Country Report Turkey

Country Experts:
Seval Akgün and Coşkun Bakar

General coordination: Prof. David Ingleby

Editing: IOM MHD RO Brussels

Formatting: Jordi Noguera Mons (IOM)

Proofreading: DJ Caso

Developed within the framework of the IOM Project “Fostering Health Provision for Migrants, the Roma and other Vulnerable Groups” (EQUI-HEALTH). Co-funded by the European Commission’s Directorate for Health and Food Safety (DG SANTE) and IOM.
This document was produced with the financial contribution of the European Commission’s Directorate General for Health, Food Safety (SANTE), through the Consumers, Health, Agriculture, and Food Executive Agency (CHAFEA) and IOM. Opinions expressed herein are those of the authors and do not necessary reflect the views of the European Commission or IOM. The sole responsibility for this publication therefore lies with the authors, and the European Commission and IOM are not responsible for any use that may be made of the information contained therein.

The designations employed and the presentation of the material throughout the paper do not imply the expression of any opinion whatsoever on the part of the IOM concerning the legal status of any country, territory, city or area, or of its authorities, or concerning its frontiers or boundaries.

IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental body, IOM acts with its partners in the international community to: assist in meeting the operational challenges of migration; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

International Organization for Migration Regional Office for the European Economic Area (EEA), the EU and NATO
40 Rue Montoyer
1000 Brussels
Belgium
Tel.: +32 (0) 2 287 70 00
Fax: +32 (0) 2 287 70 06

Email: ROBrusselsMHUnit@iom.int
Internet: http://www.eea.iom.int / http://equi-health.eea.iom.int
# TABLE OF CONTENTS

1. COUNTRY DATA .......................................................... 5
2. MIGRATION BACKGROUND ............................................. 6
3. HEALTH SYSTEM ........................................................ 12
4. USE OF DETENTION ...................................................... 14
5. ENTITLEMENT TO HEALTH SERVICES .......................... 16
   A. Legal migrants ...................................................... 16
   B. Asylum seekers .................................................... 17
   C. Undocumented migrants .......................................... 19
6. POLICIES TO FACILITATE ACCESS ............................... 20
7. RESPONSIVE HEALTH SERVICES .................................... 22
8. MEASURES TO ACHIEVE CHANGE ............................... 23
CONCLUSIONS .................................................................. 25
BIBLIOGRAPHY ............................................................... 26
This report was produced within the framework of the IOM’s EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at http://bit.ly/2g0GlRd. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

- **0** no policies to achieve equity
- **50** policies at a specified intermediate level of equity
- **100** equitable or near-equitable policies.

‘Equity’ between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country’s ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

<table>
<thead>
<tr>
<th>Section</th>
<th>Key indicators</th>
<th>Text</th>
</tr>
</thead>
</table>

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three ‘neighbour’ countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

---

¹ For the definition of these indicators please see p. 21 of the WHO document General statistical procedures at http://bit.ly/20Xd8JS
1. COUNTRY DATA

### KEY INDICATORS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
<th>RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (2014)</td>
<td>76,667,864</td>
<td>⭐⭐⭐⭐⭐⭐</td>
</tr>
<tr>
<td>GDP per capita (2014) [EU mean = 100]</td>
<td>53</td>
<td>⭐⭐⭐⭐⭐</td>
</tr>
<tr>
<td>Accession to the European Union</td>
<td>Candidate country since 2005</td>
<td></td>
</tr>
</tbody>
</table>

**Geography:** Turkey is located at a point where three continents converge – Europe, Asia and Africa. It is situated in South-eastern Europe and South-western Asia and borders the Black Sea between Bulgaria and Georgia, the Aegean Sea, and the Mediterranean Sea between Greece and Syria. The terrain consists of a high central plateau (Anatolia), narrow coastal plains, and several mountain ranges. It is the third most populous country in the European region. Ninety-one percent of the population lives in urban areas, nearly 20% of them (13.8 million) in the largest city Istanbul.

**Historical background:** Modern democratic and secular Turkey was established in 1923, and over the last four decades the country has undergone rapid social and economic development.

**Government:** Turkey is a republican parliamentary democracy divided into 81 provinces. EU accession membership talks started in 2005.

**Economy:** Turkey is currently classified as an upper middle-income country by the World Bank. The country’s largely free-market economy is among the ten largest in Europe and is increasingly driven by its industry and service sectors, although its traditional agriculture sector still accounts for about 25% of employment.

Between 2000 and 2010, Turkey’s GDP doubled. Poverty was halved between 2002 to 2012, urbanization increased dramatically, the country was opened up to foreign trade and finance, and many of its laws and rules were brought into line with EU norms. Global economic conditions and tighter fiscal policy caused the GDP to contract in 2009, but growth rebounded strongly to about 9% in 2010-11.

Since then, however – as in larger ‘emerging markets’ such as Brazil, Russia, India and China (the BRICs) – the pace of growth has slackened. The Turkish economy slowed in 2013–14 and 2015 because of election-related uncertainties, geopolitical developments and concerns over the government’s handling of corruption allegations. Uncertainties following the attempted coup d’état in July 2016 created further setbacks for the economy, though growth was restored by the end of the year. Since the global financial crisis, Turkey has created some 6.3 million jobs, but increases in the labour force have kept unemployment at around 10%. Labour force participation by women, though low in international terms, has been steadily increasing, while the creation of new jobs has barely kept pace.

