services, there are still some issues to be coped with. The barriers emphasized in the interviews were the language difficulties, registration problems, differences in health care system and reflections of health care system were identified in the interviews.

6.2 Policy Suggestions

Elimination of barriers is significant for addressing the problems in the provision of the healthcare. These barriers prevent Syrian women refugee from accessing health care services. Producing solutions for these is important to tackle this problem. I would like to discuss my recommendations which including concept of refugees, health, and CEDAW for policy makers.

Language barriers in healthcare services is reflected in interviews. Translator services are needed for both health care professionals and patients. The healthcare providers need this service to be able to better understand the health problems of their patients to be able to express the recommended treatment (Mardin,2017). Provision of translators help the communication

process for Syrian women refugees. Recruit multilingual employees to work at information points to help patients (Cloeters & Osseiran, 2019).

Complexity of registration system is important issue for Syrian women refugees. It is essential to establish a straightforward registration system to provide accessible, quick, and anti-discriminatory access to healthcare facilities for all refugees. Syrian women demand for the access of health care services in other provinces rather than the provinces they have been registered. Since in Turkey refugees can only benefit from free health care service only in their provinces where they have registered. They are not allowed to use health care services in other cities. This causes a lot of problems for refugees (İçduygu & Şimşek, 2016). That is why, unregistered Syrian women cannot access affordable health care services. Syrian women refugee should access to health care services in all cities.

Interviews also reflect that Syrian woman prefer female doctor for examination. Therefore, the provision of female doctors will often improve the quality of the health system. It is important to hire an adequate number of female professionals to attend information centres to directly address refugee women and enable Syrian female gynaecologists to incorporate into various layers of the healthcare system (Cloeters & Osseiran, 2019). Many Syrian women expect female doctor in healthcare facilities since they feel relaxed. Lack of female doctors mostly increase stigma or anxiety. Thus, staffing female doctors mostly improve health situations of Syrian women refugees and support refugee women's access to knowledge about their health such as birth control, method of contraception, and sexually transmitted infections.

The data on the reproductive health issues of Syrians is insufficient. Language barriers, lack of female doctors, different healthcare system, registration problems, and mistreatment are the challenges of the healthcare system in Turkey according to the interviews. Provision of the health care remains inadequate for the Syrian women refugees (Sahlool, Sankri-Tarbichi & Kherallah, 2012)

There is a scarcity of information about reproductive health concerns and women's health in a group of Syrian refugees (Oktay, 2013). Because of lack of services, gender expectations, having communication problems and other discriminative factors worsen the health issues of Syrian women refugees and they face numerous threats in the host country both as a woman and a refugee. Protection mechanism should be applied and prevent barriers towards health care services. With the implementation of the intersectional approach in health policies, it is possible to make the situation of refugees better. The interview results reflect necessity of intersectional

approach`s diversified and comprehensive framework in the aspect of health services for refugee women Turkey on the grounds of financial, access to services, equality, and human rights.

As Syrian refugees live in different countries, international and diplomatic endavours are quite important in terms of their health and well-being. An immediate action is necessary to remove the inequalities that many Syrian women are facing. Designing effective programmes and policies to deal with this issue requires working on the common grounds. These common grounds are the areas where diversities interact. This is especially important in post construction and recovery (Samari,2014). Protection strategies are necessary for Syrian women refugees in the host countries. If effective health policies are developed and implemented in host countries, human rights will continue to be implemented even in situations such as war and conflict.

CHAPTER 7

CONCLUSION

The war in Syria began in 2011 and the United Nations announced Syrian crises as one of the terrible humanitarian disasters in the twenty first century (Baker, 2014). The refugees suffer from a lot of problems and one of the most fundamental problems for refugees is health issue. Health problems are caused by the war in Syria, but it can also be caused by thirst, hunger, fatigue in the long migration route. Getting injured in war or on the migration route, having no access to treatment and medication can lead to various chronic health problems (Esen & Duman, 2016).

This thesis is important in terms of evaluating CEDAW in the framework of health situation of Syrian refugees in Turkey. CEDAW's effects on some of the health determinants are indisputable. It has effects on countries regardless of their regimes and levels of development. Such treaties as CEDAW can be seen as one of the aspects of globalisation, which contributes to the improvement of women's rights. (Cannoy, Wong, Siddiqi, & Parnia, 2020).

A detailed examination of CEDAW indicates implicit dedication to removing intersectional discrimination. CEDAW accepts inclusive perspectives of women's lives which enables the recognition of the different identity qualities, aspects, and experiences which relate to sex and gender to discourage women from exercising their human rights. Preventing women from exercising their human rights coincides with intersectionality and discriminative approach. CEDAW criticizes all types of discrimination in the Article 2 and intersectional discrimination is a kind of discrimination. If women's rights are violated because of intersection of gender and other dimensions of identity, it can be tackled by means of CEDAW. According to CEDAW Committee, sex and gender discrimination are strongly linked with such factors which affect women as race, ethnicity, religion or belief, health status, age, class, caste, sexual orientation, and gender identity (Campbell, 2020).

Semi structure interviews also indicate that women as refugees face more difficulties than men because of gender expectations and intersectional discrimination in the society. Women refugees are vulnerable to gender-based violence, brutality, and lack of protection. It is important for policy makers to study intersectional discrimination case of Syrian women refugees. This thesis shows how intersectional discrimination affects both the migration process and the health status of Syrian women refugees.

Refugee women can be shown as the group most affected by the migration process. Refugee women have problems in accessing health services due to language problems, difficulties in accessing health institutions, lack of health insurance, lack of adequate health institutions and qualified personnel and translators in the regions receiving immigration. Women face many health problems when they escape from wars or disputes and search for refugee status in other countries. Family planning and post-natal care become extremely difficult for refugee women to benefit from these services. According to research, physical and mental health issues are extremely common in vulnerable groups including refugees and asylum seekers (Dorling, Mitchell, & Pearce, 2007).

The provision of qualified parental and reproductive healthcare is vital for providing the health services of refugee women and their families. Benefiting from maternity services has an impact on emergency and long-term health of refugee women. It also influences integration and health behaviours.

Addressing challenges to accessing health care services and meeting health requirements as well as giving health education, available and effective health care services can enhance health of Syrian women refugees (Nabolsi, Safadi, Sun, Ahmad, AlMaharma, Halasa, Saleh, & Dohrn, 2020).