---

2. MIGRATION BACKGROUND

<table>
<thead>
<tr>
<th>KEY INDICATORS (2015)</th>
<th>RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign-born population as percentage of total population</td>
<td>3,8</td>
</tr>
<tr>
<td>Percentage non-EU/EFTA migrants among foreign-born population</td>
<td>67</td>
</tr>
<tr>
<td>Foreigners as percentage of total population</td>
<td>.</td>
</tr>
<tr>
<td>Non-EU/EFTA citizens as percentage of non-national population</td>
<td>.</td>
</tr>
<tr>
<td>Inhabitants per asylum applicant (more = lower ranking)</td>
<td>33</td>
</tr>
<tr>
<td>Percentage of positive asylum decisions (2016)</td>
<td>79</td>
</tr>
<tr>
<td>Positive attitude towards immigration of people from outside the EU</td>
<td>n/a</td>
</tr>
<tr>
<td>Average MIPEX score for other strands (MIPEX, 2015)</td>
<td>23</td>
</tr>
</tbody>
</table>

Because statistics on Turkey are not collected systematically by Eurostat, most of the above figures apply to 2015 and are sourced from United Nations databases. Throughout its history, Turkey has been a country of emigration, transit and immigration. In 2005, 3.8 million Turkish citizens lived abroad (including first-generation migrants and born-abroad second and third generations):

Fig 1. Turkish citizens living abroad in 2005 (IOM 2008: 19)
Many Turks emigrated to Western Europe as ‘guest workers’ in the 1960s and 1970s. After the European oil crisis in 1973 the Middle East became a new destination, followed in the 1990s by the Russian Federation. In 2013-2015 first-generation Turkish emigrants were estimated to number 2,9 million (De Bel-Air 2016:4), of whom 2,5 million (86%) lived in the EU28, Norway and Switzerland (with nearly half in Germany); 135.000 in North America; 100.000 in Arab countries; and 137.00 in Kazakhstan, Australia, Israel and other countries.

**Migration to Turkey**

In 2015 there were three million foreign-born residents in Turkey: their origins are shown in Fig. 2.

**Figure 2. Foreign-born population in Turkey by country of birth (UN DESA 2015)**

![Pie chart showing foreign-born population in Turkey by country of birth](image)

Syrians formed the largest group, the majority having fled the violence in their country since 2011: their situation will be discussed below. Figure 2 is based on a mid-year estimate of 1,6 million for this group in 2015, but currently (June 2017) their total is estimated at twice that number,\(^5\) completely dwarfing the rest of the immigrant population. If Syrian refugees are included, foreign-born residents in Turkey formed 3,8% of the total population in mid-2015; however, if they are not included this percentage falls to 1,8%, which is close to the average for upper-middle-income countries (1,9%).\(^6\)

As we will see later, Turkish immigration policy is in flux. Since 1934, the right to immigrate has been confined to those of ‘Turkish descent and culture’, though recent changes (stimulated in particular by the possibility of accession to the EU) have weakened this restriction. In the first decades of the Turkish Republic’s existence, immigration and emigration served mainly to further ‘nation-building’ and the creation of a more homogeneous population, bringing Muslims into Turkey and returning non-Muslims to their countries of origin (Bilgili 2012). Although a visa to enter Turkey is very easy to obtain,


requirements for legal residence – especially long-term – and citizenship are hard to meet. As a result, many migrants are irregular. According to İçduygı (2008), writing before the Syrian conflict:

In the last decade, the major migration flows into Turkey have come from Iraq, Iran, Afghanistan, Pakistan and Bangladesh, while significant numbers have also arrived from Moldova, Romania, Ukraine, the Russian Federation and Georgia. Migrants from the former countries are mainly transients heading for Europe or other more developed parts of the world. They stay in Turkey only on a temporary basis. Migrants from the latter group of countries are foreign nationals who intend to work illegally in Turkey, for a limited period of time.

Figure 2 shows only registered migrants and refugees. The second largest group (immigrants from Bulgaria) has a long history of migration to Turkey, dating from the Republic’s founding in 1923 and even before. Other migrants from the Balkans and Eastern Europe arrived as asylum seekers in the 1970s, and many were probably ethnic Turks and/or Turkish citizens. Unfortunately, up-to-date data on citizenship as well as country of birth is hard to obtain, so we do not know how many immigrants are in fact returning emigrants or ethnic Turks born outside the country. This may also be the case with many immigrants from Germany, the Netherlands, and the UK (cf. Fig. 1).

Traditionally, employers and contractors in Western Turkey in sectors such as textile making, agriculture, entertainment, sex work and construction often relied on immigration from Bulgaria, Romania, Moldova and Ukraine to provide cheap labour, while upper and middle-class Turkish families employed female domestic helpers as child minders or caretakers for the sick and elderly. Many of these migrants entered Turkey legally, but overstayed their visas and subsequently become irregular while in the country (İçduygı 2006). Turkey is also a destination for human trafficking in the Black Sea region, with victims usually coming from Moldova, Ukraine, Russian Federation, Kyrgyzstan, and Uzbekistan (IOM 2008: 10). Currently, however, ‘pull’ factors for immigration are weak. Unemployment remains at about 10%, and the 3.2 million Syrian refugees – few of whom are permitted to enter formal employment – have swelled the already large informal labour workforce, since they too have to make a living. It is therefore not surprising that immigration, apart from that by refugees, remains at a low level.