In this research refugee women's access to health services were evaluated and the importance of health promotion policies in this direction was highlighted. How effective these health services were examined. How effective the health activities within the scope of the CEDAW were questioned through interviews. Interviews indicated that Syrian refugees had faced many challenges in terms of health care services. The aim of the interviews was to examine barriers which were encountered by Syrian women refugees. Semi structure interviews were conducted to explore Turkish health care services for Syrian women refugees. Even though Turkish health care system tries to make health facilities more accessible and satisfaction level is mostly high, the main challenges continue to exist for Syrian refugees living in Ankara.

The obstacles which were emphasized in the interviews involved language barriers, lack of knowledge about health care system, differences in registration system. The voice of Syrian refugee women was reflected in the interviews. According to interviews, Syrian women refugee living in Ankara were satisfied with health services, but they did not have enough information about health care services which are available for them.

What is more, women who escaped from the war also faced a series of dangers in the countries they had sought refugee status in the host countries. Syrian women encountered gender-based violence during and after the migration process. Hundred thousand of Syrian women who had lost their husbands and social support mechanisms were subjected to physical, sexual, and psychological abuse. Syrian women and girls who were exposed to the physical and sexual abuse mostly hesitated to talk about their experience. Many refugee women were unaware of their legal rights in Turkey. Problems and social issues faced by refugee women demonstrated the importance of policies that need to be developed (Yılmaz, 2016). Article 67 in the Law on Foreigners and International Protection requires effective treatment shall be supplied to victims of sexual harassment, abuse or other serious sexual, physical, or psychological violence to remove the damage stem from such acts (Kivilcim, 2016).

In this thesis, the difficulties experienced by refugee women in accessing healthcare services the health problems they experienced in the country they had migrated to were reflected. Most of the women had difficulties in accessing health services due to their low socioeconomic level, language problems, legal restrictions, and reproductive health problems. The suggestions offered in the thesis are important to improve the current situation.

"*Law on Foreigners and International Protection"* and "Temporary Protection Regulation" were adopted for Syrian to access right to health, education, and social assistance services (Esen & Duman, 2016). *"Law on Foreigners and International Protection"* guarantees "non-refoulement principle" (Article 4), definition of the concept of "refugee" (Article 61) and definition of "temporary protection" (Article 91). It forms the framework for the legal status of Syrian immigrants (Ulusoy, 2019).

Even though several regulations and policies were implemented to improve health conditions of Syrian women refugees, many women faced difficulties in terms of practice. This thesis aims to indicate how effective international treaties are in terms of health care services for Syrian women refugees. The analysis of semi structured interviews support result of other literature studies. Even if health care services are free of charge and the same with Turkish citizens, this does not mean ease of access for Syrian women refugees.

To sum up, women encounter double discrimination both as a women and refugee. It is significant to implement health polices and applied international human rights treaties. CEDAW Committee indicates that female migration should be reviewed with the approach of gender inequality, traditional gender roles, gender-based violence, and feminization of

inequality and work force migration. All these factors influence health of migrant women whose financial, and social welfare is impeded by intersecting types of discrimination based on ethnicity, economic hardship, and race (Smith, LeVoy, Mahmood, & Mercer, 2016).

Limiting access to health care services for a part of group due to the administrative identity is also a breach of international human rights standards. International human rights law preserved the right to health care, and it is a fundamental right and necessary for securing the other rights. States have a responsibility to ensure these rights without discrimination for all people in their borders (Joseph & McBeth, 2010).

One of the obligations of right to health is that the states have to ensure that health workers and professionals should act according to the ethical codes of conduct. The rights of the patients include that in case of abuses governments should hold the accountability. It has two important aspects. The first one is it applies the general human rights in the contexts of patientcare. The second one is it puts the patients at the centre and draws attention on discrimination and social exclusion (Cohen & Ezer, 2013).

This thesis aims to draw a portrait of accessibility of healthcare service for Syrian women refugees under CEDAW. This dissertation identifies barriers to access to health care system for Syrian women refugee living in Ankara. Even though Syrian women satisfied with health system in Ankara, findings of interviews showed that women refugees had faced language barriers, lack of knowledge, differences in the health care system, registration problems and inadequacy of female doctors.

Another important part of thesis is recommended policies. Recommendations are based on literature reviews from the other studies and semi structured interviews. Despite the many challenges, one of the most important concerns they could not speak host country's language. Many refugees have communication problems and they do not know how to access health care services. Translation services become insufficient. That is why, the number interpreters should be increased in health facilities for Syrian women refugees. Even though health care services free of charge, many refugees cannot access health services because of lack of registration. Non-registered Syrians have restricted to benefiting from primary and secondary health services in Turkey (Republic of Turkey, 2020).

Policy makers should give importance to increasing the free accessibility of health care services in all locations because many refugees forced to access health services only where they are registered. This prevents Syrian women refugees from benefiting health services. It is

considerably significant to provide health care services in all places. In contrast, limiting to refugees to be able to make use of these services only in provinces where they have been registered is not in line with the right to health care which is a fundamental human right.

Furthermore, the gender of the health provider is a significant issue for Syrian women refugees. Some of the Syrian women refugees prefer to go to a female doctor. If the doctor is male, they have some hesitations. Gender of the doctor can be a significant problem in the health care services for women refugees. It was revealed that male health professionals had been adversely affected by this problem, particularly in situations linked with physical examination and gynaecological problems. It mostly stems from Syrians' being Muslim, but health professionals have difficulties in family health centres because of lack of female doctors (Baser, Mıhcı, Direk & Cankurtaran, 2021). For this reason, preference of gender of a doctor can be an important obstacle in terms of accessing health care services. Preferences for doctor gender is reflected through interviews. Gender preferences has an impact on benefiting from health care services for Syrian women refugees.

This thesis examined healthcare needs of refugees, perceptions, challenges, and recommendations for refugees. Intersectional and human rights approach to health problems of refugees were reflected under CEDAW. It is important to evaluate them within the perspective of the human rights and the intersectional approaches. Because these approaches reflect the discrimination situations faced by women refugees with their different identities. This is important for policy making process in the humanitarian crises. Even though primary and secondary health care services are provided for Syrian women refugees in Turkey, there are some inadequacies because of lack of implementation of policies. This dissertation reveals that Syrians are mostly satisfied with healthcare services in Turkey, but there are many obstacles in terms of accessibility to health care. Thus, policy making process should be reconstructed to make the healthcare system more accessible for Syrian women refugees living in Turkey. This research aims to reflect how effective CEDAW is for health care services of Syrian women refugees.

REFERENCES

Acosta-Belen, E., & Bose, C. E. (1990). From structural subordination to empowerment: Women and development in third world contexts. *Gender & Society*, *4*(3), 299-320.

Alawa, J., Zarei, P., & Khoshnood, K. (2019). Evaluating the provision of health services and barriers to treatment for chronic diseases among Syrian refugees in Turkey: a review of literature and stakeholder interviews. *International journal of environmental research and public health*, *16*(15), 2660.