Asylum seekers and refugees
Though Turkey is a signatory to the 1951 Refugee Convention and its 1967 Protocol, it has maintained the ‘geographical restriction’ of the 1951 Convention and confers refugee status only on persons coming from Europe. From 1970 to 1976, some 13.500 refugees from Communist Bloc countries in Europe (including the Soviet Union) were granted asylum, although nearly all of them were resettled in other countries. Between 1992 and 1995, about 20.000 asylum seekers from Bosnia were granted temporary asylum, as were about 18.000 Kosovars. Most of them have now returned to their countries of origin.

Until 2013, non-Europeans fleeing violence and persecution had no clear legal status in Turkey: their presence could at most be tolerated on an ad hoc basis. A new law (YUKK, see below) created the status of ‘conditional refugee’, but the intention is still that such migrants should eventually either go back to their home country or move on to a new one for resettlement.

From 2011 to the present (June 2017), the Syrian civil war has led to an exodus of 5 million people from that country. Of these, at least 3.2 million have fled to Turkey, which early in the conflict opened its...
borders to them in the spirit of solidarity. However, the pace of resettlement is extremely slow, and in March 2016 an agreement between the European Commission and Turkey blocked off the route to the EU via Greece, at the same time classifying Turkey as a ‘safe’ country to which asylum seekers could legally be returned. Early in 2016, observers reported that Turkey’s borders were in practice closed to all but seriously injured Syrians, although the government denied this. By that time, one in 33 of the inhabitants of Turkey was a Syrian refugee, the proportion in the cities being much higher. This placed an enormous strain on the country’s resources and has led to a hardening of attitudes against asylum seekers, as well as great hardship for the Syrians themselves. For comparison, we may note that the Netherlands – with a per capita GDP twice as high as Turkey’s – decided that it had taken in enough Syrians when the ratio of asylum seekers to other inhabitants reached one in 514. Figure 3 shows how the total has built up.

Figure 3. Increase of Syrian migrants in Turkey (De Bel-Air 2016:11)

![Figure 3. Increase of Syrian migrants in Turkey (De Bel-Air 2016:11)](image)


---

7 http://data.unhcr.org/syrianrefugees/regional.php
8 https://www.hrw.org/news/2016/05/20/un-press-turkey-open-border
9 https://www.amnesty.org/download/Documents/MDE2400042015ENGLISH.PDF
10 http://www.asylumineurope.org/reports/country/netherlands/statistics
Policies on migration and integration

Turkey’s national immigration policy is closely tied to the notion of national identity and citizenship. Although the constitutional concept of citizenship emphasizes territoriality (jus soli) rather than descent (jus sanguinis), the concept of national identity is based on the notion of a single common culture. The legal documents reflecting this notion are the 1934 Law on Settlement (Law 2510) and the 1994 Regulation on Asylum. The Law on Settlement laid the foundations of Turkish immigration policy. It entitles persons of ‘Turkish descent and culture’ to enter the country for the purpose of permanent settlement and to opt for Turkish citizenship. According to İcduyg (2015), although the latest revision of the Law on Settlement (2006) “has made some progress in liberalizing migration policies, it continues to limit formal immigration to individuals and groups of ‘Turkish descent and culture’.”

Foreign nationals are entitled to apply for Turkish citizenship on the basis of marriage, residence, birth, and the intention to settle in Turkey permanently. The acquisition of Turkish citizenship by means of naturalization requires five years of permanent residence in Turkey and the confirmed intention to settle in the country. Turkish citizenship laws allow dual citizenship, and foreign nationals’ children born in Turkey have the right to opt for Turkish citizenship within three years after reaching legal age. In recent years, citizenship laws have been partly harmonised with EU legislative standards. According to earlier provisions, a foreign woman who married a Turkish man was automatically entitled to acquire Turkish citizenship. Due to the increasing number of marriages of convenience, the provision became subject to a number of restrictions, for example that a foreigner should only be eligible for naturalization after three years of marriage. The right to acquire citizenship by way of marriage is now granted to foreign men as well.

Due to its geographical proximity to both the EU area and the Middle East North Africa (MENA) region, Turkey is a crucial player in terms of migratory regimes. The country is a party to international agreements such as the UN Convention against Transnational Organized Crime and the UN International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. Turkey’s migration policy has changed considerably since the early 2000s, driven by a desire to meet EU membership criteria. On a national level, Turkey has been aligning its migration framework with the EU’s intended Common Migration Policy. In the process, Turkey has collaborated with international organizations like the UN High Commissioner for Refugees (UNHCR) and the International Organization for Migration (IOM) in the field of asylum and human trafficking.

In 2008 the Asylum and Migration Bureau and the Border Management Bureau were formed under the Ministry of the Interior. This development was followed by the formation of the Committee Against Irregular Migration, which was tasked with the coordination of the precautionary measures and protectionist activities. This represents a fundamental change at the administrative and institutional levels, since a new civilian authority, the Directorate General of Migration Management (DGMM) under the Ministry of Interior, was established to coordinate asylum and migration issues. In addition to its existing involvement with IOM and UNHCR, the Turkish government also partners with civil society organizations working in the field of migration.

In 2013 the Law on Foreigners and International Protection (YUKK, Law no. 6458)11 was passed (although four of its five parts did not come into force until 2014). This introduced a new legal and

institutional framework for migration and asylum. The new law put an end to the lack of a comprehensive legal structure of the previous 63 years. Within the new system, instead of providing case-by-case solutions in a discretionary manner, migration-related issues are decided by law and the administrative system. In 2016 the DGMM processed 30,000 claims for asylum; only 21% were rejected, though it is not known what form of international protection was granted.\textsuperscript{12} As explained above, full ‘Geneva’ refugee protection is not available for non-Europeans; asylum-seekers can and do also claim protection from UNHCR in Turkey.