Altman, A. (2011). Discrimination.

Amara, A. H., & Aljunid, S. M. (2014). Noncommunicable diseases among urban refugees and asylum-seekers in developing countries: a neglected health care need. *Globalization and health*, *10*(1), 1-15.

Arcel, L. T., & Kastrup, M. C. (2004). War, women and health. *NORA-Nordic Journal of Feminist and Gender Research*, *12*(1), 40-47.

Ashford, M. W., & Huet-Vaughn, Y. (1997). The impact of war on women. *War and public health*, 186-196.

Baker, D. (2014). Regional situation report for Syria crisis. *Geneva: United Nations Population Fund (accessed 8 March 2020)*.

Bal, M. D., Yılmaz, S. D., Beji, N. K., & Uludağ, S. (2014). Muslim women choice for gender of obstetricians and gynecologist in Turkey. *Journal of Human Sciences*, *11*(2), 64-73.

Baser, D. A., Mıhcı, Ö., Direk, M. T., & Cankurtaran, M. (2021). Views and experiences of family physicians about Syrian refugee patients in Turkey: a qualitative research. *Primary Health Care Research & Development*, *22*.

Bauböck, R. (2018). Refugee protection and burden-sharing in the European Union. *JCMS: Journal of Common Market Studies*, *56*(1), 141-156.

Biholar, R. (2014). Challenging the barriers to real equality: Transformative equality.

Bilecen, B., & Yurtseven, D. (2018). Temporarily protected Syrians' access to the healthcare system in Turkey: Changing policies and remaining challenges. *Migration Letters*, *15*(1), 113-124.

Burnett, A., & Peel, M. (2001). Asylum seekers and refugees in Britain: Health needs of asylum seekers and refugees. *BMJ: British Medical Journal*, *322*(7285), 544.

Bustelo, C. (1994). Reproductive health and CEDAW. *Am. UL Rev.*, *44*, 1145.

Byrnes, A. C. (2010). The Convention on the Elimination of All Forms of Discrimination against Women and the Committee on the Elimination of Discrimination against Women: Reflections on their role in the Development of International Human Rights Law and as a Catalyst for National Legislative and Policy Reform. *UNSW Law Research Paper*, (2010-17).

Campbell, M. (2015). CEDAW and women's intersecting identities: a pioneering new approach to intersectional discrimination. *Revista Direito GV*, *11*, 479-504.

Campbell, M. (2020). The Distance Between Us: Sexual and Reproductive Health Rights of Rural Women and Girls. *Intersectionality and Human Rights Law, Hart*.

CEDAW – UN Committee on the Elimination of Discrimination Against Women: Concluding observations on the seventh periodic report of Turkey [CEDAW/C/TUR/CO/7/Add.1], 30 July 2018 https://digitallibrary.un.org/record/1640731#record-files-collapse-header (accessed on 13 May 2021)

CEDAW Committee, General Recommendation No. 25, Temporary measures, 2004, Para 12.

CEDAW Committee, General Recommendation No. 28 on the core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women, UN Doc. CEDAW/C/ GC/28, 16 December 2010, Para 18.

CEDAW Committee, General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations, UN Doc. CEDAW/C/GC/30, 1 November 2013

CEDAW Committee, General Recommendation No. 33, Women's access to justice, UN Doc. CEDAW/C/ GC/33, 3 August 2015, Para 8

CEDAW Committee, General Recommendation No. 34, Rights of rural women, UN Doc. CEDAW/C/GC/34, 4 March 2016, Para 14

Chang, R. S., & Culp Jr, J. M. (2002). After intersectionality. *UMKC L. Rev.*, *71*, 485.

Charlesworth, H. (2002). The hidden gender of international law. *Temp. Int'l & Comp. LJ*, *16*, 93.

Charlesworth, H., & Chinkin, C. M. (2000). *The boundaries of international law: A feminist analysis*. Manchester University Press.

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. Signs: Journal of Women in Culture and Society, 38(4), 785–810.

Cloeters, G., & Osseiran, S. (2019). Healthcare access for Syrian refugees in Istanbul: A gender-sensitive perspective workshop report.

Cohen, J., & Ezer, T. (2013). Human Rights in Patient Care: A Theoretical and Practice Framework. *Health & Hum. Rts.*, *15*, 7.

Collins, P. (1997). Comment on Hekman's "Truth and Method: Feminist Standpoint Theory Revisited": Where's the Power? *Signs, 22*(2), 375-381. Retrieved September 11, 2021, from http://www.jstor.org/stable/3175278

Connell, R. W. (1987). Gender and Power: Society, the Person and Sexual Politics: Stanford University Press.

Crawley, H., & Skleparis, D. (2018). Refugees, migrants, neither, both: categorical fetishism and the politics of bounding in Europe's 'migration crisis'. *Journal of Ethnic and Migration Studies*, *44*(1), 48-64.

Çöl, M., Aykut, N. B., Mut, A. U., Koçak, C., Uzun, S. U., Akın, A., ... & Kobeissi, L. (2020). Sexual and reproductive health of Syrian refugee women in Turkey: a scoping review within the framework of the MISP objectives. *Reproductive health*, *17*(1), 1-12.

DALKIRAN, M. (2016). Law on Foreigners and International Protection: A Real Shift in Turkey's Migration Policy?

de Los Reyes, P., & Mulinari, D. (2020). Hegemonic feminism revisited: On the promises of intersectionality in times of the precarisation of life. *NORA-Nordic Journal of Feminist and Gender Research*, *28*(3), 183-196.

De Schutter, O. (2010). The Framework Convention on the Protection of National Minorities and the Law of the European Union. In *Double Standards Pertaining to Minority Protection* (pp. 71-115). Brill Nijhoff.

Demirtas, U., & Ozden, A. (2015). Syrian refugees: health services support and hospitality in Turkey. *Public health*, *129*(11), 1549-1550.

DeVault, M. L., & Gross, G. (2007). *Feminist interviewing: Experience, talk, and knowledge* (pp. 173-197). na.

Diker, E. (2018). Türkiye'deki Suriyeli Mültecilerle İlgili Kaynakçalar: Sağlık. *Koç Üniversitesi Göç Araştırmaları Uygulama ve Araştırma Merkezi, FMRC Serisi*, (1).

Dittrich, R., Cubillos, L., Gostin, L., Chalkidou, K., & Li, R. (2016). The international right to health: what does it mean in legal practice and how can it affect priority setting for universal health coverage?. *Health Systems & Reform*, *2*(1), 23-31.