Both the creation of the YUKK itself and the new framework that it committed to introduce were participatory in nature. For the first time, NGOs and academics were not only observers but active participants in the decision-making process. This increased involvement of multiple actors (both governmental and non-governmental) in the shaping of regulations helps them to internalize the system and motivates them to apply the regulations. Being one of the few national laws accepted unanimously, the new legislative framework is based on consensus. Most doubts concern the actual implementation of the YUKK.

Within the law’s framework, most information is online under a new electronic system.\textsuperscript{13} For instance, applicants for Turkish citizenship have the opportunity to track their admission process online. The YUKK is ‘transparent’ in the sense that information is freely available and easily accessible to those who are affected by rules, regulations, decisions, and their enforcement in the field of migration. The law introduced the new status of ‘conditional refugee’ to facilitate refugees’ access to their basic rights. Similarly, ‘integration’ for the first time became a topic of discussion and was regulated by the YUKK, fostering the conditions in which Turkish society and foreigners can coexist.

Regarding current policies in Turkey for migrant integration, concerning other MIPEX strands than Health, the conclusions of the 2015 MIPEX survey (http://www.mipex.eu/turkey) were as follows:


13 See \url{http://www.goc.gov.tr/main/En_3}
Pursuant to Article 17 of the Constitution of the Republic of Turkey (1982), everyone has the right to life and the right to protect and improve his/her physical and spiritual existence. Article 56 of the Constitution also charges the state with the duty of ensuring that everyone lives in a healthy and balanced environment. Within this framework, the Ministry of Health (MoH) strives to provide citizens with a fair, equal, accessible, effective, and well-qualified healthcare service in order for citizens to live a healthy life. By virtue of Circular No. 26918 (26 June 2008) issued by the Prime Minister’s Office of the Republic of Turkey, citizens are entitled to receive free emergency medical treatment in all public hospitals and private health institutions.

Since 2003 the Turkish government has been undergoing a far-reaching reform process, the Health Transformation Programme, and remarkable improvements have been achieved in the coverage and quality of health services (Tatar et al. 2011). The improvement in life expectancy between 2003 and 2010 was the fastest in the WHO Euro Region; maternal and infant mortality also declined markedly in this period. Of course, these improvements in health are likely to reflect not just the functioning of the health system, but also the improvement in living standards between 2000 and 2010, which saw a twofold increase in Turkey’s GDP.¹⁴

The Turkish health system is largely publicly oriented, but with increasing private sector involvement. The Ministry of Health is the main body responsible for health services. It has a broad structural capacity to cover the whole country for the purpose of providing equitable, easily accessible, effective, and efficient healthcare service. Preventive and family medicine services are provided free of charge for every citizen in 81 provinces across the country. Treatment and rehabilitation services are also provided via 1,022 public hospitals, 71 hospital universities, 545 private hospitals, and 19,198 private healthcare providers (medical centres, clinics, polyclinics, etc.).

The 112 Emergency Hotline has been established to provide free healthcare services 24/7 throughout the country, so that anyone who requires emergency medical treatment can access it in the shortest possible time. General Health Insurance coverage has been extended to every citizen, including low-income and otherwise disadvantaged groups, enabling them to take advantage of their right to equitable service provision.

Private hospitals and private healthcare providers are also included in the coverage. However, fees charged by private providers may be higher than the amount reimbursed by the State, resulting in high out-of-pocket expenses and paving the way for a two-tier system for rich and poor users.\textsuperscript{15,16} As of 2011, the health insurance premiums of the 10.2 million lowest-income citizens were partially or fully paid by the state in proportion to their income level. By September 2013, 98.24\% of the population was included in the system of General Health Insurance. However, as we shall see in section 5, coverage does not extend to all migrants.

\textsuperscript{15}http://www.bmj.com/rapid-response/2011/11/03/privatization-driving-force-turkish-health-system
\textsuperscript{16}http://www.bmj.com/rapid-response/2011/11/03/turkish-health-system-socialisation-privatisation
4. USE OF DETENTION

The legal framework for migration detention in Turkey is set out in Law No. 6458 on Foreigners and International Protection from 2013. The law provides the grounds for use of detention, which includes detaining migrants for administrative purposes; preventing absconding, unauthorized entry, stay or exit; and to establish identity and nationality. In accordance with Article 57 (3) of the law, migrants can be detained for up to one year.

In accordance with Article 68, asylum seekers should only be detained as an exceptional measure in order to verify identity documents and nationality or prevent irregular entry. It is also applied if an asylum application cannot otherwise be assessed, or if the person poses a serious danger to public order and security. Detention of asylum seekers should not exceed 30 days.

In addition, The Law on Foreigners provides that families and unaccompanied children can be detained for the purpose of removal, but separate accommodation during detention has to be provided. The law further stipulates that unaccompanied children who apply for asylum are not to be detained; however, despite this legal framework, the Global Detention Project found several reports on the detention of unaccompanied minors in Turkey, without access to the Child Protection Services.17

Detention Facilities

There is no official information available on the actual number of dedicated migration detention facilities in Turkey.18 Various reports have described approximately 24 dedicated migrant detention facilities, 15 removal centres, and 2 airport transit zone facilities in use as of 2014; however, this does not include ad hoc sites.