Dorling, D., Mitchell, R., & Pearce, J. (2007). The global impact of income inequality on health by age: an observational study. *bmj*, *335*(7625), 873.

EGİCİ, M. (2019). Migrant Health Care Services Provided by Public Sector in Turkey. *The anatolian journal of family medicine (Online)*, *2*(1), 7-12.

Ekmekci, P. E. (2017). Syrian refugees, health and migration legislation in Turkey. *Journal of immigrant and minority health*, *19*(6), 1434-1441.

Ekmekci, P. E. (2017). Syrian refugees, health and migration legislation in Turkey. *Journal of immigrant and minority health*, *19*(6), 1434-1441.

Equality in marriage and family relations: 04/02/94, General Recommendation 21, Comment 22, see http://www.bayefsky.com/general/cedaw_genrecom_21.php; UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), http://www.bayefsky.com/general/cedaw_genrecom_21.php, accessed 10 May 2021

Esen, A., & Duman, M. (2016). TÜRKİYE'DE GEÇİCİ KORUMA ALTINDAKİ SURİYELİLER: TESPİTLER ve ÖNERİLER.

Etikan, I., Alkassim, R., & Abubakar, S. (2016). Comparision of snowball sampling and sequential sampling technique. *Biometrics and Biostatistics International Journal*, *3*(1), 55.

Farmer, A. (2008). Non-Refoulment and jus cogens: Limiting anti-terror measures that threaten refugee protection. *Geo. Immigr. LJ*, *23*, 1.

Feller, E. (2001). The evolution of the international refugee protection regime. *Wash. UJL & Pol'y*, *5*, 129.

Fine, S. (2018). Liaisons, labelling and laws: International organization for migration bordercratic interventions in Turkey. *Journal of Ethnic and Migration Studies*, *44*(10), 1743-1755.

Flick, U. (Ed.). (2017). *The Sage handbook of qualitative data collection*. Sage.

Freedman, J. (2016). Sexual and gender-based violence against refugee women: a hidden aspect of the refugee" crisis". *Reproductive health matters*, *24*(47), 18-26.

Freedman, J. (2017). Women's experience of forced migration: Gender-based forms of insecurity and the uses of "vulnerability". In *A gendered approach to the Syrian refugee crisis* (pp. 125-141). Routledge.

Freeman, M. A. (2009). Reservations to CEDAW: An analysis for UNICEF. *Policy and Practice*, 48.

Frontières, M. S. (1997). Refugee health. *An approach to emergency situations*.

Gardam, J. G., & Jarvis, M. J. (2001). A Final Word. In *Women, Armed Conflict and International Law* (pp. 263-263). Brill Nijhoff.

Giorgi, A. (1997). The theory, practice, and evaluation of the phenomenological method as a qualitative research procedure. *Journal of phenomenological psychology*, *28*(2), 235-260.

Grabe, S. (Ed.). (2018). *Women's human rights: A social psychological perspective on resistance, liberation, and justice*. Oxford University Press.

Guajardo, M. G. U., Slewa-Younan, S., Smith, M., Eagar, S., & Stone, G. (2016). Psychological distress is influenced by length of stay in resettled Iraqi refugees in Australia. *International journal of mental health systems*, *10*(1), 1-7.

Gümüş, G., BAŞIBÜYÜK, M., ÖZDEMİR, S., Yılmaz, S. S., Kaya, A., & MARGİRİT COŞKUN, A. N. A. Y. İ. T. (2017). Suriyeli mülteci kadınların üreme sağlığı sorunları.

Harris, M., & Zwar, N. (2005). Refugee health. *Australian family physician*, *34*(10).

Hayden, P. (2012). The human right to health and the struggle for recognition. *Review of International Studies*, *38*(3), 569-588.

Henn, E. V. (2019). *International Human Rights Law and Structural Discrimination*. Springer Berlin Heidelberg.

Holtmaat, H. M. T., Freeman, M. A., Chinkin, C., & Rudolf, B. (2012). Article 5 CEDAW. In *The UN Convention on the Elimination of All Forms of Discrimination against Women; a Commentary* (pp. 141-167). Oxford University Press.

Holtmaat, R. (2004). Towards Different Law and Public Policy. *The significance of Article 5a CEDAW for the elimination of structural gender discrimination*.

IGAM (2013). Sivil Toplum Örgütlerinin Türkiye'deki Suriyeli Mülteciler İçin Yaptıkları Çalışmalar ile İlgili Rapor [Report on the Activities of Non Governmental Organisations for Syrian Refugees in Turkey]. Ankara,IGAM Asylum and Migration Center (https://igamder.org/uploads/belgeler/IGAMSuriyeSTK2013.pdf, last accessed 6 April 2021).

İçduygu, A. (2015). Syrian refugees in Turkey: The long road ahead. *Washington, DC: Migration Policy Institute*.

İçduygu, A., & Şimşek, D. (2016). Syrian refugees in Turkey: Towards integration policies. *Turkish Policy Quarterly*, *15*(3), 59-69.

Janssens, K., Bosmans, M., & Temmerman, M. (2005). Sexual and Reproductive Health and Rights of Refugee Women in Europe: rights, policies, status and needs. Literature review.

Joseph, S., & McBeth, A. (Eds.). (2010). *Research handbook on international human rights law*. Edward Elgar Publishing.

Jovanovski, Z. (2019). The Legal Protection of Refugee and International Security. *Social Sciences*, *8*(3), 125.

Karas, T. (2015). Not Syrian, Not Turkish: Refugees Fleeing War Lack Documentation. *ALJAZEERA AMERICA, Sept*, *24*, 9.

Khan, F., & Amatya, B. (2017). Refugee health and rehabilitation: challenges and response. *Journal of rehabilitation medicine*, *49*(5), 378-384.

Kivilcim, Z. (2016). Legal violence against Syrian female refugees in Turkey. *Feminist Legal Studies*, *24*(2), 193-214.

Koçak, M. (2020). Who is "Queerer" and Deserves Resettlement?: Queer Asylum Seekers and Their Deservingness of Refugee Status in Turkey. *Middle East Critique*, *29*(1), 29-46.

Köse, M. R., Bora Başara, B., Güler, C., & Yentür, G. K. (2014). The Ministry of Health of Turkey Health Statistics Yearbook 2013. *Republic of Turkey Ministry of Health General Directorate of Health Research. Ankara: Sentez Matbaacılık ve Yayıncılık*, 173.

Lal, J., McGuire, K., Stewart, A. J., Zaborowska, M., & Pas, J. M. (2010). Recasting global feminisms: Toward a comparative historical approach to women's activism and feminist scholarship. *Feminist Studies*, *36*(1), 13-39.