In Turkey, the main detention infrastructure consists of dedicated facilities called Removal Centres. The Asylum Information Database (AIDA) found that as of March 2015, Turkey had 15 active removal centres, with a combined capacity of up to 2,980.19 Before the 2013 Law on Foreigners and International Protection, these centres were managed by the police, under the authority of the Ministry of Interior. Since the law came into force, the centres have been managed by the Directorate General of Migration Management (DGMM).

As a result of its readmission agreements with the EU and vastly increased migratory pressures, Turkey has taken steps to reinforce its detention infrastructure. These measures have been largely funded by the EU, and have included both building new facilities and refurbishing old centres. In 2015 the DGMM started building 12 additional removal centres and planned to have a total of 27 operational removal centres, with a capacity of up to 6,900, by 2016/2017. AIDA also reported that the agency was seeking to increase the capacity of its migration detention facilities to 10,000 by 1 June 2016, to facilitate the implementation of the EU-Turkey agreement. However, no information about the realisation of these plans seems to be available.

17 https://www.globaldetentionproject.org/countries/europe/turkey
18 Ibid.
19 http://www.asylumineurope.org/reports/country/turkey/place-detention
In addition, several *ad hoc* facilities are in use when undocumented migrants are detained, including police stations and detention rooms at airports. Reception and Accommodation centres appear to contain dedicated detention sections, for the detention of international protection applicants.

**Detention Conditions**

Turkish detention policies and practices have on numerous occasions been investigated by international and regional human rights bodies, and conditions in the detention facilities have repeatedly criticized. For example, the European Committee for the Prevention of Torture (CPT)\(^20\) found in 2009 that conditions of detention included ill-treatment, overcrowding, inadequate food and hygiene, lack of access to health care and recreation, and censorship of correspondence. ‘Informal deportations’ lacking valid legal justification were also carried out (as the CPT had also noted on a visit in 2000). Since the 2009 visit the CPT has conducted 8 more visits, the most recent being in May 2017. However, the first four visits did not concern removal centres, while reports on the last four have not yet been published.

Amnesty International reported in 2015\(^21\) that during the initial attempts at EU-Turkish collaboration to prevent unauthorised sea crossings to Greece, there was widespread evidence of illegal detention, physical abuse and extra-judicial deportations (which also amounted to *refoulement*) in Turkey. To date, the European Commission has published six *Reports on the Progress made in the implementation of the EU-Turkey Statement*, but none of these concerns have been addressed in any of them. A BBC report in January 2016 claimed that the rights violations reported by Amnesty were still continuing, but the Turkish government denied this.\(^22\) The legality of the EU-Turkey agreement depends, of course, on the legitimacy of Turkey’s designation as a ‘safe country’ for asylum seekers and refugees.

**Healthcare in detention**

Healthcare access for detainees is mentioned in the Regulation of the Establishment of Reception and Accommodation Centres and Removal Centres, Residents, and Detainees, which provides that the detainees should be provided with urgent and basic healthcare services. Also, under the Law on Foreigners and International Protection (YUKK), applicants for International Protection holding an International Protection Applicant Identification Document, including a Foreigners Identification Number, should have access to General Health Insurance. Under the Accelerated Procedures section, however, which covers detained applicants, the detainees are not eligible for the General Health Insurance coverage and therefore have only limited access to healthcare.\(^23\)

In 2009, the CPT found that acute medical conditions were responded to effectively within the Turkish detention centres, and that medication was provided free of charge. However, the report also determined that no systematic medical examinations on entry were conducted, thus resulting in people with contagious diseases being placed in overcrowded detention facilities. In 2012, the UN Special Rapporteur on the Human Rights of Migrants found that detainees with visible health problems had not received medical care, which prompted the Rapporteur to call for an improvement in the access to medical care for detainees in Turkey.\(^24\) We have been unable to find more recent information about the adequacy of health service provision for migrants in detention.


\(^23\) [http://www.asylumin europ e.org/reports/country/turkey/conditions-detention-facilities](http://www.asylumineurope.org/reports/country/turkey/conditions-detention-facilities)

5. ENTITLEMENT TO HEALTH SERVICES

A. Legal migrants

Inclusion in health system and services covered

Although Turkey is not covered by the EU directive on cross-border care, which enables EU citizens to access care in any other EU country on presentation of a European Health Insurance Card (EHIC), it does have bilateral agreements on healthcare with many other countries including 18 in the EU/EFTA: Austria, Belgium, Bulgaria, Croatia, Czech Republic, Denmark, France, Germany, Hungary, Italy (since 2015), Luxembourg, Malta, Netherlands, Norway, Romania, Slovakia, Sweden and Switzerland. Non-EU countries with bilateral agreements are Northern Cyprus, Bosnia-Herzegovina, FYR Macedonia, Albania, Azerbaijan, Algeria, Egypt, Ethiopia, Georgia, Iraq, Iran, Israel, Kyrgyzstan, Moldova, China, Russian Federation, Sudan, Tajikistan, Tunisia, Ukraine, Mexico, Uzbekistan, Yemen and Libya. These agreements enable citizens of the countries concerned to obtain a Turkish social security number and register for General Health Insurance without paying premiums. (Owing to frequent changes in legislation, this list may not be accurate.)

Legal migrants with a long-term residence permit have the same rights as Turkish citizens. (Such permits are normally only issued after continuous legal residence in Turkey for at least eight years.) Like Turkish citizens, they are covered by General Health Insurance if they pay the (income-related) premiums or receive a living allowance from the Turkish State (e.g. unemployment benefit or pension). They are liable to the same out-of-pocket payments as Turkish citizens. A declaration of legal address is required to claim healthcare entitlements.