Lambert, S. D., & Loiselle, C. G. (2007). Health information—seeking behavior. *Qualitative health research*, *17*(8), 1006-1019.

Linke, U. (1997). Gendered Difference, Violent Imagination Blood, Race, Nation. *American Anthropologist*, *99*(3), 559-573.

Lippert-Rasmussen, K. (2013). Born free and equal?: A philosophical inquiry into the nature of discrimination. Oxford University Press.

Lykes, M. B. (2000). Possible contributions of a psychology of liberation: Whither health and human rights? Journal of Health Psychology, 5, 383–397.

Lykes, M. B. (2001). Human rights violations as structural violence. In D. J. Christie, R. V. Wagner & D. Du, N. Winter (Eds.), Peace, conflict, and violence: Peace Psychology for the 21st Century (pp. 158–167). Upper Saddle River, NJ: Prentice Hall.

MacKinnon, C. A. (2013). Intersectionality as method: A note. *Signs: Journal of Women in Culture and Society*, *38*(4), 1019-1030.

Mardin, F. D. (2017). Right to health and access to health services for Syrian refugees in Turkey. *MiReKoc Policy Brief Ser*, *1*.

Masterson, A. R., Usta, J., Gupta, J., & Ettinger, A. S. (2014a). Assessment of reproductive health and violence against women among displaced Syrians in Lebanon. *BMC women's health*, *14*(1), 1-8.

Masterson, A. R., Usta, J., Gupta, J., & Ettinger, A. S. (2014b). Assessment of reproductive health and violence against women among displaced Syrians in Lebanon. *BMC women's health*, *14*(1), 1-8.

MEDAK (2016). Türkiye'de Suriyeli Mülteciler ile Çalışan STK'ların İhtiyaçlarının Değerlendirilmesi ve Haritalama Çalışması [Assessing the Needs of NGOs Working with

Syrian Refugees in Turkey and Mapping Study]. Ankara, Medical Rescue Association (MEDAK).

Merry, S. E. (2011). Gender justice and CEDAW: The convention on the elimination of all forms of discrimination against women. *Hawwa*, *9*(1-2), 49-75.

Mertens, D. M. (2018). Ethics of qualitative data collection. *The SAGE handbook of qualitative data collection*, 33-48.

Miller, D. (2016) Strangers in Our Midst. The Political Philosophy of Immigration (Cambridge, MA: Harvard University Press).

Milosevic, D., Cheng, I. H., & Smith, M. M. (2012). The NSW Refugee Health Service: Improving refugee access to primary care. *Australian family physician*, *41*(3), 147-149.

Ministry of Health (2014). Gecici Koruma Altina Alinanlara verilecek Saglik Hizmetlerine Dair Esaslar Hakkinda Yonerge [Fundamentals of health services to be delivered to Syrians under Temporary Protection]. Ankara, Ministry of Health

Molnár, T. (2016). The principle of non-refoulement under international law: Its inception and evolution in a nutshell. *Corvinus Journal of International Affairs (COJOURN) Vol*, *1*.

Nabolsi, M., Safadi, R., Sun, C., Ahmad, M., Halasa, S., Saleh, M., & Dohrn, J. (2020). The health-related quality of life of Syrian refugee women in their reproductive age. *PeerJ*, *8*, e9990.

Nafziger, J. A. (1983). The general admission of aliens under international law. *American Journal of International Law*, *77*(4), 804-847.

No, G. R. (2015). *33,"General recommendation on women's access to justice", UN Doc CEDAW*. C/GC/33.

Norredam, M., Mygind, A., Nielsen, A. S., Bagger, J., & Krasnik, A. (2007). Motivation and relevance of emergency room visits among immigrants and patients of Danish origin. *European Journal of Public Health*, *17*(5), 497-502.

Oktay, Fuat. 2013. Syrian Refugees in Turkey: Field Survey Results. Turkey: Republic of Turkey Prime Ministry of Disaster and Emergency Management Authority (AFAD).

Owen, D. (2018). Refugees and responsibilities of justice. *Global Justice: Theory Practice Rhetoric*, *11*(1).

Ozcurumez, S. (2017). Lessons from Turkey: Syrians under Temporary Protection, Health Services and NGOsSaime Ozcurumez. *European Journal of Public Health*, *27*(suppl_3).

Ozcurumez, S. (2017). Lessons from Turkey: Syrians under Temporary Protection, Health Services and NGOsSaime Ozcurumez. *European Journal of Public Health*, *27*(suppl_3).

Ördek, K. E. M. A. L. (2017). Syrians Under "Temporary Protection" in Turkey and Sex Work. *Red Umbrella Sexual Health and Human Rights Association*.

Paraskevas, A., Brookes, M., & Altinay, L. (2019). Global refugee crisis and the service industries.

Phillimore, J. (2011). Refugees, acculturation strategies, stress and integration. *Journal of Social Policy*, *40*(3), 575-593.

Phillips, A. (2002). *Multiculturalism, universalism and the claims of democracy*. Washington: United Nations Research Institute for Social Development.

Pickering, S., & Cochrane, B. (2013). Irregular border-crossing deaths and gender: Where, how and why women die crossing borders. *Theoretical Criminology*, *17*(1), 27-48.

Pillay, N. (2012). Strengthening the United Nations human rights treaty body system. *A report by the United Nations High Commissioner for Human Rights*.

Pincus, F. L., & Ehrlich, H. J. (2019). The study of race and ethnic relations. In *Race and ethnic conflict* (pp. 11-13). Routledge.

Pittaway, E., & Bartolomei, L. (2001). Refugees, race, and gender: The multiple discrimination against refugee women. *Refuge: Canada's Journal on Refugees*, 21-32.

Pogge, T. W. (2008). *World Poverty and Human Rights*. Polity.

Pratto, F., Sidanius, J., Stallworth, L. M., & Malle, B. F. (1994). Social dominance orientation: A personality variable predicting social and political attitudes. *Journal of personality and social psychology*, *67*(4), 741.

Priebe, S., Sandhu, S., Dias, S., Gaddini, A., Greacen, T., Ioannidis, E., ... & Bogic, M. (2011). Good practice in health care for migrants: views and experiences of care professionals in 16 European countries. *BMC public health*, *11*(1), 1-12.

Prime Ministry Disaster and Emergency Management Authority. Syrian Women in Turkey. 2014. https://www.afad.gov.tr/kurumlar/afad.gov.tr/1 7935/xfiles/afad-suriye-kdn_eng_1_.pdf. Accessed 13 May 2020

Raistick, N., & Maglietti, M. (2014). Reporting on Gender-Based Violence in the Syria Crisis: A Journalist Handbook. *United Nations Population Fund (UNFPA)*.

Reinharz, Shulamit and Chase, Susan E. (2002) 'Interviewing women', in Jaber F. Gubrium, James A. Holstein (eds.), Handbook of Interview Research: Context and Method. Thousand Oaks, CA: Sage, pp. 221–38

Report of the Committee on the Elimination of Discrimination against Women, Forty-first Session, A/63/38 Supp (2008), pp. 78-83.

Republic of Turkey (2020) Ministry of Interior Directorate General of Migration Management. http://www.goc.gov.tr/icerik3/migration-strategydocument_913_991_998.

Saadallah, S., & Baker, D. (2016). Women and Girls in the Syria Crisis: UNFPA Response. *Egypt: United Nations Population Fund (accessed 8 March 2020)*.

Sahlool, Z., Sankri-Tarbichi, A. G., & Kherallah, M. (2012). Evaluation report of health care services at the Syrian refugee camps in Turkey. *Avicenna journal of medicine*, *2*(2), 25.

Samari, G. (2014). The Response to Syrian Refugee Women's Health Needs in Lebanon, Turkey and Jordan and Recommendations for Improved Practice" as part of the 2014 Humanity in Action. Diplomacy and Diversity Fellowship.

Samari, G. (2017). Syrian refugee women's health in Lebanon, Turkey, and Jordan and recommendations for improved practice. World medical & health policy, 9(2), 255-274.

Samet, J. M., Yoon, S. Y., & World Health Organization. (2010). *Gender, women, and the tobacco epidemic*. World Health Organization.

Schreck, L. (2000). Turning point: a special report on the refugee reproductive health field. *International Family Planning Perspectives*, *26*(4), 162-166.

Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and the social sciences*. Teachers college press.

Semaan, S. (2010). Time-space sampling and respondent-driven sampling with hard-to-reach populations. *Methodological Innovations Online*, *5*(2), 60-75.

Silveira, A. (2017). An Evidence Review of Sexually Transmitted Infections in Humanitarian Settings.

Simonovic, D. (2014). Global and regional standards on violence against women: the evolution and synergy of the CEDAW and Istanbul Conventions. *Hum. Rts. Q.*, *36*, 590.

Smith, A., LeVoy, M., Mahmood, T., & Mercer, C. (2016). Migrant women's health issues: addressing barriers to access to health care for migrant women with irregular status. *Entre Nous WHO Europe*, *85*, 18-21.

Smith, M. (2003). Health care for refugees. *Asia Pacific Family Medicine*, *2*(2), 71-73.

Smith-Cannoy, H., Wong, W. H., Siddiqi, A., Tait, C., & Parnia, A. (2020). When everyone agrees: human rights norms on women and children and their effects on health. *The International Journal of Human Rights*, *24*(10), 1537-1571.

Stasiulis, D., Jinnah, Z., & Rutherford, B. (2020). Migration, Intersectionality and Social Jusice-Guest Editors' Introduction.

Stasiulis, D., Jinnah, Z., & Rutherford, B. (2020). Migration, Intersectionality and Social Jusice-Guest Editors' Introduction.

Tamale, S. (2004). Gender trauma in Africa: enhancing women's links to resources. *Journal of African Law*, *48*(1), 50-61.

Tiburcio, C. (2001). *The human rights of aliens under international and comparative law* (Vol. 65). Martinus Nijhoff Publishers.

TMA (2014). Suriyeli Sığınmacılar ve Sağlık Hizmetleri Raporu Açıklandı [Syrian Asylum Seekers and Health Services Report Disclosed]. Ankara, Turkish Medical Association

TMA (2017). About the Turkish Medical Association. Ankara, Turkish Medical Association (Çalışma Grubu 1: Göçmenlerin Sağlık Hakkı | TTB>, last accessed 8 April 2021).

Toker, S. S. (2019). Evaluation of Adaptation Training Provided by the Ministry of Health and the World Health Organization: Patient Guides within the Context of Healthcare Interpreting Training in Turkey.

Trends, U. G. (2016). Forced Displacement in 2015-Geneva: UNHCR. 2015. *URL: http://www. humanite. fr/sites/default/files/576408cd7. pdf*.

Truscan, I., & Bourke-Martignoni, J. (1995). International human rights law and intersectional discrimination. *Berkeley Women's Law Journal*, *10*, 16.

Truscan, I., & Bourke-Martignoni, J. (1995). International human rights law and intersectional discrimination. *Berkeley Women's Law Journal*, *10*, 16.

Tunaligil, V., Tüzgen, İ. E., Özdemir, H., & Albayrak, S. (2019). Health care services in Istanbul for "Syrians of concern". *Cumhuriyet Medical Journal*, *41*(3), 576-591.

Turkish Statistical Institute. 2020. Marriage and divorse statistics. Press Release No: 37211. https://data.tuik.gov.tr/Bulten/Index?p=Marriage-and-Divorce-Statistics-2020-37211. Accessed 12 July 2021

Turshen, M. (1998). Women's war stories.

Ulusoy, K. (2019). Türkiye'de bir devlet kapasitesi sorunu olarak geçici koruma altında Suriyeliler.

UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), 1999, A/54/38/Rev.1, chap. I, available at: https://www.refworld.org/docid/453882a73.html [accessed 12 September 2021]

UN, "Gender and Racial Discrimination," (2000) Report of the Expert Group Meeting 2000, on-line: https://www.un.org/womenwatch/daw/csw/genrac/report.htm

UN. (2007). Compilation of guidelines on the form and content of reports to be submitted by States parties to the international human rights treaties: report of the Secretary-General (Report No: HRI/GEN/2/Rev.4), Report of the Secretary-General. https://digitallibrary.un.org/record/600446#record-files-collapse-header

UN. Committee on the Elimination of Discrimination against Women (64th sess. : 2016 : Geneva), Concluding observations on the seventh periodic report of Turkey, 25 July 2016, available at: https://digitallibrary.un.org/record/840825#record-files-collapse-header [accessed 12 May 2021]

United Nations (UN). (1979). Convention on the Elimination of All Forms of Discrimination Against Women. http://www.un.org/womenwatch/daw/cedaw/

United Nations (UN). (2011). Progress of the world's women: In pursuit of justice. New York: United Nations Entity for Gender Equality and Empowerment of Women.

Üstübici, A. (2019). The impact of externalized migration governance on Turkey: Technocratic migration governance and the production of differentiated legal status. *Comparative Migration Studies*, *7*(1), 1-18.

Vagle, M. D. (2014). Vagle, Mark D., Crafting Phenomenological Research. Walnut Creek, CA: Left Coast Press, 2014.