Short-term residence permits are valid for a maximum of two years, but are renewable. A private health insurance contract (with an insurance company operating in Turkey in compliance with Article 15 of the Law on Insurance No. 5684) is required when applying for a short-term permit. After one year of continuous residence, foreigners must register for General Health Insurance and pay the usual premiums, regardless of whether they maintain their private health insurance. At present, the premium is TRL 426.60 a month (about €107) for a married couple (including their children) or a single person. State insurance can be used in private hospitals and clinics, but is usually not sufficient to cover costs entirely.

The following treatments are not covered by social security in Turkey:

- Fertility treatment for women older than 39
- Cosmetic surgery (unless medically necessary)
- Cosmetic dental work.

---

26 http://www.goc.gov.tr/icerik/6/residence-permit-types_917_1060_8865_icerik
27 http://photos.state.gov/libraries/ankara/9104/PDF%20Files%20for%20E-Alert/faqs_sgk_foreigners.pdf
Special exemptions
In the following cases, medical treatment is given without conditions:

- Emergencies
- Work accidents and vocational illnesses
- Infectious diseases
- Preventive health services (drug and alcohol abuse)
- Childbirth
- Extraordinary events (war, fire, earthquake)

Barriers to obtaining entitlement
None

B. Asylum seekers

Inclusion in health system and services covered
According to the 2006 Social Insurances and General Health Insurance Law 5510, Article 60, asylum seekers are included in General Health Insurance coverage. They are covered by the same system as nationals and liable for the same supplementary or additional payments. Because their income is assumed to be low the DGMM pays their premiums, but if they are later found to have sufficient means they can be asked for repayment.29

On January 22, 2013, after the outbreak of the Syrian civil war, circular AFAD 2013/1 No.374 was introduced to enable Syrian citizens to benefit from the same health services as citizens of Republic of Turkey. All Syrians in Turkey could receive free health services in public hospitals, whether they were being accommodated in camps or residing in cities, and regardless of how they entered the country. Free access to health services was first limited to hospitals in the eight provinces where camps have been established, but later in 2013 extended to 81 provinces. As a result, all Syrians in need of healthcare can access Turkish health clinics and receive emergency healthcare, although access to secondary and tertiary healthcare is restricted to those registered with the government.

However, there have been issues with the implementation of these generous entitlements. According to the report by the Turkish Medical Association in 2014,30 the problems can be listed as follows:

1. Most refugees (especially Syrian refugees) are not aware of applicable legislation, law, and the existing circular order;
2. They are not aware that they are covered by the same system as nationals, free of charge;
3. There is a language barrier, since all health services are delivered in Turkish. Many of the doctors do not speak English and refugees who cannot speak Turkish usually need a translator. There are no routine services available for translation either in the camps allocated for refugees or the small cities where refugees primarily live. As with most

29 http://www.asylumineurope.org/reports/country/turkey/health-care
30 Available in Turkish at http://www.ttb.org.tr/kutuphane/siginmacirpr.pdf
public hospitals the world over, public hospitals in Turkey also have to deal with overcrowding and lengthy waiting periods;
4. Some patients have had to pay for healthcare services which are supposed to be free;
5. Refugees only have access after they are registered in the camps or in the system. Most of the refugees leave the camps or the small provinces where they were housed by the government, thus losing their right as an asylum seeker to access health services free of charge;
6. Refugees need to cover some of the medication costs like nationals;
7. They don’t know the locations of the healthcare settings;
8. Social reasons can be a barrier (e.g. the husband doesn’t allow it);
9. Inability to leave the living places (camp) because of security reasons;
10. Lack of comprehensive public health system for asylum seekers;
11. There are no screening programs except for vulnerable groups;
12. Physical and physiological trauma because of war.

Most of the problems apply specifically to the asylum seekers living outside the camps (see also Dinçer et al. 2013). There are some local hospitals in the camps which provide healthcare services, but asylum seekers living outside have much fewer options. Only about 60% of the latter group have access to health services.

According to the report by AFAD (Republic of Turkey Prime Ministry, Disaster and Emergency Management Presidency),\(^\text{31}\) over 90% of the Syrian refugees in the camps and close to three-fifths of the refugees out of the camps stated that they used health services in Turkey, and over three quarters were very satisfied or satisfied with the quality of health services (AFAP 2013). Nevertheless, for access to medications, 31% of men and 28% of women in the camps and about 55% of people outside the camps had difficulty finding medicines. Especially asylum seekers living outside the camps may be subject to higher supplementary payments than nationals, due to language problems and service providers’ lack of awareness about entitlements.

The right of all registered asylum applicants and refugees to access health services under the general health insurance mechanism was reaffirmed in a part of the Law on Foreigners and International Protection (YÜKK) that entered into force in 2014. In the camps, health issues are addressed by emergency and curative services directly provided through health centres and field hospitals, as well as through referral systems. Outside camps, the limited information for Syrians on available services has been reported as a problem.

**Special exemptions**
See section on legal migrants.

**Barriers to obtaining entitlement**
Officially, there are no requirements for documents or forms of administrative discretion which stand in the way of asylum seekers obtaining entitlement to care, but this does not exclude the possibility that such barriers may be created by health workers ignorant of the law.

\(^{31}\) Website: [https://www.afad.gov.tr/en/](https://www.afad.gov.tr/en/)
C. Undocumented migrants

Inclusion in health system and services covered

Undocumented migrants, who can qualify neither as asylum seekers nor as conditional refugees, are not covered by the same system as nationals. They have no legal status, and thus no access to the health care system.