Weissbrodt, D., & Divine, M. (2012). International human rights of migrants. Founda-tions of International Migration Law. Ed. by B. Opeskin, R. Perruchoud and J. Redpath-Cross.

Weldon, S. L. (2008). Intersectionality. *Politics, Gender and Concepts: Theory and Methodology, ed. Gary Goertz and Amy G. Mazur*, 193-218.

Yamin, A. E. (2005). The right to health under international law and its relevance to the United States. *American Journal of Public Health*, *95*(7), 1156-1161.

Yılmaz, S. A. (2016). Suriyeli Mülteci Kadınlar: Göç Travması ve Entegrasyon. *içinde, Türkiye'de Geçici Koruma Altındaki Suriyeliler: Tespitler ve Öneriler*, 195-211.

Young, I. M. (1994). Gender as seriality: Thinking about women as a social collective. *Signs: journal of women in culture and society*, *19*(3), 713-738.

APPENDICES

Appendix A. Ethical Permission

Evrak Tarih ve Sayısı: 10.03.2021-2342

TED ÜNİVERSİTESİ

TED ÜNİVERSİTESİ
İnsan Araştırmaları Etik Kurulu

Sayı : E-27535802-100-2342 .....
Konu : İnsan Araştırmaları Etik Kurulu Başvurunuz 10.03.2021

Sayın Prof. Dr. Şebnem AKİPEK ÖCAL
İşletme Bölümü - Öğretim Üyesi

İnsan Araştırmaları Etik Kurulu kararınız ektedir. Bilgilerinize Sunarım

Saygılarımla

Kurul Başkanı

TED ÜNİVERSİTESİ
İNSAN ARAŞTIRMALARI ETİK KURULU
ETİK KURUL KARARLARI

Toplantı Tarihi	28.02.2021
Toplantı Sayısı	2021/02
Toplantı Yeri	Dekanlık Toplantı Odası
Toplantı Saati	10:00
Toplantıya Katılanlar	

Raportör Serkan Karaca İAEK Sekreteri

Gündem : Ted Üniverisetesi İnsan Araştırmları Etik kurulu Toplantıları COVİD-19 salgını nedeni ile online yapılmış olup kararları toplu olarak yazılıp e-imza ile imzaya açılmıştır.

GÖRÜŞME MADDELERİ

G.09 : TED Üniversitesi, İşletme Bölümü Öğretim Üyesi Prof. Dr. Şebnem Akipek Öcal'ın " CEDAW Sözleşmesi Kapsamında Sağlık Hizmeti Alma Hakkı ve Suriyeli Kadın Mültecilerin Durumu " başlıklı çalışmasının araştırma etiğine uygunluğu görüşüldü

Karar 2021-02/09: : TED Üniversitesi İşletme Bölümü Öğretim Üyesi Prof. Dr. Şebnem Akipek Öcal'ın " CEDAW Sözleşmesi Kapsamında Sağlık Hizmeti Alma Hakkı ve Suriyeli Kadın Mültecilerin Durumu " başlıklı çalışmasının başvurunuzun araştırma etiğine uygun olduğuna

OYÇOKLUGU İLE KARAR VERİLDİ.

TEDÜ İAEK Üyelerince Yeniden Düzenlenmesi/Değiştirilmesi Talep Edilen Konular

Katılımcılara nasıl ulaşılacağı yeterince açık değildir. Kartopu örneklem araştırmacının önce bir kişiye ulaşması sonra o kişinin diğer katılımcılara ulaşması şeklinde olur. Böyle bir yöntemde bir duyuru metni gerekmektedir. Araştırmacının o bir kişiye nasıl ulaşacağını ve diğer olası katılımcıların kendisi ile nasıl iletişim kuracağını açıklaması gerekmektedir. Bu şekliyle katılımcı bulma hususlarında etik ihlal olup olmadığı yeterince değerlendirilememektedir. Ayrıca mülakatların nerede yapılacağı bilgisi yöntemde net verilmemiştedir. Zoomdan bahsedilmiş ancak katılımcıların hangi ortamda (evlerinde mi yoksa sığındıkları kurumlarda mı) zoom üzerinden görüşme yapılacağı belirtilmemiştir. Bilgilerin gizliliği güvenirliği açısından bu hususların belirtilmesi önemlidir.

Katılımcılara zorunlu göç ile ilgili sorular sorulmaktadır. Bu sorular mutlaka travmatik deneyimler içerecektir. Bu deneyimleri hatırlamak günlük yaşamdaki stresten daha yüksek olacaktır. Katılımcılar rahatsızlık belirtileri gösterdiğinde ağlamaya başladıklarında ya da bu tür olası durumlarda katılımcıya nasıl bir müdahale yapılacağı başvuru formunda (13. Soru) böyle durumların olmayacağı varsayılarak (Hayır) belirtilmemiştir. Bunun belirtilmesi gerekmektedir. Görüşmelerin online olduğu da ve görüşmeyi yapacak kişilerin ruh sağlığı uzmanlığı olmadığı da düşünülerek böyle durumlarda ne gibi önlemlerin alınacağı açıkça belirtilmelidir.

Çalışmanın zoom üzerinden de yapılacağı düşünüldüğünde "Bu çalışma kapsamında elde edilecek olan bilimsel bilgiler sadece araştırmacılar tarafından yapılan bilimsel yayınlarda, sunumlarda ve eğitim amaçlı çevrimiçi bir ortamda kimlik bilgilerinizi içermeyecek şekilde paylaşılacaktır. Sizin izniniz olmadığı durumda veriler tamamıyla silinecektir. İzin verdiğiniz takdirde görüntülü ya da sesli kaydınız, bilgisayarda şifreli bir dosyada iki yıl süreyle tutulacaktır ve bu şifre sadece araştırmacılar tarafından bilinecektir" ibaresinin eklenmesi önerilir.

Zoom görüşmelerinin nasıl yapılacağı hakkında onam formunda bilgi verilmesi önerilir.

Appendix B. Informed Consent

Sayın Katılımcı,

Bu araştırma, TED Üniversitesi, İktisadi ve İdari Bilimler Bölümü'nde öğretim üyesi Prof. Dr. Şebnem Akipek Öcal danışmanlığında, Göç Çalışmaları Yüksek Lisans programı öğrencisi tarafından yürütülmektedir. Araştırmanın amacı, Ankara'da yaşayan Suriyeli kadın mültecilerin sağlık problemlerini ve sağlık hakkına erişmede nasıl sorunlar yaşadığını ortaya çıkarmak ve CEDAW Sözleşmesinin sağlık hakkını nasıl şekillendirdiğini ortaya koymaktır. Bu çalışmanın katılımcılarını 18 yaşından büyük Ankara'da yaşayan Suriyeli kadın mülteciler oluşturmaktadır. Katılımcılar Türkçe bilen Suriyeli kadınlardır.