To fill this gap, the Turkish government encourages the foundation of societies and dedicated funds (e.g. Social Assistance and Solidarity Fund, IIMP, Turkish Red Crescent). In July 2005, the Istanbul Tuberculosis and AIDS Program (ITAP) was founded as a community-based health care program for impoverished asylum seekers, refugees and irregular migrants. With the collaboration of Istanbul Anti-Tuberculosis Association (IVSD), 237 patients were screened between September 2005 and 2006. Out of 237, 17 tested as TB+, 7 of them were cured. In this program, 42 house visits were made with community representatives and food packages, clothing, blanket, prepaid phone access, as well as ancillary medication (see also Yasin et al. 2015).

Special exemptions

See section on legal migrants.

Barriers to obtaining entitlement

Declaration of legal address is needed to obtain treatment, which increases the (perceived or real) risk of being reported to the authorities.
6. POLICIES TO FACILITATE ACCESS

Score 32  Ranking ⬜⬜⬜⬜⬜

Information for service providers about migrants' entitlements
There is no systematic approach to ensure that service provider organizations receive up-to-date information on migrants’ entitlements, so the organizations cannot pass such information on to their employees. Usually, dissemination of information is on an ad hoc basis. When a circular is issued (for instance, on Syrian refugees), the Ministry of Health forwards it to the healthcare facilities in the country, but this is not part of a system of routine information dissemination.

Information for migrants concerning entitlements and use of health services
There is a policy of providing information targeted at migrants on an individual basis, e.g. through personal meetings or one-stop-shops, campaigns in certain regions or in the camps for Syrian refugees, brochures, and websites of agencies and institutes working on migration. The website of the DGMM is in five languages (Turkish, English, German, French, Arabic and Russian), but many of its pages have yet to be filled. Using Google it was possible to find one link on the site about health care, oriented to students, but not reachable from the Home Page. Searching on internet for information about health service coverage for foreigners mainly brings up web pages of commercial agencies (often with official-sounding names like turkeycentral.com or istanbulforeignersoffice.com), which exist in order to promote private insurance policies and tend to give incomplete information about the alternatives.

Health education and health promotion for migrants
Health education and health promotion for Turkish citizens is covered by a specific directorate in the Ministry of Health, which runs many public campaigns and websites on different health topics (e.g. obesity and physical activity, smoking, immunization) and conducts education sessions and workshops through family medicine and patient relations units in hospitals. In addition, brochures are developed and these public education materials are disseminated in public places, as well as through the above channels. TV programs also provide some messages to the community in order to reduce health risks and motivate them to join health promotion activities.

The Public Health Institution of Turkey, as along with municipalities in each province, also have public health education and health promotion programs and share information using many different channels. Non-profits and the private sector are also creating awareness on different health issues in order to promote an active and healthy life style. Some links (Ministry of Health) are given below. All these programmes are in Turkish and none of them are specific to the migrant population, but they can reach migrants who speak the language.

http://www.thsk.gov.tr
http://www.sggm.saglik.gov.tr
http://disab.saglik.gov.tr

http://www.sb.gov.tr
https://www.facebook.com/saglikbakanligi

There is no evidence of specific health education and promotion activities for migrants. There might be some *ad hoc* activities in the camps, but these are not documented.

**Provision of ‘cultural mediators’ or ‘patient navigators’ to facilitate access for migrants**

There is no program to improve communication between migrants, asylum seekers, or undocumented migrants and service providers using such provisions.

**Is there an obligation to report undocumented migrants?**

Healthcare professionals or organizations are not required to report undocumented migrants to the police or immigration authorities.

**Are there any sanctions against helping undocumented migrants?**

There are no legal sanctions or other pressures on professionals to deter them from helping migrants who cannot pay.
7. RESPONSIVE HEALTH SERVICES

Score 4  Ranking ⬜⬜⬜⬜⬜

Interpretation services
Interpretation services are provided only in the camps. Outside the camps, language barriers are a huge problem in health service delivery to migrants: they are a major reason why migrants – especially refugees living outside the camps – do not fully utilize health care services. There are no interpreters or any requirement to recruit an interpreter at state and private health facilities, and very few healthcare professionals speak a language other than Turkish, so migrants are seriously challenged in their efforts to communicate with health care staff.

Requirement for 'culturally competent' or 'diversity-sensitive' services
There are no standards or guidelines requiring that health services take account of individual and family characteristics, experiences and situations, respect for different beliefs, religion, culture, competence in intercultural communication. Nor do standards or guidelines exist on ‘culturally competent’ or ‘diversity-sensitive’ services.

Training and education of health service staff
There are no policies to support training of staff in providing services responsive to the needs of migrants.

Involvement of migrants
Migrants are not involved in service delivery, in the development and dissemination of information, in research (other than as respondents), or in the design of services.

Encouraging diversity in the health service workforce
There are very few recruitment measures (e.g. campaigns, incentives, support) to encourage participation of people with a migrant background in the health service workforce amongst the migrant population in Turkey.

Development of capacity and methods
Diagnostic procedures and treatment methods are not adapted to take more account of variations in the socio-cultural background of patients, and in general specific treatment schemes for health problems specific to certain migrant communities were developed for health problems in order to better serve migrant communities in the country.
Data collection

Migration statistics are often limited by the scarcity and poor quality of the data. The most reliable data are those collected by the General Directorate of Security, General Command of Gendarmerie, and the UNHCR. The passport registries and censuses also provide some data. Turkish censuses need to collect basic information regarding the various dimensions of international emigration and immigration. Although information is collected on place of birth, residence, and citizenship, which could normally be used (alone or in combination with other data) to summarize some of the characteristics of international migrants, the Turkish Statistical Institute (TUIK) has been slow to provide details of these migration-related data, apart from simple frequency tables of the total number of foreign-born persons. None of the data collected by the above-mentioned institutions provide information about the health status of the migrants. The routine data collected by the Ministry of Health (MoH) from primary care centres and other health institutions include data about citizenship, but MoH does not analyse any statistics specific to migrants.

There is no routine data collection system on migrants’ health status in Turkey. There is some research on the health status of migrants conducted by health professionals working in university hospitals (though most of this concerns internal migrants).

Support for research

Funding bodies have not supported research on the occurrence of health problems among migrant or ethnic minority groups, social determinants of migrant and ethnic minority health, issues concerning service provision for migrants or ethnic minorities, or evaluation of methods for reducing inequalities in health or health care affecting migrants or ethnic minorities.

The number of studies conducted on health status of the MEMs in Turkey is very limited. Most of the studies were conducted on internal migrants (frequently on mental health and women’s health). Significant emotional problems have been found in Turkish migrant children compared to non-migrant children; migration to a remote settlement appears to be negatively associated with the psychological well-being of the adolescents who have migrated. Migration is viewed as a significant factor in determining gender roles among Turkish women. Female migrants view their experiences as improving their maturity and ability to handle affairs compared to non-migrant women; they exercise more independent behaviour but retain traditional responsibility for housework. However, a master’s thesis on the subject stated that migrated women were less successful in coping with stress. There are studies reporting that communicable diseases are more common among migrant populations.

A study conducted on Kurdish women living in Diyarbakir reported that they were not exclusively breastfeeding their babies and that only a small percentage of them initiated breastfeeding in the first hour after delivery. Another study conducted on Bulgarian immigrants forcibly migrated to Turkey reports that the immigrants had low scores for life satisfaction.
"Health in all policies" approach
No consideration is taken of the impact on migrant or ethnic minority health of policies in sectors other than health.

Whole organisation approach
No systematic attention is paid to migrant or ethnic minority health in any part of the health system. Measures are left to individual initiative.

Leadership by government
There is a Migration Policies Board and a Directorate General charged with determining migration policies and strategies (DGMM), as well as with executing the preparatory work of strategy documents, programs, and implementation documents in the field of migration. A commission named ‘Migration Research Centre’ has been established, affiliated with the Directorate General Training Department pursuant to article 117 of the law no 6458, and responsible for enabling any political, legal, economic, historical, strategic, and up-to-date national and international examination, research, scientific study, project, training, and consultancy; following new developments in the literature and implementation, obtaining continuous, and up-to-date information about the issue; contributing to creating scientific works, both in Turkish and other foreign languages; creating alternative decision choices and objective recommendations regarding strategy and implementation and submitting them to the Directorate General, and organising seminars, both national and international.

Involvement of stakeholders
Relevant public institutions and organisations, universities, non-governmental organisations, international organisations, academics, both domestic and from abroad, and the experts to be determined by the Directorate General will be assigned in the above-mentioned commission, and the duties of the commission will be executed within the scope of the principles and procedures determined by the Directorate General.

There are also some national centres as follows:

- Hacettepe University Migration and Political Research Centre (HÜGO)
- İstanbul Bilgi University Migration Studies and Implementation and Research Centre
- Koç University Migration Researches Implementation and Research Centre
- Gaziantep University Migration and Policy Implementation and Research Centre
- Yüzüncü Yıl University Population and Migration Implementation and Research Centre

Migrants’ contribution to health policymaking
Migrant organizations are not explicitly consulted on health policy.
CONCLUSIONS

Turkey achieves an above-average score on Entitlements, although provisions for irregular migrants differ starkly from those for regular migrants and asylum seekers. Unfortunately, little effort is made to ensure that migrants know about their entitlements and to help them navigate the health system, which hinders migrants’ access to health care. The notion of adapting services to migrants’ needs seems virtually unknown in Turkey, while measures to improve the situation are also lacking. This inertia is no doubt partly due to the fact that apart from the recent influx of Syrian refugees, numbers of (legal) migrants in Turkey are low (1.8% of the population). It may also have to do with the long-established ideological goal of strengthening national identity and striving for a homogenous population and culture.

Beyond these challenges, additional migrant issues such as security, accommodation, employment, and socio-cultural integration come into prominence. New arrivals want to deal with their employment problems before their health needs. When their need for health care emerges, their lack of knowledge about the host country and about the health care system presents obstacles. Even if they are able to overcome these obstacles, migrants are faced with major problems once they find themselves in the healthcare facility.

Chief among them is the language barrier: even if they stayed in the country long enough to learn Turkish, it would probably still not be enough for them to articulate and discuss their medical problems. Since Turkish health care facilities do not employ interpreters, the language problem remains unsolved. By contrast, for the last decade most of the privately owned health care facilities catering for overseas patients have employed interpreters. This is a possible solution for the few immigrants who can afford to pay for health care services and who can communicate in languages such as English, German, etc. For migrants struggling with poverty and relying on languages such as Chinese, Arabic, etc., the language barrier remains a daunting challenge and a serious barrier to health care access.

Efforts to advocate for more ‘diversity sensitivity’, especially in public health care organizations, should probably emphasize the importance of patient-centred care for efficient and effective service delivery. However high the technical quality of health care, it cannot work optimally if communication with the patient is inadequate.