Bu araştırmaya katılımınızı onayladığınız taktirde, 15.03.2021-01.05.2021 tarihleri arasında projenin katılımcısı olacaksınız. Proje araştırma ekibince size bilgisi iletilecek olan mülakat uygulamasına önceden belirlenen takvim doğrultusunda katılmanız istenecektir. Çalışma süresince ve sonrasında kimlik bilgileriniz proje dışındaki hiç kimseyle izniniz dışında paylaşılmayacaktır. Bu çalışma kapsamında elde edilecek olan bilimsel bilgiler sadece araştırmacılar tarafından yapılan bilimsel yayınlarda, sunumlarda ve eğitim amaçlı çevrimiçi bir ortamda paylaşılacaktır. Toplanan veriler isminiz silinerek, bilgisayarda şifreli bir dosyada tutulacaktır.

Bu çalışmaya katılım gönüllük esasına dayalıdır. Bu projeye katılımınız temel sağlık hakkı ve bu konuda yaşanan problemler konusunda bilgilenmenize katkı sağlayabilir ve sağlık hakkına erişim ve sahip olunan hakların farkındalığını arttırma konusunda sizi destekleyebilir. 1 saat sürecek bu uygulamada yer alan hiçbir aşama, kişisel rahatsızlık verecek nitelikte değildir. Ancak herhangi bir nedenden ötürü kendinizi rahatsız hissederseniz, uygulamaları nedenini açıklamaksızın yarıda bırakıp araştırmadan çıkmakta serbestsiniz. Böyle bir durumda vermiş olduğunuz bilgilerin araştırmacı tarafından kullanılması ancak sizin onayınızla mümkün olacaktır. Bu çalışmaya katıldığınız için şimdiden teşekkür ederim. Çalışma hakkında daha fazla bilgi almak ve yanıtlanmasını istediğiniz sorularınız için araştırmayı yürüten Işılay Boran ile (E-posta: telefon : iletişim kurabilirsiniz.

Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesip çıkabileceğimi biliyorum. Bu proje kapsamında gereken mülakat uygulamasında yer alacağımı biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum. Proje süresince video kaydı ve ses kaydı alınacağını ve fotoğraf çekileceğini biliyorum. Videolar ve fotoğrafların bilimsel makaleler, akademik sunumlar ve çevrimiçi bir eğitim ortamı dışında kesinlikle kullanılmayacağını biliyorum.

Projeye katılmak istiyorum Evet /Hayır

Fotoğraf ve videolarımın araştırma amaçlı kullanımına izin veriyorum Evet /Hayır

Ses kaydı kullanılmasına izin veriyorum Evet /Hayır

Raporlar, makaleler,ilgili haberler gibi görsel ve yazılı materyallerde kullanılabilir Evet /Hayır

Bu çalışma kapsamında elde edilecek olan bilimsel bilgiler sadece araştırmacılar tarafından yapılan bilimsel yayınlarda, sunumlarda ve eğitim amaçlı çevrimiçi bir ortamda kimlik belgelerinizi içermeyecek şekilde paylaşılacaktır. Sizin izniniz olmadığı durumda veriler tamamıyla silinecektir. İzin verdiğiniz takdirde görüntülü ya da sesli kaydınız, bilgisayarda şifreli bir dosyada iki yıl süreyle tutulacaktır ve bu şifre sadece araştırmacılar tarafından bilinecektir.

Ad Soyad:

Katılımcının İmzası:

Tarih:

Teşekkürler,
Araştırmacının adı, soyadı ve imzası
IŞILAY BORAN

Araştırmaya katılımınız ve haklarınızın korunmasına yönelik sorularınız varsa ya da herhangi bir şekilde risk altında olduğunuza veya strese maruz kalacağına inanıyorsanız TED Üniversitesi İnsan Araştırmaları Etik Kurulu'na telefon numarasından veya posta adresinden ulaşabilirsiniz.

Appendix C. Semi Structured Interview Questions

"İstemediğiniz soruyu cevaplamadan geçebilirsiniz."

1) Kısaca sizi tanıyabilir miyim/z? (Yaşınız, medeni durumuz, eğitim durumunuz, çocuğunuz var mı vs.)
2) Türkiye'ye geliş hikayenizden bahsedebilir misiniz? Nasıl, kimlerle ve ne zaman geldiniz?
3) Göç hareketinin çoğunu kadınlar ve çocuklar oluşturuyor. Özellikle kadın mülteci olarak göç sürecinde ve sonrasında yaşadığınız sorunlar nelerdir?
4) Türkiye'ye geldikten sonra hiç sağlık sorunu yaşadınız mı? Hastaneden veya doktordan hizmet aldınız mı?
5) Sağlık hizmeti alma konusunda yaşadığınız sorunlar var mıdır varsa bunlar nelerdir? (Dil sorunu, sağlık sigortasının eksikliği, vb.)?
6) Herhangi bir kurumdan (Sivil toplum kuruluşları veya Birleşmiş Milletler vb.) sağlık hizmeti talep ettiniz mi?
7) Suriyeli bir kadın olarak hastanelerde ya da herhangi bir sağlık merkezinde olumsuz bir durumla karşılaştınız mı?
8) Suriyeli kadın mültecilerin sağlık hizmeti almasında toplumsal veya dini tercihler var mıdır? (Doktorun cinsiyetini seçmek, çekingenlik, karşı cinsten olan sağlık görevlisine kendini rahat ifade edememe gibi)
9) Kadın sağlığını koruyan hizmetlerden yararlanma konusunda sağlık çalışanları tarafından bilgilendirildiniz mi?

Appendix D. Tez Fotokopisi İzin Formu

Anabilim Dalı: Lisansüstü Programlar Enstitüsü

YAZARIN

Soyadı: Boran

Adı: Işılay

Bölümü: Göç Çalışmaları

TEZİN ADI (İngilizce): The Right to Healthcare Under CEDAW and The Position of Syrian Women Refugee"

TEZİN TÜRÜ : Yüksek Lisans [x] Doktora [ ]

1. Tezimin tamamından kaynak gösterilmek şartıyla fotokopi alınabilir. [ ]
2. Tezimin içindekiler sayfası, özet, indeks sayfalarından ve/veya bir bölümünden kaynak gösterilmek şartıyla fotokopi alınabilir. [ ]
3. Tezimden bir bir (1) yıl süreyle fotokopi alınamaz. [x]

TEZİN KÜTÜPHANEYE TESLİM TARİHİ: