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Uncertain Practices:

Healthcare Provision and Access for Syrian Refugees in Turkey

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Sociology

by

Nihal Kayali

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ABSTRACT OF THE DISSERTATION

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Professor Gail Kligman, Chair

Sociological research has examined how temporary legal statuses suspend migrants' lives between inclusion and exclusion in a polity. Yet scholarship analyzing the effects of temporary policy on the organizational terrain of migrant reception is scant. This dissertation addresses this gap by asking: How do explicitly temporary migration policies shape service provision for refugees? Specifically, how do forced migrants themselves—both as consumers and purveyors of services—shape these organizations? And what are the implications of these activities for refugees' access to services?

I answer these questions through a qualitative, longitudinal study of one organizational field in a case of forced migrant reception: healthcare provision for Syrians in Istanbul. In 2014, Turkey established the Temporary Protection Regulation, granting registered Syrians free access to state healthcare services. Yet, despite the extension of free state healthcare, Syrian doctors

mobilized to provide care through informal, nonstate providers and have gradually institutionalized their services. Drawing on over 175 interviews with Syrian patients, Syrian doctors, Turkish doctors, NGO administrators, and government officials, the dissertation examines the persistence of these clinics, the factors driving refugees to seek out nonstate services, and the efforts of refugee doctors to formalize their work within a complex legal environment that both accepts Syrians and forestalls their full integration.

Integrating scholarship on organizations, refugee reception, and immigrant entrepreneurship, the study traces how Syrian healthcare providers institutionalize in Istanbul's urban fabric. The dissertation argues that when national policies are ambivalent about integration, immigrant organizations embed themselves in the host community by leveraging local and transnational networks for legitimacy and resources. First, it analyzes how informal immigrant organizations survive in "humanitarian niches" that emerge in host states shocked by large refugee populations. Next, it examines how providers adapt their work within shifting opportunity structures, as humanitarianism recedes as an organizing principle. Finally, it demonstrates how immigrant organizations gradually re-position themselves as facilitators of transnational economic exchange and essential providers in their localities. Over time, humanitarian organizations privatize, serving diverse groups of local immigrant beneficiaries and international tourists, even as national policies hinder their full legalization—a phenomenon I refer to as "cosmopolitan embeddedness".

The dissertation of Nihal Kayali is approved.

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Kevan Kimberlin Harris

Gail Kligman, Committee Chair

University of California, Los Angeles

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List of Acronyms

AFAD – Afet ve Acil Durum Yönetimi Başkanlığı / Disaster and Emergency Management Authority

AKP – Adalet ve Kalkınma Partisi / Justice and Development Party

ASAM – Association for Solidarity with Asylum Seekers and Migrants

ECHO – European Civil Protection and Humanitarian Aid Operations

FHC – Family Health Center / Aile Sağlığı Merkezi

GDMM – General Directorate for Migration Management (also referred to as Directorate General for Migration Management)

HTP – Health Transformation Program

IHH – İnsan Hak ve Hürriyetleri ve İnsani Yardım Vakfı / The Foundation for Human Rights and Freedoms and Humanitarian Relief

IOM – International Organization for Migration

LFIP – Law on Foreigners and International Protection

MEDULA – Medikal Ulak Sistemi

MHC – Migrant Health Clinic / Göçmen Sağlığı Merkezi

MSF – Medecins Sans Frontières

PKK – Partiya Karkerên Kurdistanê / Kurdistan Workers' Party

SGK – Sosyal Güvenlik Kurumu / Social Security Institution (SSI)

SIHHAT Project – Geçici Koruma Altındaki Suriyelilerin Sağlık Statüsünün ve Türkiye Cumhuriyeti Tarafından Sunulan İlgili Hizmetlerin Geliştirilmesi Projesi

SNC – Syrian National Council

SUT – Sağlık Uygulama Tebliği / Health Implementation Law

TPR – Temporary Protection Regulation

UNHCR – United Nations High Commissioner for Refugees

UNRWA – United Nations Relief and Works Agency for Palestine Refugees in the Near East

UNICEF – United Nations Children's Fund

WHO – World Health Organization

YYD – Yeryüzü Doktorları / Doctors Worldwide

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This dissertation would have been impossible without the help of Radia Androun, Ghenwah Kharbeet, and Hwaida Androun. At various stages of the project, these three brilliant and generous Syrian women interpreted Arabic language interviews for me. But they were not only translators—all three helped me find more interlocutors, more health clinics, more friends, and more community among Syrians in Istanbul as I continued to work on this project throughout my visits to the field. In some instances, they were braver than I was in approaching new people to talk to, jovially pulling me along when a lurking shyness would sometimes get the better of me in the field. I thank them from the bottom of my heart for their research assistantship and friendship over the years.

I thank Gail Kligman for shepherding me through the PhD process with kindness and humanity, and for continually reminding me why my work mattered when I would get lost in the weeds of research and writing. Gail has maintained the highest standards for my work, but this care has always been matched by her wider concern for me as a scholar and a person. Roger Waldinger's exacting eye for clear and effective argument is so forceful that it shapes my writing before I even have words on the page. I have benefited immeasurably from the serious consideration and analytical clarity that Rogers Brubaker brings to every idea and every argument he engages with, including those contained within this dissertation. Aslı Bali's ability to articulate complexity while maintaining an unwavering commitment to justice inspires me to balance precision and moral clarity in my work. Kevan Harris's ability to draw on vast wells of knowledge as he provides focused feedback has been a boon to my work since he began advising me from my first day at UCLA. If even a tiny fraction of the analytical rigor, intellectual generosity, and clarity of thinking my committee members possess has rubbed off on me, I consider graduate school an unambiguous success. Aside from my committee members, I am grateful to have had Ed Walker, Omar Lizardo, Cecilia Menjívar, and Victor Agadjanian provide useful guidance and support on my works in progress, when I was not always sure what exactly I was trying to say. I am moderately more aware now.

I could not have imagined just how much I would reap from the UCLA community when I first came to graduate school. The Soc 237 seminar and the Political Sociology and the Global South Working Group have been cornerstones of my intellectual experience here. The rigor, dynamism, and good humor of these discussions has shown me what sociology—and academia

more broadly—can be at its very best. The Migration Working Group and the Center for the Study of International Migration seminar series were critical for my development as a scholar of migration. The former was a vibrant laboratory to discuss work in progress, and the latter exposed me to scholars from all over the country and world on the cutting edge of migration research. The UCLA Center for Near East Studies has also been a valuable interdisciplinary home. The hardest thing for me at UCLA was tempering the number of talks and discussions I attended across these wonderful working groups and centers so I could actually do my work. I do not regret erring on the side of the former.

I am daunted by the task of reducing my sprawling UCLA Sociology community to a list of names, but it is better than no mention, so here goes. I would say "in no particular order", but then you might assume Wisam Alshaibi starts off the list due to the strictures of alphabetical order—this would be wrong. I have absolutely no idea what graduate school would have looked like had I not navigated it in lockstep with Wisam, but I am certain it would have been exponentially duller. We were lucky to land in a raucously fun cohort, including Alexis Coopersmith, Luis Manuel Olguin, Cory Mengual, and Keith Cox, that made coming to campus daily something to look forward to. Kevan Harris assembled a remarkable group of students studying the Middle East in our department who have become dear friends, including Rohan Advani, Sima Ghaddar, Shiva Rouhani, Zep Kalb, and Gilad Wenig. PSGS and 237 facilitated lively discussions and friendships with Sandy Xu, Joel Herrera, Dan Zipp, Gabriel Suchodolski, Oscar Contreras, Andrea Zhu, Natasha Bluth, Joseph Weinger, Andrew Le, Andrew Chalfoun, and Koh Choon Hwee. On the migration side of things, Chiara Galli and Molly Fee have been guiding lights throughout graduate school and beyond, and Nathan Hoffman, Tianjian Lai, and Amelia Reese Masterson have been brilliant colleagues and friends.

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To say that "I could not have done this without the support of my parents Ayşe and Hasan" feels almost comical—I cannot begin to capture the magnitude of their support throughout these years, somehow rendered with the lightest touch. Their belief in me in every endeavor has been steady and unequivocal for as far back as I can remember. Any whisper of uncertainty I might have ever raised to them about this undertaking was always summarily swatted away like a bad joke. Finally, I am grateful for my brother Murat's near-daily phone

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Chapter 1: Introduction

Dr. Bilal hastily shuffles through the Rafah Clinic[1] in a grey t-shirt, monitoring operations throughout the premises. It's the summer of 2018, and he has invited me to the refugee outpatient clinic he helps run for our interview. It looks like this time it will happen. Our meetings are frequently postponed because Dr. Bilal is the point-person to resolve any unexpected issues at Rafah, of which there seem to be many. Often, I show up to the wrong building—the clinic that Dr. Bilal runs had, for a time, three different buildings in the same neighborhood. Two of them seem identical to me—plain first floor buildings with frosted glass, with about six rows of black leather chairs facing a simple check-in counter. Like the employees shuttling lab samples taken from patients in one clinic to the lab in another building, I would find myself jogging between buildings to try to find Dr. Bilal. Whenever I finally found him—usually looking just as frenetic as I felt in my search for him—he was generous with his scarce time and animated in conversation.

Dr. Bilal was a hematologist[2] in Syria, working in the laboratories of hospitals and clinics in Damascus before the war broke out in 2011. He has not been able to practice his specialty in Turkey—he does not have degree equivalency, and the clinic he helps run does not have the equipment or capacity to do advanced laboratory work, beyond simple bloodwork. Dr. Bilal has not seriously considered the main formal work option available to Syrian doctors in Turkey: working as a primary care doctor in a Migrant Health Center. Like many Syrian doctors who trained their whole lives in their specialties, Dr. Bilal has no interest in relatively low-paid primary care work. Instead, he continues to dedicate his time to managing a clinic created and

[1] All clinic, doctor, and patient names are pseudonyms.
[2] I have changed the specialties of a handful of doctors mentioned in the study to further anonymize individuals' identities.

run by Syrian doctors, and affiliated with a Syrian NGO registered in Turkey. In addition to the two buildings I continually mix up, there is a third building in the neighborhood. It houses Islamic education courses for children, charity offices, and a café, in addition to medical examination rooms. Despite these other services, Rafah is first and foremost a health clinic.

Dr. Bilal's job is stressful. Given the clinic's questionable registration status, he always has one eye on WhatsApp to see if there is word of any Ministry of Health sweeps in the neighborhood, when police or other officials go around to cite informal clinics. If word gets out of a sweep from another clinic, Rafah shuts down, and everyone goes home--employees and patients alike. When word does not come in time, employees sometimes throw off their white coats to blend in with the patients in order to avoid getting whatever punishment might be doled out to those practicing without the necessary certification. Any hints of money being exchanged are quickly hidden to make it appear like the health services are rendered for free. At the check-in desk, the clinic administrators scribble IOUs in their records for future payment.

Yet the clinic is not simply "illegal." In 2016, the clinic gained legal recognition as a charity health clinic under a new law allowing NGOs to provide healthcare to refugees. But that registration was defunct within a year. Rafah, along with many other clinics with the same registration, lapsed into informality. Dr. Bilal continued to help operate the clinic through an increasingly restrictive period of sweeps from 2018 to 2019. They finally closed when they could no longer avoid the health directorate's threats to arrest doctors and managers.

I met Dr. Bilal again in 2021. At that point, he had helped establish a private clinic, now called the Oasis Clinic. This process of formalization had been a challenge that took over two years. In 2021, Oasis was registered but still not fully legal—some of their doctors did not yet have

Turkish equivalency. But they were operating like other private clinics in the neighborhood, with thirty doctors cycling in to work there. Gone were the days of religious classes and charity. The clinic, sparkling and sleek, was just as likely to get patients coming for "Hollywood smile" dental implants as those seeking practical low-cost care. Dr. Bilal, in his typical excitement, toured me around the brand-new building, showing me the new medical departments while cheekily pointing out the clinic's "view"—one of the few grassy parks in the otherwise concrete labyrinth of Istanbul's city center.

We finally sat down in a neighborhood café to have our interview. Dr. Bilal, who always has a glint in his eye and a seemingly unrelenting energy, soon became deflated about the whole enterprise he was helping manage. I was surprised, given that, at last, the clinic was on a path to relative stability after years of pronounced uncertainty. As we drank our tea, he complained about life in Turkey. "How is it that ten years later, Turkey still doesn't have a solution for Syrian health professionals?" He had attempted Turkey's medical equivalency exam once and failed—he had no time to learn Turkish or study for the exam as he ran the clinic to make ends meet. He fantasized about leaving the clinic behind and moving to Europe, where Syrian doctors had professional respect and a clearer pathway to employment. "After all that work you put into setting up the new clinic?" I asked him. He sighed and gazed off into the distance, looking equal parts restless and resigned. It seemed that for Dr. Bilal, the Oasis Clinic was not a solution so much as the next iteration of a problem yet to be solved.

Dr. Bilal's professional story is not unique among the thousands of Syrian doctors who sought refuge in Turkey as the war in Syria dragged on.[3] Most of the doctors I spoke to were grateful for

[3] The number of doctors who came to Turkey from Syria is not known. However, some contextual statistics can get us closer to a general idea. The Syrian health system had about 30,000 physicians in 2010, before the war in Syria

the safety afforded by Turkey's generous reception of over 3.6 million Syrians. But they also resented the lack of a clear pathway to permanent, stable work. Even as many were gradually granted citizenship, they felt that they could not establish a viable professional trajectory in Turkey. When the Syrian war broke out, Turkey had the world's broadest refugee reception policy for Syrians fleeing the war. At first accepting Syrians informally as "guests" starting in 2011, Turkey later instituted a temporary protection policy in 2014 that formalized Syrians' status. Syrians who registered for the status would be entitled to free state healthcare and education services. Turkey's broad orientation toward Syrians was one of humanitarian generosity, but it did not anticipate the sheer length and brutality of the war in Syria that would lead millions across the border, attempting to access the state's services.

The feelings of "in-betweenness" that Syrian doctors—and Syrians more broadly—experience in Turkey is familiar to scholars of temporary statuses in migration studies. Cecilia Menjívar (2006) coined this suspension between inclusion and exclusion in a host state as an experience of "liminal legality." This liminal outcome is by design—temporariness is, after all, codified in the name of the status. States endow individuals with temporary protection statuses rather than official refugee status as a practical and strategic choice. Whereas the recognition of individuals as refugees under the Geneva Convention necessitates a durable solution with international legal protections, temporary protection allows states to establish and adapt protection for forced migrants in an ad hoc manner (Fitzpatrick 2000). This allows states to bypass the bureaucracy of refugee status conferral to individuals, facilitating the reception of

started. In 2020, the UN gathered data from healthcare facilities in Syria nine years into the war, and found just under 16,000 physicians, and over half of those were residents, indicating that they were newly and swiftly trained to fill gaps of fleeing doctors. This suggests that only one quarter of the 30,000 doctors, or about 7,500, remained in Syria. The rest went abroad. It is likely that Turkey and Germany host the majority of those doctors, but Turkey keeps no official statistics. Journalists Mark Lee Hunter and Loujein Hajj Youssef refer to the doctors that fled Syria and disappeared from official statistics as the "vanishing diaspora" (Hunter and Youssef 2023).

large numbers of forced migrants swiftly. Yet, as domestic policy rather than policy born out of international legal commitments, states can also revoke this status whenever they determine the refugees' home country is "safe." These policy decisions may be shaped both by domestic political interests and the nature of a capricious regional or international context of conflict, instability, and geopolitical maneuvering.

While extending protection to a vulnerable forced migrant population may serve a country's strategic geopolitical interests (Abdelaaty 2021), this policy choice may also stoke domestic frustration toward immigrants. Codifying temporariness, then, becomes a political release valve. The threat of status discontinuation and deportation forecloses, for a time, the prospect of integration. While this stated temporariness may placate anti-immigrant citizens, it looms for the protected population. Temporary protection produces experiences of liminality (Menjívar 2006), precarity (Coutin et al. 2017; Goldring, Berinstein, and Bernhard 2009), or uncertainty (Biehl 2015) for migrants. These concepts have been readily applied in studies of Syrians' experiences in Turkey, most notably in Ilcan, Baban, and Rygiel's (2018) characterization of Turkey's temporary protection policy as an "ambiguous architecture of precarity". The ambiguous architecture of precarity, in their formulation, refers to the ways that legal protection ends up producing precarity for Syrian refugees—not just in terms of their legal status, but also regarding their ability to access services and move freely within and beyond Turkey's borders.

We know from these scholars that temporary status causes uncertainty for forced migrants as they are suspended in an uneasy stage of settlement without ensured integration. Scholarship that looks at these experiences of uncertainty often addresses immigrant organizations, or organizations created and operated by the migrant population, as important

institutions in helping ease these precarious experiences. Immigrant organizations appear primarily as stabilizing forces that help with access to services, rights, lobbying, advocacy, or other forms of empowerment and solidarity for individuals (Menjívar 2006, Coutin et al. 2017). Immigrant organizing, then, empowers individuals destabilized by the ambiguous architecture of temporary protection.

But temporary protection is more than an individualized status—it also shapes the institutional terrain in which status-holders try to gain their footing, as Ilcan, Baban, and Rygiel suggest. This means that the very organizations that help relieve individual precarity are also influenced by the institutions that shape immigrants' lives. Take the Rafah Clinic, for example. It was opened to provide Arabic-language healthcare to Syrians who were struggling with accessing care in the Turkish health system. Rafah was temporarily legalized as a humanitarian provider. But then, not long after, that status was revoked—an organization level process not unlike what individuals who hold temporary statuses might fear on the individual level. We know little, however, about how the organizational terrain of service provision for immigrants is itself shaped by the institutional vagaries of policy rooted in ambivalence toward immigrant incorporation.

How, then, do explicitly temporary migration policies shape service provision for refugees? More specifically, how do forced migrants themselves—both as consumers and purveyors of services—shape these organizations? And what are the implications of these activities for refugees' access to services? These questions address a basic empirical puzzle that emerges from clinics like Rafah in the introductory anecdote. Refugee-run clinics emerged as humanitarian stopgap measures, and were approved to operate as such. Yet, these clinics did not all close after fulfilling their temporary purpose, as many Syrians gained their footing accessing

free state healthcare services. Instead, many of these organizations became permanent fixtures in the host community in a variety of forms. Why?

Understanding how temporary protection policies affect refugee service provision is becoming more urgent as the implementation of these policies expands globally. The use of temporary protection policy in profound humanitarian crises has increased precipitously since Turkey's conferral of the status to millions of Syrians. In 2021, Colombia extended temporary protection status to millions of Venezuelans fleeing a collapsing economic and political situation in their home country. Almost two million Venezuelans now hold temporary status in Colombia (Morales 2023). Countries in the European Union have also extended temporary protection status to nearly 4 million Ukrainians fleeing the Russian invasion (Council of the EU 2023). Moreover, Iran hosts over 2.5 million Afghans under a temporary protection policy (D'Souza 2023). As temporary protection becomes a refugee policy norm, it is essential that we analyze its institutional contours.

Refugee Healthcare and the Case of Turkey

While the research questions above orient us toward a range of social services in host states, this dissertation focuses on refugee healthcare in particular. The healthcare domain serves primarily as a site of analysis, with an eye toward extending theoretical insights to services beyond the realm of healthcare. Yet access to healthcare is also a substantively important issue that underlies refugees' fundamental wellbeing. Once forced migrants settle in new locations, their access to healthcare institutions transforms from a matter of emergency care in the aftermath of violence and upheaval to a more quotidian issue. Over time, care that may have been the purview of nonstate actors like Medecins Sans Frontières (MSF) and the United Nations becomes a host

state mandate. The way states facilitate access to healthcare services becomes an important issue in forced migrant's lives.

From a host state perspective, refugee and immigrant health bears on public health more broadly. Inclusive health policies that incorporate vulnerable immigrant populations have a benefit to society at large, particularly when it comes to infectious disease (WHO 2018: 11-12). Of course, refugees' healthcare access also matters for refugee individuals' ability to flourish. Good health is a prerequisite to active participation in daily life. Healthcare providers are a key site of encounter with state services, making health a "key aspect of integrating into a new society" for refugees (Ager and Strang 2008: 172-173). Refugees' well-being depends on their ability to make claims for their right to healthcare. Yet the encounter with healthcare institutions can also, sometimes, draw the unwanted gaze of the state. Refugees may selectively interact with formal and informal providers to mediate the ways in which they make themselves legible to state governance (Ong 1995). Healthcare, then, is an institutional domain that highlights tensions between national welfare, humanitarianism, and the contours of refugees' social citizenship.

As temporary protection policies like Turkey's become more prevalent, states must consider these intersecting dimensions of refugee healthcare. Numerous questions emerge. What type of care can refugees access in their host state? What is the cost, and who bears that cost? What difficulties may refugees face in accessing healthcare? And what are possible solutions to overcoming these barriers? While every host country faces different constellations of challenges in providing care to refugees, they must all contend with these basic questions. Turkey serves as a case study to think through the ways that refugee reception policies intersect with other state institutions to shape healthcare for refugees.

Refugee healthcare in Turkey has been hailed as a humanitarian triumph. Among the various welfare programs extended to Syrian refugees—including formal employment registrations, access to Turkish schools for children, and financial support for the poor—healthcare has been the domain the Turkish government has most proudly touted as a success. Within the "welfare mix" of state and humanitarian services extended to Syrians, refugee healthcare has been relatively well-consolidated under the auspices of the Ministry of Health (Yilmaz 2019). As discussed in more detail in the next chapter, temporary protection provided Syrians free access to state care starting in 2014. Yet in spite of this legal access, practical barriers remained. The language barrier, coupled with delays in registration, a lack of information about services, and the bureaucracy of navigating state care together continued to keep Syrians' access to state providers partially compromised. The Turkish government, with the European Union's financial support, attempted to alleviate some of these challenges by establishing Arabic-language Migrant Health Centers.

Yet despite this state consolidation of refugee healthcare provision, a growing number of health clinics run *by* Syrian refugees, *for* Syrian refugees emerged in Turkey. These informal providers operated as low-cost outpatient clinics and were run by Syrian doctors lacking Turkish medical equivalency (Kayali 2020; Sürmeli et al. 2021). For a long time, these clinics were either ignored by the state or expressly approved to operate as registered humanitarian providers. Yet these registrations did not last, and the state gradually cracked down, shutting many of the clinics down. But they did not all disappear. Some closed. Of those that closed, some eventually reopened, in different places, with different services, and motivated by different missions—just as the Rafah Clinic did. Some Syrian doctors opted to work in Migrant Health Centers. Others continued working in private clinics. Some sought out equivalency to formalize their work.

Many combined these pursuits simultaneously. How Syrian refugees—as both patients and providers—shaped healthcare provision from the bottom up through this period of flux is a key focus of this dissertation.

The Turkish case provides both empirically and theoretically useful insight into dynamics of forced migrant reception. At the most basic but perhaps the most important level, Turkey hosts the largest refugee population in the world. Located between a Middle East region beset by instability and a European continent sought out by many seeking a better life, Turkey is a literal geographic crossroads. And while it used to be primarily a country of immigration transit or a sending country, it has more recently become a destination for immigrants and refugees (Kaya 2023; Kirişçi 2007). Turkey's temporary protection policy has also recently become a model for other countries hosting large forced migrant populations. When it comes to refugees, what happens in Turkey matters for the rest of the world, whether as a model or as a cautionary tale.

Within Turkey, I focus on the city of Istanbul. Istanbul alone hosts more than 500,000 registered Syrian refugees—more than most countries in the world, save for Germany, Jordan, and Lebanon. Istanbul province also has more refugees than any other province in Turkey.[4] This tally does not include the large number of unregistered Syrians in Istanbul, many of whom arrived in the city after it stopped registering Syrians in 2018. Even among those registered, many had their registrations processed in other provinces, complicating their ability to access services. Istanbul is also a massive city, counting over 15 million people among its population. It is an ideal site of analysis precisely due to its scale. All the relevant types of healthcare organizations—state providers, international organizations, domestic NGOs, and Syrian healthcare providers—are numerous and active in the province. Moreover, the presence of a

[4] As a percentage of provincial population, border provinces such as Şanlıurfa, Hatay, and Gaziantep have considerably larger refugee populations than Istanbul.

large refugee population with irregular registrations in Istanbul has made the persistence of nonstate forms of support critical, given that hundreds of thousands of refugees cannot legally access the benefits of temporary protection. In this sense, Istanbul presents a "pointy case"—large numbers of Syrians with a range of legal statuses, as well as a high concentration of state and nonstate providers, help us more readily observe organizational phenomena that may not be as visible in other city contexts (Ermakoff 2014; Pacewicz 2020).

Istanbul is also a useful site of analysis when we consider other refugee- and immigrant-hosting cities around the world. Often, the biggest cities with the greatest economic vitality in a country attract the most migrants and refugees, given their relative abundance of job opportunities and dense international networks. Large cities, whether they are "global cities" or growing metropolises, are often deeply embedded in networks of global economic exchange (Sassen 1991). Cities like Bogotá and Tehran now each host millions of refugees under temporary protection, as well as unregistered refugees and migrants. Refugees create organizations and pursue work in these populous cities that are often marked by intense urbanization and marked urban informality. By analyzing the case of Istanbul, we can also better understand how refugees who are not placed on an institutional pathway to integration in their host cities nevertheless become enmeshed within them in particular ways.

Literature Review

Theoretically, this dissertation takes up a call among scholars to refocus attention on immigrant organizations as key actors in the study of migration. Given that immigrant organizations shape the daily lives of immigrants—as service providers, as points of socialization and interaction, and as nexuses for advocacy and lobbying--their emergence, survival, and establishment matter for patterns of immigrant incorporation in the longer-term (Bloemraad, Chaudhary, and Gleeson

2022). The dissertation integrates three main strands of scholarly inquiry in examining service provision for refugees in ambivalent legal contexts: (1) the migration scholarship on contexts of reception for forced migrants, (2) the organizations literature on hybridization in uncertain contexts, and (3) the scholarship on immigrant entrepreneurship and "mixed embeddedness".

These bodies of work may seem like strange bedfellows. Yet I contend that, in fact, there is insufficient cross-fertilization of organizational analyses with more standard approaches to migration scholarship that focus on individuals' experiences and integration outcomes. Like much of the research on refugee reception, I examine the "context of reception" for forced migrants: that is, how does temporary policy shape the institutions that refugees interact with in their daily lives? But instead of focusing solely on individual migrants, I turn attention to the organizations. Doing so not only opens up space to analyze how forced migrants access available services, but also how refugee-serving organizations emerge from the bottom up as complements or supplements to the existing terrain of service provision. These bottom-up organizing practices can actively shape the broader service provision context.

Moreover, in order to analyze emergent refugee-run organizations, I resist commonly accepted analytical categories of organizations that have siloed immigration research. Specifically, I reconsider the boundaries of what defines an "immigrant organization". Moving beyond the confines of the voluntary organization, I bring in the messier reality of unstable forms that may move between for-profit and nonprofit operations, or hybridize these activities contemporaneously. Hybridization provides an analytical lens that helps explain the dynamism of immigrant organizing in turbulent contexts of reception. As the introductory anecdote with Dr. Bilal shows, immigrant organizations are anything but static, and must respond to the environment in which they are embedded in order to survive. Drawing on scholarship on the

embeddedness of immigrant entrepreneurs, I explore how particular immigrant organizations transform to become fixtures of the host society terrain while others disappear within a context of temporary protection. The next sections expands the key theoretical discussions that inform the dissertation.

Temporary Protection: Forced Migrant Reception "In-Between"

Scholarship on refugee reception tends to examine either refugees with formal refugee status in the global North or forced migrants contending with less clearly defined statuses in the global South. Refugees in the global North are placed on a pathway to permanent residency with access to services comparable to the host state's citizenry (Hein 1993). While they may contend with resettlement organizations at the outset as they gain their footing in the host state, these individuals are typically granted access to the welfare state akin to citizens. As refugees interact with host institutions and build social networks, the expectation is that they will gradually integrate into the host society (Ager and Strang 2008). Many will, eventually, become citizens.

In contrast, forced migrants in the global South are more likely to face ad hoc arrangements of reception. Even for individuals recognized formally as refugees, "refugee" in the global South is more likely to be a "life" label than the "threshold" label proffered in global North settings as a means toward long-term integration (Feldman 2018). Refugees and forced migrants may live in refugee camps run by international organizations like the United Nations High Commissioner for Refugees (UNHCR), which can take on a surrogate state role (Kagan 2011). Or, if states do not have formal reception policies, individuals may end up legally indistinguishable from the undocumented immigrant population. Much ink has been spilt by migration scholars on how migrants are labeled as refugees, and the implications of these labels

for protection and settlement (Zetter 1991; Zetter 2007) or, on the other hand, for exclusion from a polity (DeGenova 2002).

Yet, labeling individuals as refugees is not the only way to designate forced migrants as in need of protection. A range of middle income and wealthy countries are increasingly endowing large groups of forced migrants with temporary protection. Temporary protection policies have been applied in various forms since the 1960s, not long after the refugee conventions were codified in international law and expanded in their geographic reach. But their application increased during the 1990s, when European countries granted temporary protection to groups fleeing ethnic violence in the Balkans (Fitzpatrick 2000).

The status is invoked in cases where refugee status conferral may be bureaucratically impractical. It is often also a strategic choice that allows states to provide protection without making an overt political judgment on the geopolitical context that produced the humanitarian emergency (Mountz et al. 2002). For example, when Central Americans began fleeing politically volatile home country contexts destabilized in part by the US's intervention, the US opted to establish a temporary protection status rather than to grant refugee status. This was out of concern that the latter could suggest that the US recognized the long-term destabilization it had wrought abroad (Menjívar 2006). Temporary statuses are not levied with the intention of enshrining immigrants with durable rights in the polity, but may rather more accurately be understood as "administrative act[s] of grace" (Chacon 2014: 729).

Nevertheless, temporary protection statuses do endow individuals with significant social rights. As claimants of rights to public goods and services, those under temporary protection practice *substantive* citizenship through a "continuing series of transactions between persons and agents of a given state" (Tilly 1995: 8). Even as formal citizenship acts a form of social closure

(Brubaker 1992), expansive social rights claims by migrants can blur the boundaries of inclusion and exclusion. As Menjívar argues, in-between statuses "rais[e] the possibility of new forms of citizenship" (Menjívar 2006: 1003). These individuals, neither fully included in nor excluded from the polity, expose the contours of how the nation-state shapes belonging through the conferral of different legal statuses (Coutin 2000). When political claims to membership are circumscribed, populations suspended in temporary legal arrangements may make alternative legal or economic claims to their belonging in the polity (Lori 2019; Vora 2013).

Temporary protection policies are being implemented at progressively larger scales, bringing questions about temporariness, membership, and exclusion into sharp relief. Millions of Ukrainians, Venezuelans, and Afghans are contending with these questions in their host states. The specificities of the temporary protection policies they encounter are unique. For example, while Ukrainians' temporary protection proceeds in periodic short-term extensions, Venezuelans in Colombia receive a blanket ten-year protection. This is because, unlike refugee law, temporary protection policies are national policies (or in the European Union's case, a regional policy) that are subject to the whims of domestic politics. Yet they all share a common characteristic: they provide rights and protection in the short term but are uncertain in whether or how they will integrate protected populations in the long term. Some pave a pathway to apply for permanent residency, others do not. In some country contexts, individuals' eligibility to become permanent residents or citizens is arbitrary, and the institutional architecture of the policy remains fundamentally temporary.

Yet it is also the case that refugee policies in global South settings have hinged on an implicit temporary logic for decades. Refugee camps and UNHCR governance are not meant to be permanent, even though they do frequently lapse into a realm of what artists Alessandro Petti

and Sandi Hilal have called "permanent temporariness", as temporary arrangements institutionalize over time and no durable solutions become available for large numbers of displaced populations. Indeed, the United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA) continues to manage Palestinian refugee camps seventy years since the organization's founding. Many Palestinians are still denied permanent membership status in their host states, multiple generations on from their ancestors' initial displacement. Temporary policies, then, may at times be less about enshrining a clearly bounded temporal scope of reception than they are about legally forestalling a population's inclusion in a host polity. The policy is a gamble, with unclear odds about whether return or settlement will be more likely.

Given that temporary policies are becoming increasingly institutionalized and implemented as a tool for refugee reception, it is important to understand how policies rooted in ambivalence structure refugees' incorporation and membership in host states. Scholars of refugee reception have long focused on the "structures of refuge," comprised of the "complex of state policies, refugee programs, and segmented welfare systems" that shape these processes of incorporation (Rumbaut 1987: 99). Policies within the receiving state shape the types of employment, schools, and services individuals can access, which bear directly on refugees' quality of life as they settle in a new place. As a result, refugees originating from the same country with similar socioeconomic resources and education levels may face profoundly different integration trajectories depending on host state policies (Gowayed 2022).

Given that institutions shape refugees' patterns of incorporation, and refugee policies shape institutions, this dissertation turns attention to the effects of temporary or ambivalent policy on institutional configurations of reception. By examining the healthcare field, the study

also gains insight into a series of other modes through which refugee policy shapes institutions. Temporary protection does not just specify the healthcare services Syrian refugees are entitled to. It also shapes how and whether refugee doctors can get their certification equivalencies. It shapes the rules around who can open a health clinic. It shapes Syrians' geographic mobility both within and beyond Turkey, and the services status-holders can access in some localities but not others.

The confluence of rules emanating from different state agencies under a broader umbrella of temporary refugee policy can produce semi-legality. Kubal (2013: 566-567) conceptualizes semi-legality as a "multi-tiered space" between legality and illegality in which laws may contradict each other. In a state of semi-legality, individuals with rights in a polity may nevertheless remain structurally confined to illegal modes of work, survival, or organizing. Ultimately, refugee policy structures informal activity. The informal organizations that emerge in the interstices of refugee policy are revelatory of features of the policy itself, as well as the broader welfare terrain in which immigrant organizations are embedded.

Immigrant Organizations through an Organizational Lens

The terrain of healthcare providers for refugees--and indeed for populations more broadly--is institutionally complex. In countries with a public healthcare system, government ministries manage a collection of state-run clinics and hospitals. Often, these institutions coexist with private healthcare institutions. Providers may be funded through private investment and sustain their operations through fees for service and insurance payments. Some of these providers may operate as nonprofits. Other providers may offer free services and rely heavily on donations. Like other service domains—education, for example—the field of healthcare organizations is made up of a variety of public, private, and various hybrid organizations.

The scholarship on organizations prepares us well to contend with the messiness of the organizational world of service provision in general, and healthcare in particular. In organizational theory, organizations are conceived of broadly. Organizations are "stable elements of social life designed and created for the purpose of goal achievement" (Breckenridge and Savage 2011). They are the structures through which work, business, and policy come together to organize daily life. Within organizational theory, analysts are both attentive to *fields* of organizations—communities of organizations that interact and share meaning systems--as well as the *forms* of organizations (Romanelli 1991). While some organizations conform to expected forms within a field, sometimes others recombine existing elements of organizations in new ways, creating hybrid forms (Ruef and Patterson 2009). Scholars of organizations are well-equipped to analyze organizational emergence, survival, and transformation, with attention to the particularities of both the forms of organizations and the fields in which they emerge.

The scholarship on immigrant organizations, on the other hand, conceives of "immigrant organizations" in a decidedly more narrow sense. More scholarly focus has been directed toward disaggregating "immigrant" organizations and "ethnic" organizations than has been focused on considering the boundaries of what constitutes an organization. Babis ventures a focused definition of immigrant organizations as "nonprofit organizations, founded by immigrants at all stages of immigration, with the purpose of serving mainly the immigrant group itself" (Babis 2016: 359). In the discussion of this definition, Babis makes a clear distinction between immigrant organizations and immigrant for-profit enterprises. Bloemraad, Chaudhary, and Gleeson (2022: 321) provide a two-step definition of immigrant organizations. First, they define an organization as "a collective group with some shared history, goals, or identity that offers opportunities for recurring interactions or activities over time." This, as a standalone definition,

is not too distant from organizations' scholars conception of the organization. But then, in defining the "immigrant organization" in particular, they narrow their interest to "not-for-profit or voluntary" organizations, and "bracket off ethnic businesses" (ibid: 322).

The term immigrant organization thus conjures images of hometown associations, mutual aid associations, refugee assistance organizations, resettlement NGOs, religious organizations, or other types of voluntary organizations. While this makes sense given migration scholars overriding interests in (and relative ease of research access to) organizations like NGOs, it creates two analytical tensions that this dissertation seeks to expose and analyze. First, organizational forms are not static, particularly during the first years of emergence as they attempt to gain their bearings in a new terrain. This means that organizations may move between a variety of forms and functions. An afterschool tutoring NGO might become a for-profit language course, a job support NGO might become an employment broker, or a humanitarian healthcare provider might become a private for-profit health clinic. Or, as in some cases I examine, these forms may exist simultaneously, blurring the lines between businesses and non-profit orientations. Migration scholars, however, tend to demarcate a clear analytical separation between the voluntary NGO and the immigrant business venture.

One goal of this dissertation is to reconsider this intellectual boundary. The scholarship on ethnic entrepreneurship is well-attuned to how both the environment in which organizations emerge, as well as the characteristics of the immigrants themsevles—as both entrepreneurs and as consumers—shape the businesses they create (Zhou 2004). Immigrant networks facilitate individuals' employment in and access to immigrant-owned businesses by creating "ethnic economies" (Light and Gold 2000). These ethnic economies are created and sustained as a result

of demand for particular goods from immigrants as well as "opportunity structures" that immigrant businesses can adeptly fill in a host community (Aldrich and Waldinger 1990).

Opportunity structures, in turn, are the supply-side openings shaped by host community regulations, local market conditions, as well as the broader economic forces that shape national markets, which scholars have referred to as the "macro-institutional framework" (Kloosterman 2010). Kloosterman and colleagues have conceptualized this multi-level dynamic as a "mixed embeddedness" perspective (Kloosterman and Rath 2001). Entrepreneurs, then, identify a demand niche among an immigrant population. In the upstart process, these entrepreneurs may undertake informal activities as they situate themselves in the local market (Kloosterman, Van Der Leun, and Rath 1999). Their activities are shaped by the broader regulatory context in which they emerge.

This framework has been largely limited in its application to entrepreneurial businesses. Yet these processes are applicable to organizations, broadly conceived. Indeed, Bloemraad, Chaudhary, and Gleeson (2022) begin to make the conceptual connection between immigrant organizations and embeddedness but stop short of exploring the implications of such a conceptual move. The authors posit an "urgent need to study organizational embeddedness, that is, the ways in which temporal, social, political, and geographic context affects the prospects for building and sustaining IOs [immigrant organizations]" (p. 328). The authors recognize that the concept of organizational embeddedness is, in essence, a study of how contexts of reception affect organizations. They do not, however, elaborate an analytical path forward.

The concept of mixed embeddedness, which identifies specific features of the opportunity structures in which immigrant businesses emerge, can point us to the specific features of a "context of reception" that shape the immigrant organizational terrain. It helps us link the more

immediate opportunity structure—the bounded market opening—with both individual level skills and the macro-level institutional environment, defined by regulations, existing welfare state organizations, and the national economy (Kloosterman 2010). Moreover, the framework lays bare how informal activities facilitate immigrant organizational survival in the interstices of "indigenous" organizational terrains (Kloosterman, Van Der Leun, and Rath 1999: 253).

It is surprising that an analytical approach that focuses on institutional embeddedness of immigrant organizations has not gained more traction in migration studies. Embeddedness as a concept has been applied extensively in the organizations literature. The concept of "institutional embeddedness" directs our attention to the connections between an organizational population and key institutions in the environment (Baum and Oliver 1992; DiMaggio and Powell 1983). This embeddedness, in turn, facilitates legitimacy and resource accrual (Meyer and Scott 1983). The more effectively organizations can build ties in their organizational environments, the more likely they will be seen as appropriate and thereby legitimate (Galaskiewicz 1985). Indeed, the more embedded an organization is, the better it is protected from the destabilizing effects of environmental uncertainty (Baum and Oliver 1991).

Migration scholars would be well-served by broadening the application of embeddedness from businesses to organizations writ large to understand how organizations emerge, establish legitimacy and accrue resources, and institutionalize in the longer term. This dissertation takes a first step in this direction by analyzing the humanitarian niche that emerges in contexts of refugee reception. This is not a market niche in the narrow, business-focused sense, but rather an emergent organizational niche. In most refugee receiving contexts this niche is filled by organizations like the UNHCR, other international organizations, and national or local NGOs mobilizing to meet the needs of a displaced population, with some participation of the host state.

In contexts of temporary protection, the state takes a much larger role in filling the humanitarian niche, by facilitating forced migrants' access to basic services. Yet, they do not, cannot, and perhaps choose not to mobilize the resources to fully meet the needs of the refugee population. In the remaining humanitarian niche, nonstate organizations, including immigrant organizations, emerge.

The Argument

Up to this point, I have discussed the various conceptual tools migration scholars have at their disposal to better understand how refugee policy affects immigrant organizations. This analysis is not at the expense of focusing on individuals' lived experiences of refugeehood. Rather, it focuses on the interactional level where individuals encounter a host community's institutional landscape. The specific types of immigrant organizations that emerge and survive become a part of the social fabric in which immigrants live their day to day lives. Which organizations survive, and in what form, matters for individuals.

Analyzing refugee-run healthcare organizations, this dissertation makes an overarching argument about immigrant organizational survival in contexts of ambivalent migration policy. It applies the mixed embeddedess framework already developed by scholars of immigrant entrepreneurship in an institutional environment that incorporates refugees, on the one hand, but simultaneously forestalls their integration, on the other. The dissertation argues that when national policies are ambivalent about integration, immigrants organize by drawing on local and transnational networks for legitimacy and resources. This results in the institutionalization of forms in a configuration I call cosmopolitan embeddedness, where immigrants embed in the host community organizational fabric through local and international claims to legitimacy despite national policies that forestall their legal inclusion. It advances this argument through analysis of

immigrant demand for services, organizational supply of services, and the structuring rules, regulations, and broader political and economic forces at play. Below are some key junctures I identify in this process.

The Humanitarian Niche

First, the dissertation identifies the *humanitarian niche* that emerges in the aftermath of the exogenous shock of refugees' swift arrival in a host community. It examines how organizations that emerge to meet refugees' needs face a paradox of survival: their legitimacy and ability to garner resources hinges on how well their operations advance short-term humanitarian objectives and eventual return to a home country where conflict has resolved. Organizations that can credibly align with the host state's humanitarian and political goals are able to gain an early footing. Yet as organizations continue operating in this niche, they inevitably become less legitimate as the logic of humanitarianism is replaced by more settled—if not fully integrated—forms of organizing. At this juncture, humanitarian organizational survival typically necessitates a pivot in either their target beneficiary group or the type of service they provide. In order to maintain their operations, immigrant organizations draw on both logics of humanitarian and other available legitimizing logics that will keep bringing in resources.

Reframing Roles within a Shifting Opportunity Structure

As the humanitarian organizing principles of refugee reception recede, everyday life becomes more settled for refugees. Yet it does not become fully settled. This is in part because of the looming temporariness of the status and sustained hopes of returning home. It is also partly due to changing legal enforcement practices and resentment from the host community that destabilize the refugee community. This is the tension captured in the concept of liminal legality, wherein individuals are neither fully excluded nor included in the host community. During this period,

immigrant organizations, and the entrepreneurs and employees who work in them, cope with this suspension in distinct ways. Organizational entrepreneurs highlight institutional problems, discursively discredit existing systems of organization, and renegotiate their legitimacy as they transform their role in the organizational field (Koene and Ansari 2013; Schneiberg and Soule 2005; Strang and Meyer 1993). I find that the way immigrant entrepreneurs renegotiate their role in the host community is a politically-inflected process: while initial claims to legitimacy were premised on aligning with state humanitarian interests—both domestic and geopolitical—the renegotiation process leads entrepreneurs to position themselves in opposition to temporary protection policy. By discrediting the state policies that circumscribe their work, and by making appeals to international and local legitimacy based on shifting dynamics of demand for services, entrepreneurs justify new ways of organizing.

Cosmopolitan Embeddedness

Ultimately immigrant entrepreneurs, and the organizations they work in, either close or transform their work to survive in the longer term. They embed themselves in institutions that will facilitate survival not just through discursive reframing, but through transformations of tangible work practices. Activities that once aligned with state geopolitical and humanitarian aims and accrued sizeable resources gradually shift toward apolitical, economic alignments. I refer to the process through which they attempt to stabilize their operations as *cosmopolitan*[5] *embeddedness.* The term refers to the process through which immigrant entrepreneurs and

[5] Cosmopolitanism is a value-laden term in political theory, given that it is often used in reference to an aspirational global society in which individuals are equal citizens, stripped of the inequalities wrought by national citizenship. I do not use cosmopolitan here with this moral or ethical-aspirational valence. Instead, I use "cosmopolitan" as a direct analytical counterpart to "national". Blocked by state rules, individuals within a context of temporary protection justify their work through appeals to their merit as members of elite transnational networks as well as essential local humanitarians. They also orient market activities transnationally and to locally diverse yet institutionally excluded populations like refugees and immigrants. The term "cosmopolitan", then, also captures this increasing diversification of the organizations' beneficiary bases. This latter application speaks more to the colloquial use of the term to refer to highly diverse cities and localities.

organizations orient their work toward diverse local immigrant and refugee populations as well as international populations while bypassing or bending host state rules that circumscribe their operations. Building on, yet distinct from, the concept of transnational embeddedness, the concept focuses on the effects of onerous state policies that push immigrant entrepreneurs toward local and global opportunities. Rather than diminishing the relative relevance of the nation-state, the argument places state institutions as they key driver of both the localization and transnationalization of these entrepreneurial and organizational activities.

Methods, Positionality, and Ethics

The analysis that follows is primarily an interview-based study drawing on conversations with a variety of interlocutors, described in detail below. But the design draws on principles of ethnography. Social scientists pursue "ethnography of the state" as a way to understand how state rhetoric and rules penetrate society and become taken for granted ways of organizing social life (Kligman 1998: 3). When state institutions are in flux, training one's analytical gaze on local political action at successive points in time can help demystify state processes (Verdery 2020: 228-229). Analyzing swift social changes in a turbulent political field presents an analytically rich context for understanding the state itself. This project, however, may be better likened to an "ethnography of the nonstate", in that its analytical focus remains squarely trained on the interstices of the state. Examining nonstate activities is revelatory about state action and, perhaps more notably, state inaction. It is also an ideal object of study for understanding how state policies shape the contours of informal organizing and service access among those who are suspended from full inclusion in a polity. It reveals how these organizations become embedded in the host community social fabric.

The scalar interactions between individuals and their institutional contexts can reveal dynamics of refugee agency in the face of ambivalent policies. To this end, I also draw analytical inspiration from Biao Xiang's multi-scalar mode of analysis, which emphasizes the "frictions" that may occur at local, regional, national and global levels for individuals in the context of migration (Xiang 2013: 284). Xiang writes that multi-scalar ethnography "simultaneously 'studies up' to interrogate the center of power (Nader 1972), 'studies down' to examine everyday interactions, and…'studies through' to 'trace ways in which power creates webs and relations between actors, institutions, and discourses across time and space'" (295). I operationalize this multi-level methodological framework by integrating data from nonstate organizational personnel, state officials, healthcare professionals and Syrian individuals in order to make sense of the implementation and effects of healthcare policy on Syrian refugees.

While I have spoken about ethnography as a tool for analyzing the state and the informal activities that occur in its interstices, this project leans on interviews as the primary window into the world of refugee healthcare. It draws on 178 interviews as well as field notes collected during in-person visits to over 40 different healthcare providers that provide care to immigrants and refugees. These included small refugee-run apartment-sized clinics, larger Syrian-run polyclinics, Syrian-run dental clinics, Turkish private polyclinics where Syrians work, clinics run by other immigrants groups that employ Syrians, Migrant Health Centers, state Family Health Centers, Turkish healthcare NGOs, and state hospitals.[6] I also used social media, particularly the Facebook and Instagram posts of Syrian-run health clinics, for periodic updates about clinic operations. Especially during Covid-19, which limited my ability to visit clinics in person, social media proved to be a constant and informative source of information about refugee healthcare.

[6] The differences between these types of clinics are clarified in the following chapter, which provides background on the Turkish healthcare provider terrain.

The study unfolded over successive visits to the field—in the summer of 2017, the winter of 2017-2018, the summer of 2018, the fall of 2019, and during an extended period during the pandemic between late 2020 and mid-2022. The focus of the interviews shifted over time; what started as an interest in what appeared to be Syrian women's disproportionate utilization of nonstate health clinics transformed into a study of the clinics themselves. I had planned to begin my fieldwork in a health clinic run by the Turkish NGO Doctors Worldwide in collaboration with the International Organization of Migration (IOM) and funded by the Directorate General for European Civil Protection and Humanitarian Aid Operations (ECHO). I had visited this clinic for a story when I was working as a journalist in Istanbul before graduate school and had gotten to know one of the administrators.

When I first arrived in the field, however, the Doctors Worldwide clinic had drastically slowed down its operations. Their EU funding was being redirected to other projects, and only a handful of patients were still coming for care. This was, it turns out, a first data point: the humanitarian task of the clinic had been "met", and it was time for the clinic, which had a temporary legal status as an NGO approved for humanitarian healthcare, to close. Yet the managers did not skip a beat in redirecting me to where the Syrian patients were *really* going for their care. They directed me to the Shifa Clinic. There, they said, I would find a health clinic for Syrians still operating at a steady clip.

I went to the clinic with two Syrian friends one day and, sure enough, found a bustling health center. We went inside and introduced ourselves, after which we were promptly led up to the administrative offices on the fourth floor. We met a group of administrators and chatted with them. I told them, with the assistance of my two friends, about my research. It did not hurt that my friends happened to have mutual friends with them. It turned out they already had a system in

place for researchers like me: if I gave them a project summary and list of sample interview questions, they would be happy to facilitate my research on Syrians' access to healthcare at their clinic. I came back later that week, handed over my flash drive with the requested documents, and was welcomed to come back as I pleased to observe and conduct interviews.

Since then, each visit to the field focused on changing dimensions of refugee healthcare and nonstate service provision. While the first summer I primarily conducted interviews with Syrians about their healthcare practices, I also became increasingly interested in the variety of informal clinics they seemed to be seeking out. During my following two visits I shifted focus to providers, interviewing doctors and visiting the informal clinics that kept coming up in my interviews. Once many of the clinics shut down in 2019, I shifted my research to the broader field of nonstate support for refugees.

Yet, I later noticed that clinics' closure announcements on Facebook were gradually followed by organizational reincarnations. My 2020-2022 fieldwork sought to understand these transformations in the field, as well as how Syrian doctors and patients fit into the organizational story. During this stretch of fieldwork, I was able to conduct in-depth retrospective interviews with patients, health professionals, and a variety of other actors in the field to help carefully chart the processes I had been observing in snapshots during my previous visits. Accordingly, the quotes in this dissertation were primary drawn from interviews conducted during the 2020-2022 period, though data from earlier periods was essential to shaping the questions and insights about the field, particularly in charting changes in clinic form over time.

Interviews with Syrian refugees about healthcare access. In total, I conducted 66 interviews with Syrians about their healthcare access over the course of the research. Forty-four of these interviews were conducted in 2020-2021 and serve as the primary data on refugees' access to

care for this dissertation. In contrast to the earlier set of interviews, these interviews were conducted after the state established Migrant Health Centers. They provide a detailed understanding of how Syrian refugees navigate the multiplicity of services available to them, both at the time of the interview and retrospectively. Below are key statistics of the sample analyzed in chapter four of this dissertation:

Table 1.1: Sample Characteristics for Healthcare Access Interviews, 2020-2021 (N=44) [7]

Gender		
	Male	10
	Female	34
Legal Status		
	TPR-Istanbul	31
	TPR-not Istanbul	6
	Residence Permit	5
	Turkish Citizen	2
City of Origin		
	Aleppo	12
	Damascus	15
	Latakia	6
	Homs	2
	Deir Ezzor	2
	Qamishli	1
	Daraa	2
	Idlib	3
	Afrin	1

The gender skew is partially by design and partially a product of the chance involved in snowball sampling. When I first visited Syrian clinics in Istanbul, the majority of patients in the waiting rooms were women. My preliminary interviews made clear that there were a number of reasons for this: Syrian women were less likely than their male counterparts to have a basic command of Turkish, and therefore were more likely to seek out Syrian doctors. Men often learned the language in the workplace, while the vast majority of Syrian women in Turkey do not work.

[7] See Appendix A for complete interview list.

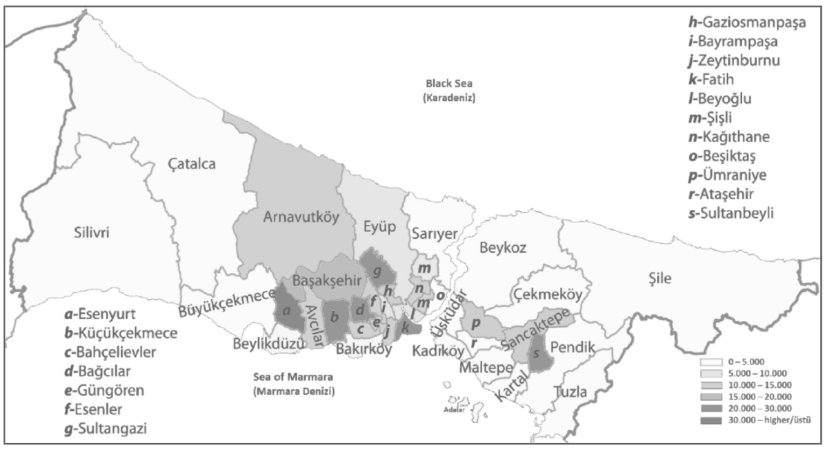
Second, many were seeking out care for sensitive issues—gynecological care, maternal care, pediatrics for their children, and endocrinology. These were areas in which many were willing to pay a small fee for the comfort of seeing a Syrian doctor, whom they could select themselves. I also found quickly in my interviews that mothers were often the point-person for managing the healthcare of the household. This is consistent with other immigration health scholarship that finds that women are usually in charge of family health (Chavira-Prado 1992; Menjívar 2002: 439). Men's responses only systematically differed insofar as most did have some basic command of Turkish, and, anecdotally, there were more cases of workplace-related health issues, like injuries in factory work.

While most respondents had temporary protection status in Istanbul, a handful had other relevant statuses. Those with TPR in other provinces do not legally have access to healthcare in Istanbul. Moreover, those who opted for residency must purchase their own insurance. This insurance can vary markedly in the quality of coverage and can lead to significant medical costs borne by the individual, who cannot benefit from the social rights afforded by TPR. Citizens have functionally the same access as Turks. While I did not have any unregistered Syrians in my sample, I interviewed social workers at NGOs that work with unregistered Syrians to understand the healthcare strategies used by this particularly vulnerable population. These dimensions of legal status are explored in detail in chapter 4.

Finally, all but two individuals in my sample lived on the European side of Istanbul. They were concentrated in the urban and peri-urban Marmara Sea regions that include Fatih, Zeytinburnu, Güngören, Bağcılar, Küçükçekmece, Esenyurt, and Beylikdüzü. The map below shows the concentration of Syrians in Istanbul by district in 2017, a general distribution that has

largely persisted despite frequent intra-city migration among Syrians. My respondents roughly map on to the areas with the highest numbers of Syrians.

Figure 1: Concentration of Syrians in Istanbul, 2017[8]



Interviews with Syrian healthcare professionals and clinic managers. Interviews with Syrian doctors and clinic managers form the crux of the analysis of this dissertation. In total, over the course of the research, I conducted 77 interviews with Syrian healthcare professionals, broadly conceived. In the first year of research, most interviews with doctors focused on the healthcare needs of refugees. As the project became increasingly about configurations of care provision, these questions began shifting more toward doctors' own professional trajectories, and the organizational contexts in which they worked in Syria and Turkey. The dissertation analyzes data from 44 interviews from 2021-2022 rather than on earlier interviews with doctors, even though insights from those interviews—as well as the site visits they entailed—were critical for the subsequent fieldwork. The one exception to this is chapter 3, which also draws significantly from 18 interviews conducted with administrators of various Syrian-run clinics in the 2017-2019

[8] This figure is taken from a policy report I co-authored with Auveen Woods while working at the *Istanbul Policy Center* called "Engaging Syrian Communities: The Role of Local Government in Istanbul"(Woods and Kayali 2017).

period. Below are key sample characteristics of the health professionals interviewed, analyzed in chapter 5, 6, and 7.

Table 1.2: Sample Characteristics for Healthcare Professional Interviews, 2021-2022 (N=44) [9]

Gender		
	Male	40
	Female	4
Legal Status		
	TPR-Istanbul	1
	Residence Permit	9
	Turkish Citizen	33
	Tourist Visa	1
Type of healthcare work		
	MHC	6
	Hybrid[10] or private clinics	32
	Other (NGO, house visits, studying, only working in admin role)	7

*One doctor worked in both an MHC and private healthcare simultaneously, so total number in type of work category exceeds 44. It is also possible that other MHC doctors did not mention additional private clinic work, given that they are not supposed to work outside of their MHC posts.

Of these 44 Syrian health professionals, not all were physicians. Thirteen of them were dentists, and one was a physical therapist. Three had medical school degrees in pharmacy that did not have an equivalent degree in Turkey. One was an x-ray technician in Syria who worked in an administrative capacity in a Syrian clinic. Three helped manage clinics but did not practice as doctors. The rest were physicians. Like my interviews with Syrians who navigate healthcare in Turkey, these interviews were also gender skewed—in the opposite direction. Only four of these

[9] See Appendix B for full interview list.
[10] I use "hybrid clinic" to refer to anyone who works in the humanitarian providers discussed in chapter 3 of the dissertation.

interviews total were with women. This skew largely reflects the reality of the gender balance among Syrian healthcare professionals. In a report of Migrant Health Center employees' job satisfaction conducted by the Ministry of Health, their survey elicited responses from 267 male physicians and 69 female physicians (Zikusooka and Elci 2020: 8). This 4:1 ratio likely still overrepresents the number of women among Syrian health professionals in Turkey, given that the MHCs placed special emphasis on hiring gynecologists and general medicine physicians, two specialties with higher rates of female participation, globally (Levaillant et al. 2020: 8). Anecdotally, my female respondents also noted that many female health professionals they knew were not willing to take the risk to work informally, unlike many of the male doctors I encountered in my research.

Interviews with NGO personnel working in refugee support field. In an effort to get a sense of the broader field of nonstate service provision, I also did a significant amount of fieldwork interviewing a variety of NGOs in the refugee support field. I conducted 25 interviews with NGO personnel. These included healthcare NGOs as well as NGOs in other fields, including aid provision, education, employment support, and advocacy. These interviews were critical for understanding the nature of state-nonstate organizational relations in the broader field of refugee reception in Turkey, and a subsample of these organizations form the basis for a paper I published in 2023 on state-NGO relations (Kayali 2023). I exclude Syrian-run health clinic employees, who are included in the preceding tally of interlocutors.

Interviews with Turkish state personnel. This final group is a residual category of other interviews with ten actors in the field of refugee healthcare in Turkey. It includes five Turkish general medicine doctors whose work in Family Health Centers or early versions of Migrant Health Centers involved daily encounters with the Syrian population in the neighborhood. It also

includes two interviews with Turkish employees of the European Union's Facility for Refugees in Turkey, which is the EU's official organization managing the 6 billion Euro budget of EU grants to Turkey's refugee reception regime. I also interviewed two municipal officials managing refugee affairs for their local municipalities. Finally, I interviewed a Ministry of Health official based in Ankara managing key aspects of the SIHHAT Project, the EU funded refugee health project.

Language, positionality, and ethics

Interviews for this project proceeded in three different languages, depending on the interlocutor's language proficiencies: Arabic, Turkish, and English. As a native English speaker and fluent heritage Turkish speaker, I conducted all English and Turkish interviews myself. For Arabic language interviews, I worked closely with three translators throughout my fieldwork who provided both essential language assistance as well as deep insights about the topics and an eagerness to help me find more clinics, more doctors, and more interlocutors to interview. All three were women my age—in our late twenties and early thirties throughout the research—and were themselves Syrian refugees who lived in Istanbul. In early days, I would visit Syrian clinics with my translator, whose accompaniment as a community insider helped anticipate the nature of interlocutors' hesitations and reassure them that I was trustworthy, beyond my own proclamations about my research.

I have also been a student of the Arabic throughout my graduate studies and gained greater facility with the language throughout each successive field visit. I would introduce myself and do introductory small talk in Arabic. Nevertheless, I worked with translators throughout the research to ensure that I could delve into requisite depth in the interviews. I also found that the three-person interview format often made for a less clinical interview setting,

turning the interview into a social and conversational environment. It was also the case that, by the early 2020s, many of my Syrian interlocutors had learned Turkish. Among doctors, English proficiency as well as Turkish proficiency was common, and indeed critical to their professional lives. Interviews would sometimes move through all three languages in entertaining ways (though this sometimes lost its playful sheen when it came to transcribing these interviews).

From November 2020 to September 2021, I conducted all my interviews virtually, due to the Covid-19 pandemic. After September 2021, once vaccinations had been taken up by the willing population in Turkey, I transitioned to hybrid methods. A detailed exploration of my methodological strategies during this period of intense disruption can be found in my article "Managing Uncertain Times in Turkey: Refugee Healthcare Research During a Global Pandemic" in the *International Journal for Middle East Studies* (Kayali 2024). Nevertheless, a few notes are in order here. I conducted virtual interviews using either Whatsapp Video, Zoom, or Whatsapp voice, depending on my interlocutors' preferences. For interviews with translation, conversations were conducted as three-way calls. Sampling during Covid-19 diverged among different types of interviewees. For interviews about Syrians' access to services, I relied on snowball sampling through friends of friends, neighborly ties in heavily Syrian neighborhoods, neighborhood network nodes like local shopkeepers, and Turkish-language classes for Syrians. For doctors, I snowballed within professional networks but also found that directly messaging doctors' whose numbers I found online was sometimes more effective than snowballing (see Kayali 2024 for elaborated discussion).

As a Turkish-American in a field primarily researching Syrian refugees, I was constantly thinking about the multiplicity of power relations I was embedded in. These were partially linked to my identity but also colored by the types of interlocutors I was interviewing. My translators

were essential for easing relations between myself and my interviewees who were discussing their healthcare access. My ability to speak Arabic well enough to demonstrate keen engagement with the region was also useful. The fact that I was Turkish-American, and not just Turkish, also worked in my favor in interviews with Syrians. Given swelling anti-refugee sentiment in Turkey, I was able to situate myself as an American outsider and often would explicitly acknowledge and denounce the increasingly vocal and confrontational nativism among Turks. Given that my interlocutors were refugees and experienced a variety of vulnerabilities in Turkey, I was happy to discuss the field of refugee support in Istanbul with them, should they decide to seek out institutional support for specific issues. My interviews with a variety of NGOs in Istanbul helped facilitate this knowledge, as I had developed deep insight into the organizational field of refugee support in Istanbul. Yet, to frame my interlocuters as vulnerable refugees in need of support is also to do them a disservice—many of the Syrians I interviewed had expertly figured out life in Istanbul and confidently moved through the city as workers, parents, students, friends, and neighbors. This was in spite of the fact that locals in Istanbul were becoming increasingly resentful of their presence.

The interview dynamic with doctors was different. Doctors had placed great value on their own medical school experiences, and many were eager to talk with a researcher similarly invested in advanced degree pursuits. In fact, for Syrian doctors who were working informally and had faced the frustration of not having their degrees recognized, interviews served as a rare space in which they could fully explain their qualifications, their years of training, and their expertise to a willing ear. These interviews also had a clear axis of vulnerability—given that some individuals worked informally, they sometimes approached interviews with initial caution. As an addendum to my oral consent procedures and lengthy discussion of the project, I always

reiterated that, in addition to anonymizing their own identities, I would not use the real names of any of the clinics in which they worked.

The fact that I was working both with vulnerable populations *and* informal organizations meant that I was particularly careful with how I approached recording interviews. Until 2019, I did not record interviews with Syrians. Instead, I would take handwritten notes and then immediately reconstruct and transcribe my interviews the same day. As I gained a better sense of the field, I began introducing the option of recording cautiously, on a case-by-case basis, and assessing whether and how this change affected interviews, if at all. In the stretch between 2020 and 2022, I began asking most interlocutors if they would be comfortable with recording the interviews at the completion of the oral consent procedure.[11] Almost all individuals talking about healthcare access said yes. With doctors, there was more variation, but many were enthusiastic. As a result, most of the data in the dissertation are quoted extracts from recorded conversations. A handful are reconstructed from handwritten notes. I included reconstructed quotes in instances when I was confident that I had gotten virtually all of a quote down in writing—these are often rendered as short sentences or phrases in the dissertation, rather than long excerpts.

The volume of interview transcripts has also produced copious material for analysis. My data has gone through multiple rounds of coding. Each year leading up to 2020 was coded separately, with the specific questions I had developed through analysis of the previous year's data. In regard to clinics, initial findings about the precarious state of refugee-run clinics, as well as the variety of organizational strategies to remain operational, led to abductively-generated

[11] With a handful of interviewees, I would not bring up the idea of recording and would default immediately to handwritten notes. This was a judgement call based on the tenor of the initial conversation preceding the interview. I automatically skipped recording with interlocutors who, throughout the oral consent procedure, may have seemed a little cagier. I did not want to risk losing trust in these scenarios, and proceeded with care, reiterating periodically that we would only talk so long as they wanted to continue the conversation. See Ozgen 2024 for a discussion of the precarious nature of building trust in Turkey with interlocutors as a researcher based at a foreign university.

hypotheses about organizational adaptation strategies over time. Important emergent themes that were probed in subsequent interviews included modes of resource acquisition; the nature of interactions with street-level bureaucrats, other organizations, and the broader community; organizational self-identification and mission; and day-to-day behavioral responses to uncertainty. These more focused questions in follow-up years were analyzed alongside newly emergent data about experiences within a shifting policy and enforcement landscape. For individuals, interviews shifted over time from examining individual health status to healthcare-seeking behavior, as the research veered more toward questions of provision. After completing dissertation fieldwork, I re-coded transcripts and notes in atlas.ti with an eye to the broader themes that had emerged over time. These included codes on formalization, privatization, certification and equivalency processes, and international mobility and networks.

I was especially careful with how I analyzed data about informal practices among healthcare providers. It goes without saying that interviews about activities that are legally proscribed may garner responses that are incomplete or misleading. For this reason, I relied heavily on triangulating responses from both different administrators and doctors in the same clinics. I also triangulated across clinics by encouraging respondents to discuss the field of formal and informal healthcare provision for refugees more broadly. Administrators often referred to other clinics by name, making it possible to compare both clinics' self-representation and perception by other Syrian clinic personnel. Interviews are a particularly useful tool for accessing individuals' "imagined meanings of their activities [and] their self-concepts," which is critical for analyzing how organizations tried to present their activities to the various actors in their perceived audience as legitimate (Lamont and Swidler 2014: 159). Finally, I also triangulated data with journalistic accounts of informal refugee-run healthcare in Istanbul and

other cities around the country, which were covered across multiple outlets in both Turkish and English.[12] Moreover, the presence of Syrian health providers on Facebook and Instagram has made cursory checks of certain interview proclamations about organizational operations relatively straight-forward.

Chapter Outlines

The following chapter situates the empirical case of healthcare provision for Syrian refugees in Turkey's broader (geo)political and institutional context. It explains how Turkey-Syria relations over time led to the passing of the Temporary Protection Regulation that would shape Syrian refugees' reception in Turkey in the wake of intractable war across the border. It then examines how geopolitical forces during the war have further impacted the contours of Turkey's policies toward Syrian refugees. The chapter also situates refugee healthcare provision within Turkey's existing healthcare system. Finally, it provides an overview of existing studies of healthcare for Syrian refugees in Turkey. This chapter provides the background for the ensuing analyses of how refugee healthcare providers emerge, adapt, and survive in the Turkish context.

Chapter 3 analyzes the emergence and initial survival of Syrian refugee-run health clinics in Istanbul. Although Syrian refugees gain access to free state healthcare in Turkey under temporary protection, a number of informal refugee-run clinics emerged to meet the unmet needs of refugee patients. While some of these clinics are swiftly shut down, others survive and expand. What explains clinic survival? This chapter introduces the idea of the "humanitarian niche" within which immigrant organizations emerge as new actors in a field shocked by the

[12] *Newsweek,* as well as numerous Turkish language outlets, including national outlets like *T24* and *Milliyet,* ran stories on informal Syrian-run healthcare providers. Many Turkish fringe media outlets have also done so periodically, using more alarmist language about their illegality.

arrival of a large refugee population. It shows how organizations hybridize religious humanitarian and for-profit practices strategically to both establish (geo)political legitimacy and to acquire resources in the host state. By negotiating the boundaries of the humanitarian niche, hybrid humanitarian organizations are able to survive, even as standard humanitarian NGOs close once humanitarianism begins to recede as an organizing principle.

Chapter 4 turns analytical attention toward the demand side. Why do Syrian refugees utilize fee-for-service healthcare providers when they have access to free state healthcare? This chapter pays heed to the reasons refugees and immigrants may struggle to avail themselves of healthcare services in state providers, including a combination of language barriers, challenging bureaucratic processes, and discrimination. Yet, accounting for these challenges, it examines why even *after* state providers offering Arabic-language care are established, some refugees continue to pay for informal care rendered by Syrian doctors. What explains the persistence of this market? It argues that Syrian doctors are comparatively stable brokers of care that remain accessible in an organizational field marked by institutional, interactional, and legal exclusion. Even as the niche for Syrian healthcare providers evolves, they remain a practical option for Syrians navigating a complex field where even expansions of services for refugees can be experienced as exclusion. This persistent demand leads refugees to seek out Syrian doctors for comfort and convenience, for second opinions, and as informed network connections to a broader terrain of private providers.

Chapter 5 ventures back to supply side dynamics, focusing on the professional trajectories of Syrian doctors in Turkey. After years where they had no formal legal employment options in

healthcare, Syrian doctors were presented two professional pathways in 2018—to work in newly established Migrant Health Centers or to begin the equivalency process for foreign doctors in Turkey. How did Syrian doctors navigate these options, and what are the implications for refugee healthcare more broadly? This chapter examines the framing strategies that doctors use to explain and justify their work trajectories. It argues that doctors discursively situate themselves in an international and multiethnic field of healthcare providers through critiques of Turkey's temporary protection policy and its effects on their employment options. This discursive move relies heavily on vernacular comparisons to Syrian colleagues outside of Turkey. Drawing attention to what they frame as Turkey's policy missteps, doctors legitimize efforts to cater to a more diverse and international patient clientele through informal and semi-legal means.

Chapter 6 examines how Syrian-run clinics transform their operations once they are advised to either formalize or close. Why—and how—do these organizations keep operating? This chapter finds that as the humanitarian niche narrows and hybrid humanitarianism loses its legitimacy, a move toward more complete forms of privatization becomes the most viable pathway for organizations to survive in the longer-term. The "most humanitarian" clinics become the most successful private clinics because the legitimacy and resources they have accrued allows them to transform their operations the *least.* While these clinics operate primarily as private outpatient clinics, the other clinics that cannot compete downsize their private care operations to dental care. The chapter argues that because successful hybridization strategies endow organizations with agility, the most agile organizations can cope with environmental turbulence through incremental adaptations and thereby avoid drastic operational changes.

Chapter 7 once more turns to the Syrian doctors. How have doctors carved out work in Turkey despite legal barriers to their entry into the labor market? The chapter examines how immigrant entrepreneurs situate themselves in an institutional terrain that does not make adequate legal space for their work. I argue that when highly-skilled immigrant entrepreneurs face legal barriers to work, they organize in ways that demonstrate their essential social and economic importance in the host country. They do this by both meeting local demand for goods as well as shepherding international dollars into host country coffers. More broadly, it argues that the work arrangements they devise produces an outcome of cosmopolitan embeddedness, wherein Syrian healthcare providers become both local and transnational destinations for care for refugees, immigrants, and tourists, while simultaneously remaining outside of the strictures of Turkey's state policies. This also ultimately leaves the most vulnerable refugees—those who lack legal status and the sufficient funds for private care—without accessible care.

Chapter 8 concludes the dissertation. It explores the implications of a framework of immigrant organizational transformation that accounts for local communities, national policy, and international political and economic dynamics. It extends the discussion of healthcare clinics in Turkey to other cases of service provision in temporary refugee reception arrangements that may become protracted or functionally permanent. It also considers the policy implications of the study, discussing potential pitfalls and promising ways forward in implementing temporary protection regimes beyond the Turkish case.

Chapter 2: Border Politics, Healthcare Politics

One of the basic rights ensured to the 3.6 million Syrian refugees registered in Turkey is the right to free healthcare. This right is a central tenet of the Temporary Protection Regulation, a law that has been lauded internationally for its generosity towards Syrian refugees. This extension of care is not merely a function of neighborly good will. It is, rather, the product of political calculations by the Turkish government as well as longer durée institutional and political legacies in Turkey. This chapter provides background on three interrelated fields that animate refugee healthcare: the geopolitical field, the migration policy field, and the healthcare policy field. It shows how a logic of humanitarianism coalesces these disparate policy fields under temporary protection while also introducing ambiguity regarding longer term questions about Syrian healthcare and integration in Turkey.

First, the chapter situates Turkey's open-door policy toward Syrians within the broader historical context of Turkey-Syria relations. It then provides an overview of Turkey's migration policies toward Syrians in the aftermath of the Syrian Revolution in 2011 and its devolution into protracted civil war. In turn, the chapter focuses both on domestic policy considerations as well as the evolving geopolitical dynamics that factor into the progression of Turkey's policies toward Syrian refugees. Next, the chapter briefly describes the healthcare terrain in Turkey that preceded Syrians' arrival. Finally, the chapter provides a basic introduction into Turkey's specific healthcare policies for Syrian refugees. These policies--especially the establishment of an EU-funded refugee healthcare program in 2016—will be analyzed in greater depth throughout the dissertation but are introduced here in broad strokes. After describing the laws governing Syrians' access to care, the final part of the chapter surveys some of the existing scholarship on their access to healthcare in Turkey. Throughout much of this scholarship, Syrian access to

healthcare is described as, broadly, "partial." In subsequent chapters, this dissertation will explain how "partial" access is institutionally implicated, as well as how it is individually experienced and, at times, overcome.

The Turkey-Syria Border

The Turkish-Syrian border has been a source of both contestation and cooperation since it was officially drawn after World War I. Both Turkish and Arabic-speaking populations lived in the border region for centuries, dating back to the early days of the Ottoman Empire. What is now Syria was administered under the Ottoman Empire as a collection of Arab provinces for over four hundred years. In the twilight years of the Empire, relations between the imperial center and Greater Syria deteriorated as Arab subjects chafed under a revolutionary administration (Aras and Köni 2002: 51). Following the First World War, in which the Arab provinces sided with the Allies in opposition to the imperial center, the Syrian provinces extricated themselves from Ottoman control and were instead placed under European tutelage in the Mandate system (Khoury 2014).

Borders sketched in the post-war Treaty of Sevres of 1920 and renegotiated in the 1923 Treaty of Lausanne after Turkey's fight for greater territorial autonomy were left somewhat porous in practice following years of war. Cross-border economic and social activity was fluid in the early days of the so-called modern nation-states (Öztan 2020). Nevertheless, nationalist narratives within both countries laid fodder for mutual antipathy that could be harnessed if the political occasion arose. Turks were depicted as racist oppressors in Syria while Arabs were seen as treasonous and unreliable by Turks (Aras and Koni 2002, Jörum 2014). Despite these post-imperial antagonisms, intermingling of Arab and Turkish communities continued in the borderlands. This was particularly the case in the contested province of Iskenderun, which was

annexed by Turkey in 1939 after the French retreat and renamed as Hatay (Shields 2011). Syria still claims the area as its own in name, though it is now internationally recognized as Turkish land (Jörum 2014).

Tensions between Turkey and Syria ebbed and flowed in the following decades. Opposing allegiances in the Cold War, water disputes, and Syria's strategic support for Turkey's Kurdish Worker's Party (*Partiya Karkerên Kurdistanê – PKK*) worsened the relationship between the two states until the 1990s (Abou El Fadl 2013; Hinnebusch 2015; Olson 1997). These tensions abated when the current ruling party in Turkey, the Justice and Development Party (*Adalet ve Kalkınma Partisi - AKP*) came to power in the early 2000s and proclaimed a policy of "zero problems with neighbors." Border tensions over land and water supply were transformed into opportunities for cooperation and increased trade. Trade volume between the two countries more than tripled between 2006 and 2010, and discussions of a "zone of free movement" led to visa exemptions for travel between the two countries in 2009 (Aras and Mencütek 2015: 199). The discourse in Turkey began to refer to the two countries as "brothers artificially separated by the break-up of the Ottoman Empire" (Hinnebusch 2015: 14). Turkey and Syria's shared opposition to the Iraq War, as well as a more pointed shared distrust for the creation of an autonomous Kurdish-Iraqi region, brought Prime Minister Recep Tayyip Erdogan and President Bashar Al-Assad politically closer (Hinnebusch 2016).

The two countries' mutual warming of relations in the 2000s was upended in 2011. The self-immolation of a street vendor despairing over dysfunctional Tunisian governance sparked a series of anti-government protests throughout authoritarian states in the Arab World. What came to be known as the Arab Spring protests reached Syria in March of 2011, where they precipitated a brutal crackdown by Bashar al-Assad's regime. A stable Syria would have been in Turkey's

interest, and the Turkish government became frustrated with Bashar Al-Assad's unwillingness to heed calls for reform, instead escalating the conflict into full-scale war. Turkey began to receive refugees, including sizeable numbers of opposition groups and regime defectors. The fragile détente between Syria and Turkey cultivated in the 2000s was upended as Turkey's southern border became a primary gateway for groups opposed to Assad's regime, and Turkey cemented its anti-Assad stance (Hinnebusch 2015).

Overall, the border region between Turkey and Syria has been, for centuries, an area of both Turkish and Arab settlement that is in turn politicized or depoliticized depending on the two neighbors' strategic orientation toward one another. Indeed, the salience of the border has transformed over time—with the gradual establishment of the Hatay border, then as a NATO-USSR border, later as an arena to control Kurdish insurgent movements, a mutually advantageous point of economic exchange, and finally as an increasingly securitized conduit for (and barrier to) refugee movements, humanitarian aid, and tactical military support.

Geopolitics of Temporary Protection

Turkey's Temporary Protection policy was born out of the ruling AKP's geopolitical orientation toward Syria in the immediate aftermath of the Arab Spring protests. The deterioration in Turkey-Syria relations in the wake of the 2011 uprisings is central to understanding Turkey's initially welcoming orientation toward Syrian refugees. At the outset of the uprisings, a Turkey confident in its improved relations with Syria urged Bashar Al-Assad to make concessions to the opposition. Assuming that the Assad regime would not last long, Turkey recognized the Istanbul-based Syrian National Council (SNC) as the official governing body of the opposition (Hinnebusch 2015). Among the SNC were a substantial cadre of the Syrian Muslim Brotherhood, a Sunni Islamic political group that shared mutual affinity with Erdogan's AKP,

making this support politically expedient for both the AKP and the Syrian opposition (Aras 2012). Once Turkey began supporting opposition groups, the "zero problems with neighbors" policy of the previous two decades under the AKP was summarily reversed. Instead, Turkey undertook a broad strategy of supporting Sunni opposition groups, which included safe haven in Turkey for organizational purposes, aid, and arms support (Hinnebusch 2015).

During this period, Turkey began accepting Syrians across the border as "guests" in what came to be known as an "open door policy" for Syrians in 2011 (Kirişci 2014: 5). Movement across the Syrian-Turkish border was not merely a flow of refugees inward, as it is often conceived, but rather a dynamic two-way gateway where refugees and opposition groups entered, while opposition networks and humanitarian organizations coordinated support for rebel-held Syrian territories (Hamdan 2017). Turkey's interest in supporting Sunni Islamist opposition groups was part and parcel of Turkey's larger aims of maintaining regional hegemony in its Ottoman image (Aras and Mencütek 2015; Hinnebusch 2015).

This identity-based political strategy also informed the country's discourse around refugees. Reception of Syrian refugees was framed as a temporary welcoming of Sunni Muslim brothers. Turkey couched its welcome in the Islamic discourse of *ensar* and *muhajir,* a reference to the welcoming orientation of the Muslims of Medina who protected Muslims expelled from Mecca in the 7th century (Akcapar and Simsek 2018; Polat 2018). Yet this open-door orientation was conceived with the view that Bashar Al-Assad's regime would fall swiftly. As the war dragged on and the Assad regime doubled down on its onslaught against opposition, the increase in the number of refugees in Turkey required a more institutionalized system of reception.

Turkey's development of an institutional framework for refugee reception initially relied not on the principles of international refugee or asylum law, but on Turkey's domestic political

calculations. Although Turkey is signatory to the Geneva Convention, it retains a geographic limitation established in 1951. The original text of the Geneva Convention on refugees was conceived in the post-World War II era and limited its scope to refugees fleeing "events originating in Europe". A corollary 1967 Protocol expanded the geographical scope of the law, but Turkey, along with a handful of other countries, did not sign the updated legislation.[13] Given that the refugees that have come to Turkey—like most other countries—have not originated in Europe in the last seventy years, the state has dealt with refugees on an ad hoc basis (İçduygu 2015; Soykan 2012).

Turkey's humanitarian reception toward its "Syrian brothers" was institutionalized in 2013 and 2014. The initial 2011 temporary protection policy, which drew on Turkey's 1994 law on temporary asylum allowing for asylum-seekers to stay in the country while waiting for resettlement elsewhere, was replaced by a new Temporary Protection Regulation within a reinvigorated framework of asylum law (Koca 2016). In 2013, Turkey established a General Directorate for Migration Management and instituted the Law of Foreigners and International Protection (LFIP) as the legal basis for refugee and asylum reception in the country (Aras and Mencutek 2015). The LFIP established the institutional structure for individuals seeking protection in Turkey who cannot return back to their countries for fear of safety, explicitly upholding the international legal principle of *non-refoulement*. Nevertheless, the law still does not define individuals afforded protection as refugees in line with international law, instead applying its own criteria for status determination and application. Only individuals who are

[13] Only Congo, Madagascar, Monaco, and Turkey retained the geographical limitation. See http://www.unhcr.org/en-us/protection/basic/3b73b0d63/states-parties-1951-convention-its-1967-protocol.html.

officially categorized as refugees by the UNHCR in Turkey are given the opportunity to resettle in a third country (İçduygu 2015).[14]

Central to the application of the LFIP is Article 91, which establishes a framework for temporary protection. The Temporary Protection Regulation (TPR) born out of Article 91 delineates the rights and regulations applied to those under protection.[15] These rights include access to basic services, including education, legal employment, and healthcare services. It also applies both geographical and temporal limitations to those under protection. Those with temporary protection must stay either in Temporary Accommodation Centers (the official name of the camps within Turkey that avoids the refugee label) or within the province in which they are registered. Individuals need transit permits to travel between provinces, and the length of temporary protection remains uncertain, more than ten years on from its first application.

All Syrian nationals who came to Turkey on or after April 28, 2011 became eligible for registration under the newly established Temporary Protection framework. Unlike refugee status, which is typically granted on an individual basis, Syrian refugees were granted this status as a national group. By accepting Syrian refugees and providing a relatively generous bundle of rights, Turkey sought to distinguish itself as a moral and humanitarian actor in the region while simultaneously consolidating strategic leverage on refugee flows in the region (Aras and Mencütek 2015). Turkey swiftly became host to the largest refugee population in the world. Yet Turkey's dual role as refugee recipient and Syrian opposition supporter began to pose political costs domestically. For one, domestic constituents became perturbed by the increasing numbers of refugees and perceived security concerns. Combined with a number of cross-border bombings

[14] Law 6458, approved April 11, 2013. Full text available in the Official Gazette *(Resmi Gazete)* No. 28615 or at this link: https://www.mevzuat.gov.tr/MevzuatMetin/1.5.6458.pdf.
[15] For the full text of the Temporary Protection Regulation, published in October 2014 as the implementing framework for Article 91 of the LFIP, see link: https://www.resmigazete.gov.tr/eskiler/2014/10/20141022-15-1.pdf.

that rattled the border region, public opinion toward Turkey's Syria policies began to sour early on (Kirişci 2014: 31). Moreover, the politics of supporting the Syrian opposition became increasingly muddled as the Syrian opposition became progressively fragmented (Aras and Mencütek 2015).

As a result, what was still referred to as an "open door policy" quickly began limiting who could travel through those doors by securitizing the border. As early as 2012, legal border crossings became increasingly circumscribed, and most Syrians began finding alternative ways of crossing the border into Turkey (Okyay 2017). Nevertheless, the transfer of refugee management from the Ministry of Interior to the newly established General Directorate of Migration Management (GDMM) also served to make refugee reception more of an issue of rights rather than security, at least administratively, once individuals were within the borders of Turkey (Norman 2020). An uneasy combination of rights-based laws, moral discourse on humanitarian brotherhood toward refugees, and increasing security concerns about refugee activities came to characterize Syrian refugee reception in Turkey.

Between 2014 and 2016, the number of registered Syrian refugees grew from around 500,000 to over 2.5 million individuals.[16] Turkey's relative generosity toward refugees became a political signal of humanitarian leadership not just in the Middle East but in the world, as the Syrian refugee "crisis" became a central global concern (Çorabatır 2016). This concern was particularly acute in Europe, as progressively larger numbers of refugees began to undertake treacherous and illegal journeys across the Mediterranean Sea or the Balkans in an effort to reestablish their lives in Europe. Given its geographic location, Turkey became the primary transit country for refugees across both routes. While images of teetering dinghies filled with

[16] These data are drawn from the graphics at UNHCR's Operational Data Portal on Syria's Regional Refugee Response, retrieved at https://data2.unhcr.org/en/situations/syria/location/113.

refugees crossing the Mediterranean became increasingly visible in the media, it took the shocking image of two-year-old Aylan Kurdi laying lifeless on the Turkish Mediterranean shores to spur meaningful policy changes to prevent the precarious journeys (Arar 2017).

The centerpiece policy change that came out of the period of increased refugee movements across Turkey was the EU-Turkey Deal.[17] Signed into law in March of 2016, the landmark deal promised six billion euros in aid to Turkey to provide for refugees in exchange for stricter border management with the goal of preventing refugees from crossing illegally into Europe. The deal stipulated that for every refugee returned to Turkey from the Greek Islands, the European Union would resettle one refugee through UNHCR's resettlement procedures.[18] The Facility for Refugees in Turkey was established to fund cash transfer programs for refugees, expand educational infrastructure for refugees, and to improve healthcare access for refugees.[19]

The deal externalized European border control to Turkish authorities and established Turkey as the spigot of refugee flows from West Asia to Europe. This gave Turkey unprecedented leverage in regional affairs, as it could use the refugee flows as a political bargaining chip in negotiations with the European Union for its own political interest. Central to Turkey's maneuvering was the possibility of visa liberalization for Turkish travelers to Europe (Okyay and Zaragoza-Cristiani 2016). While the European Union was criticized for reneging its responsibility to refugees and offloading a divisive political issue onto Turkey, the deal also infused Turkey's refugee institutions with critical funding that the state had largely been

[17] Full details on the EU-Turkey Deal are available at the European Parliament website https://www.europarl.europa.eu/legislative-train/theme-towards-a-new-policy-on-migration/file-eu-turkey-statement-action-plan.
[18] Ibid.
[19] See the EU Facility for Refugees in Turkey factsheet for more details https://ec.europa.eu/neighbourhood-enlargement/sites/near/files/frit_factsheet.pdf.

shouldering before (Rygiel, Baban, and Ilcan 2016). Indeed, it is funding from the EU-Turkey Deal that supported Turkey's major healthcare provision project for Syrian refugees.

As Turkey became the holding ground for refugees on the European frontier, its open-door policy at the Syrian border was gradually securitized. Yet Turkey's concerns at the border were not merely about refugee flows inward. What had begun as support for Syrian opposition groups that represented Turkey's vision for a post-Assad Syria turned into direct Turkish interventionism across the border. Spurred in part by increasing skepticism about international support for Kurdish forces fighting ISIS and the emergence of autonomous Kurdish regions in Northern Syria near the Turkish border, as well as increasing incidences of ISIS-backed terrorism inside Turkey's borders, Turkey began direct military intervention (Okyay 2017; Waldman and Caliskan 2017: 224).

In 2018 and 2019, domestic economic decline, looming local elections, and government concerns about Kurdish groups at the border together altered Turkey's border politics both in the heart of Turkey and at its frontiers. At the Syrian border, Turkey continued to pursue its goal of eliminating any neighboring autonomous Kurdish pockets. Turkey's solution to what it saw as the existential threat of border-adjacent Kurdish administrative entities was to attack them militarily and forcibly create a Sunni-Arab buffer zone along the border, extending Turkish control into Syrian territory (Adar 2020). Turkey now controls a patchwork of territory[20] in Northern Syria (Aydintasbas 2020). The border between Turkey and Syria, as such, is itself no longer a clear boundary but rather a patchwork zone of Turkish control.

Within Turkey's borders, by 2018 there were nearly 3.5 million Syrians registered in Turkey, with an unknown number of unregistered people. While routes exiting Turkey into

[20] Turkey's patchwork territory stretches between Tel-Abyad, and Ras al-Ain, Afrin, the Euphrates Shield Zone, and dominates the city of Idlib.

Europe had been gradually closed with the EU Deal, Turkey began further securitizing its refugee reception regime both at the border and in provinces throughout the country with large refugee populations (Şimşek 2017). In 2018, Human Rights Watch reported that border guards at the Turkey-Syria border were indiscriminately shooting at approaching Syrians trying to cross the border, and those who crossed were being sent back into Syria, a clear violation of the principle of *non-refoulement* enshrined in Turkey's Law on International Foreign Protection and international law (Human Rights Watch 2018a). Moreover, Turkish citizens, already skeptical of the government's generous policies toward Syrian refugees, became more fervently anti-refugee as numbers of refugees continued to increase in conjunction with a deteriorating domestic economy. By 2018, Istanbul and nine other provinces had informally stopped registering Syrian refugees. At this juncture, Human Rights Watch documented an increase in deportations, as well as the unlawful denial of education and healthcare services to newly arrived refugees (Human Rights Watch 2018b).

The severe economic downturn in late 2018 turned already tense relations with the Syrian population more turbulent. Citizens, politicians across the political spectrum, and the media often scapegoated Syrian refugees for taking jobs that led to increases in unemployment rates for Turkish citizens (Cupolo 2019). Given the looming municipal elections in Turkey, the allegedly too-generous AKP policies of refugee reception became a primary campaign target for opposition parties. Again, Syrian refugees found themselves in a precarious situation as political pawns, and, at times, targets of intercommunal violence (International Crisis Group 2018).

By 2018, it was reported that over 80 percent of Turkish citizens wanted Syrians to return to Syria (Karasapan 2019). Provincial governments began to crack down on immigration enforcement policies as public opinion soured and local government capacities to continue

supporting refugees faced increasing pressure. In the summer of 2018, the governor of Istanbul Province issued a memorandum calling for all refugees who did not have Istanbul registrations to leave the province.[21] Those with registrations in other provinces were advised to return to their province of registration, and unregistered refugees were threatened with deportation. During this period, Syrian refugees experiences a flurry of illegal deportations to Syria, often without any notice or explanation of where they were being taken (Human Rights Watch 2018c).

Domestic anti-Syrian refugee pressure played directly into the AKP's foreign policy during the 2018-2019 period. The "safe zone" that the Turkish military sought to carve out along the border in order to push back the Kurdish forces and communities, it was announced, would also serve as a region to repatriate (Sunni Arab) Syrian refugees from Turkey. Despite the legal, economic, and logistical questions that swirled around this dubious proposition, it served to rally much of the Turkish population's support for Turkey's interventions into Syria (Adar 2020). On the domestic front, however, the ruling AKP was still dealt a decisive blow in the municipal elections, when Ankara and Istanbul mayoral races were both won by the main opposition party candidates from the Republican People's Party (CHP). Nevertheless, the AKP retains control of the national government, even withstanding a closely contested election in 2023 that many imagined would be a decisive referendum on Erdogan's poor handling of the economy as well as his refugee policies. Throughout this period, Turkey continued to both exert its direct control in the Syrian border region and to limit further numbers of refugees from registering in the country. While the government has not carried out a massive repatriation project, it has been reported that Sunni Muslim families of members of the Turkish-backed Syrian National Army have been settled in the buffer zone region (Aydintasbas 2020).

[21] For the press release of the governor's statement, see "Düzensiz Göçle Mücadele İle İlgili Basın Açıklaması, T.C. İstanbul Valiliği, 22 July 2019: http://www.istanbul.gov.tr/duzensiz-gocle-mucadele-ile-ilgili-basin-aciklamasi.

Ultimately, Turkey's "open doors" were gradually closed, first by securitizing the southern border, and later by limiting the provinces in which individuals could register. The punitive turn toward deportations and the policing of province-based registration statuses has further chilled the humanitarian ethos of the policy. Nevertheless, despite the temporary basis for the status regime, the government continues to legally uphold the rights of those who hold the status, within their province of registration. Healthcare is one domain in which the state has actively expanded its efforts in providing care for registered refugees. The fate of the unregistered, or those living in provinces other than the one they are registered in, remains precarious. The next section examines the institutional precursors to configurations of state healthcare for refugees.

Temporary Protection and the Right to Healthcare

The extension of free healthcare services to Syrians registered under Temporary Protection Regulation is a commendable policy. Many countries—the United States included—do not even extend such a right to their citizens, let alone to immigrants. The policy is part of a larger project of the universalization of health care services for Turkish citizens that the ruling-AKP undertook in the mid-2000s. In order to understand the nature of Syrian refugees' access to the Turkish healthcare system, as well as its shortcomings, it is important to understand the Turkish system into which they have been integrated.

Turkey's March Toward Healthcare Universalism

Since the establishment of the Turkish Republic in 1923, the goal of creating a robust nation-state has been intertwined with improving healthcare provision and access. Healthy citizens meant productive citizens—both economically and biologically—who could perpetuate the Turkish population. Healthcare provision became a political issue in the post-World War II era,

when the establishment of a multi-party system ushered in electoral competition and political commitments to expand care. Institutionally, the state generally had two institutional objectives in healthcare provision—the expansion of primary care to rural populations in the provinces and the systematization of social protection for formal workers (Agartan 2008; Tatar et al. 2011).

Social protection for workers was systematized from the 1950s to the 1960s. Narrowly targeted employment-based insurance schemes for civil servants (Retirement Chest, or *Emekli Sandığı*) and formal workers (Social Insurance Institution, *Sosyal Sigortalar Kurumu – SSK*) were gradually expanded to self-employed workers in the 1970s (*Bağ-Kur*), with healthcare's late inclusion into the scheme in the 1980s. During this period, informal workers and other uninsured populations often relied on informal mechanisms of social welfare tacitly tolerated by the state. In the realm of healthcare, this meant that many uninsured citizens would go to hospitals with others' ID cards, and doctors would look the other way. Ağartan (2008) refers to the emergent system as a "dual welfare system" in which formal workers were entitled to generous benefits while informal workers navigated the healthcare system using piecemeal, improvised practices.

The corporatist model was transformed beginning in 2003 with the AKP's Health Transformation Program (HTP) reform. Led by Prime Minister Recep Tayyip Erdogan, the AKP implemented a new healthcare insurance system that eliminated the tiered corporatist model and replaced it with the single payer Social Security Institution (*Sosyal Güvenlik Kurumu - SGK)*. Under the new system, state providers that used to be linked to specific insurance funds were transferred to the Ministry of Health and financed by the state. As in the case of many healthcare reforms during this period, the World Bank and other international institutions had a firm hand in shaping the reforms, training the implementing personnel, and financing the project (Yilmaz

2017, Agartan 2008). This universalization was also accompanied by increasing marketization of healthcare, with a growing prevalence of private healthcare providers, which could negotiate contracts with the SGK. Insured patients could then choose between free state care or private care for an additional fee (Agartan 2012). This dual process of privatization and universalization is particularly relevant to discussions in chapters 6 and 7.

Structurally, the HTP established a number of reforms that shape how both citizens and immigrants navigate the healthcare system today. Under the Ministry of Health, private healthcare facilities increased in number as the government encouraged competition among providers and established a purchaser-provider split in which the Ministry of Health controlled providers while the general insurance fund of the Ministry of Labor and Social Affairs purchased services. Moreover, the primary care system that the state had built up over the past decades was transformed from a population-based system of community health centers to a family care-based referral system. In the new system, Family Health Centers (FHCs) were established separately from pre-existing primary health centers, which were Community Health Centers. In the FHC system, providers maintained their own patient lists rather than being assigned geographically predetermined patients. While this reform aimed to reduce demands on hospital care, the referral system was never formally implemented, making FHC utilization highly uneven (Öcek et al. 2014). The reform also established a national pharmaceutical agency and instituted a new automated healthcare information system (Agartan 2008).

The HTP was largely touted as a success in improving healthcare access and making access more equitable (Baris, Mollahaliloglu, and Aydin 2011). Other scholars have acknowledged these egalitarian strides while sounding alarm about the new inequalities that emerge in an increasingly privatized system where those who can pay the extra fees for private

care are able to access superior care (Agartan 2012; Yilmaz 2013). The reform also institutionalized monthly premiums and contributory payments for outpatient services beyond the level of primary care, except in cases of emergency (Yilmaz 2013). These payments—and the fact that at the outset of refugee reception these payments were not applied to Syrians—contributed to Turkish citizens' antipathy toward state policies or refugees (Siviş 2022).

As it stands today, the Turkish healthcare system is run by the Ministry of Health and financed by the Social Security Institution (SGK) under the Ministry of Labor and Social Affairs. The SGK covers Turkish citizens who were covered by previous social insurance schemes and those who have unemployment insurance. It also covers foreign residents without coverage in their home countries and individuals under International Protection as governed by the LFIP. All primary care services are provided for free, and any healthcare costs in secondary or tertiary care institutions that are covered by the Health Implementation Guide (*Sağlık Uygulama Tebliği – SUT)* are provided for free. Costs for treatments that are not fully covered are outlined in the SUT regulations (Bilecen and Yurtseven 2018).

Beyond the SGK insurance scheme, emergency services are provided to anyone within Turkey for free. The Regulation on Emergency Healthcare Services provides free assessments for anyone who comes to the emergency department. After determination by healthcare officials as to whether the treatment merits emergency care, the treatment is either covered or transferred to the standard SGK scheme of healthcare coverage. Importantly, free emergency care legally includes all unregistered migrants and refugees, who are otherwise excluded from the Turkish healthcare system (Bilecen and Yurtseven 2018). In practice, emergency care is not always provided for free for unregistered refugees and other foreigners. Instead, healthcare providers sometimes charge individuals the steep fees imposed by the Health Tourism Regulation, even

though this regulation is not supposed to be applied to emergency care (Sevinin 2020). This will be discussed in more detail in chapter 7.

There has been a long arc toward healthcare universalism in Turkey. While these goals were first explicitly set forth by politicians in the 1960s, the last three decades have shown clear and seismic policy changes to try to realize this goal. The question as to how far healthcare universalism should extend in practice—to those under temporary protection, or all migrants regardless of registration status—has become a pressing political issue with the continued arrival of Syrians and other refugees in Turkey. In terms of the structure of care, building up a preventative primary care system and then instituting a family care system has also been a decades-long project. Yet the piecemeal implementation of the referral system has led to a somewhat awkward relationship between family health centers, community health centers, secondary care providers, and pharmacies (Öçek et. al. 2014).

Turkey's decision to focus its migrant healthcare efforts on primary healthcare therefore had some coordination issues that extend back to the system in place prior to their arrival and incorporation. Additionally, the establishment of a general health insurance fund was meant to make access to care universal. Yet this universality, when extended to non-citizens, has created friction between Turkish citizens and Syrians. Finally, the increasing prevalence of private care and the marketization of care have also manifested in migrant healthcare in the form of Syrian healthcare providers which straddle an ambiguous space between NGOs, private hospitals, and private medical tourism providers. All of these phenomena will be explored in the empirical chapters of the dissertation.

Syrians' Access to Turkish Healthcare

When Syrians first started arriving in Turkey, their healthcare needs were addressed through institutional structures of humanitarian care. This period, characterized by state management and NGO support of humanitarian health aid to Syrians, was oriented primarily towards alleviating the emergency healthcare needs of newly arrived refugee guests. Activity was concentrated in the border areas, and hospitals were dealing with individuals arriving with injuries. Refugee healthcare was largely managed under the Regulation on the Center for Disaster and Emergency Management passed in February of 2011. The Turkish Disaster and Emergency Management agency (*Afet ve Acil Durum Yönetimi Başkanlığı - AFAD*) was tasked with coordinating the country's refugee response, including healthcare access.

During this initial period, AFAD managed camps in the border region that provided basic needs, including healthcare and education. NGOs became important actors in providing healthcare support in urban areas as well, as the number of Syrians arriving in Turkey increased into late 2012. Large NGOs would provide medical deliveries to camps and help coordinate transportation of individuals from camps to hospitals, while also providing emergency care near the border gates (Özden 2013: 9).

This emergency response was gradually regularized, first with a series of circulars institutionalizing healthcare for refugees under the coordination of AFAD, then with a new and comprehensive legal framework for Syrian refugee reception in Turkey. A series of AFAD circulars in 2013 established free healthcare for Syrians in camps and non-camp refugees in ten border provinces, then later all 81 provinces in the country.[22] Rights for Syrian refugees were

[22] The first circular, titled "Health and Other Services for Syrian Guests", was passed in January 18, 2013. The geographic scope was expanded with the September 2013 "Circular on Health and Other Services for Syrian guests," the latter of which is available at this link: https://www.afad.gov.tr/kurumlar/afad.gov.tr/2311/files/Suriyeli_Misafirlerin_Saglik_ve_Diger_Hizmetleri_Hakkinda_Genelge_20138.pdf.

formally and comprehensively delineated with the Temporary Protection Regulation under the 2014 Law on Foreigners and International Protection (LFIP). The Temporary Protection Regulation ensures the immediate provision of emergency care for those in need,[23] as well as the provision of healthcare by the Health Ministry in temporary accommodation centers, and ensures free primary care for infectious disease, women's health, mental healthcare, children's care, and vaccination, all covered by the Social Security Institution and reimbursed by AFAD.[24]

Importantly, TPR limits the utilization of healthcare to an individual's province of registration. The TPR healthcare rights are further elaborated in a Ministry of Health Circular from March of 2015, which affirms he humanitarian nature of healthcare provision for refugees while detailing the standard process through which Syrians—like citizens—should navigate the Turkish system. First detailing the process of providing emergency care to anyone injured who has not yet been registered[25], the circular goes on to explain the process through which those who register will be able to avail themselves of primary, secondary, and tertiary care (with referral) in their localities. While the original March 2015 circular required that Syrians have referrals from primary care providers to access secondary care in state hospitals, this requirement was eliminated in a November addendum, allowing those with temporary protection to directly approach secondary care. This change created some confusion among both providers and patients, many of whom continued to operate as if referrals were required for secondary care, unaware of or unwilling to implement the change.

The Temporary Protection ID numbers made it possible for Syrians to be entered into the Ministry of Health's online patient portal, called MEDULA. Yet this transition too created some

[23] Article 20, TPR.
[24] Article 27, which is the main healthcare-related item in the TPR legislation.
[25] Article 5, TPR.

initial confusion. Syrians who registered in Turkey were given initial foreign ID numbers starting with the number 98. These ID numbers were to serve as evidence of legal residence in Turkey. However, the official Temporary Protection ID numbers rolled out in 2014 followed a different numerical scheme and started with the numbers 99. Only the latter could be registered in the MEDULA system (Refugee Rights Turkey 2017). As a result, Syrians who had begun the registration process but had not yet received the official 99 cards could not be entered into the official system for healthcare services. This process of full registration often took months, if not over a year, once the numbers of refugees arriving in Turkey increased. This left many Syrians in an administrative no-man's land when visiting healthcare providers.

The 2015 circular also explains how healthcare services will be rendered for free to Syrians under temporary protection. Unlike citizens, until recently Syrians registered for Temporary Protection did not have to pay a contribution fee to the SGK for their healthcare coverage. AFAD would also pay 80 to 100 percent of all costs for medicines prescribed to Syrians (Bilecen and Yurtseven 2018). This measure caused a number of issues both in terms of its domestic optics and its implementation. For one, the idea of free medicine for refugees led to frustration among Turks who felt that refugees were being treated more favorably than citizens in the healthcare system (Siviş 2022). Secondly, while AFAD was slated to reimburse pharmacies for medicines distributed to refugees, there were serious delays in the reimbursements that made pharmacies unwilling to provide refugees the medicines they were legally entitled to. Indeed, in March of 2015, 5,000 pharmacies in Istanbul came to a joint decision to stop providing free medicines to refugees due to a nearly year-long delay in receiving AFAD's reimbursements (Özgenç 2015).

Increased pressures on the healthcare system were not limited to pharmacies. The lack of translators or healthcare personnel that could communicate with the largely Arabic-speaking Syrian population, as well as a general increase in numbers of people seeking care, led to a variety of difficulties in both provision and access. A study conducted in 2015 by the Ministry of Family and Social Affairs found that the majority of Turks blamed the influx of Syrians on deteriorating healthcare services (Önder 2019). Recognizing the challenges of providing access through the state healthcare system, the 2015 circular outlining the parameters of provision and access also laid out the legal requirements for humanitarian organizations' provision of healthcare to refugees. According to the circular, nonstate organizations could apply to the Ministry of Health for legal status as purveyors of health services so long as they were staffed with registered doctors, operated out of legally compliant facilities, provided care to registered refugees, and did so for free. These applications would need to be renewed every six months.[26] While a number of nonstate organizations applied for this status, the law was not fully implemented and those that received initial permissions were not officially renewed within the parameters of the law after six months (Yıldırım, Komsuoğlu, and Özekmekçi 2019).

The government also began operating Migrant Health Centers in conjunction with existing community health centers in order to provide primary healthcare to migrants and refugees. Established under the "Migrant Health Centers/Migrant Health Units" circular in September of 2015, these Migrant Health Centers were established to relieve Family Health Centers of the added burden of caring or refugees by staffing social workers, physiologists, and translators (Ekmekci 2017).[27] The creation of these MHCs at times created more trouble for

[26] Item 10, TPR.
[27] Ministry of Health Law No. 49654233/703.99, passed September 3, 2015, available here: https://hsgm.saglik.gov.tr/dosya/mevzuat/genel_nitelikli_yazilar/toplum_sagligi_db/GOCMEN_SAGLIGI_MERKEZLERI-BIRIMLERI.pdf.

Syrians at FHCs, because doctors could now use the MHCs as an excuse to refuse to add Syrians to their patient lists. Moreover, the original iteration of these centers did not meaningfully alter the landscape of care for refugees; this is because the doctors working in the centers were still Turkish, like in the Family Health Centers, and communication barriers remained.

The 2016 EU-Turkey Deal was a turning point in healthcare provision for Syrian refugees in Turkey. Of the six billion Euro deal, 300 million Euro was earmarked for the Ministry of Health to fortify its refugee healthcare services. This infusion of funds was used to finance a project for "Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities," referred to by its Turkish acronym as the SIHHAT Project.[28] The aim of the SIHHAT Project was to provide expanded primary care services in Arabic to Syrians under temporary protection. It also presented an employment opportunity for Syrian healthcare personnel. In 2016, the "Regulations for Work Permission for Foreigners under Temporary Protection" was passed, providing a legal pathway for the employment of Syrian healthcare workers. This law facilitated employment of the SIHHAT Project, which trained Syrian doctors, nurses, and translators to work in Ministry of Health-run Migrant Health Centers (MHCs). A total of 790 "migrant health units," comprised of one Syrian doctor and one Syrian nurse, were trained to work in 178 MHCs established in parts of Turkey with high refugee populations. The geographic distribution of the MHCs would aim to assign about 4000 patients per doctor (Yildirim, Komsuoglu, and Ozekmekci 2019). By September of 2020, the 178 MHCs had been completed, providing Syrians with the option of

[28] The full Turkish name is Geçici Koruma Altındaki Suriyelilerin Sağlık Statüsünün ve Türkiye Cumhuriyeti Tarafından Sunulan İlgili Hizmetlerin Geliştirilmesi Projesi, abbreviated to SIHHAT, which means "health" in Turkish.

Arabic-language primary care. In 2021, the Turkish government began SIHHAT-2, a reinforcement of the existing system, with three additional years of funding.

In addition to the SIHHAT Project, the centerpiece of refugee healthcare services in Turkey, some healthcare laws have been altered since the initial legal frameworks were established in 2014 and 2015. In 2016, a separate Migrant Health Directorate responsible for refugee healthcare planning and coordination, data collection, and NGO management was established under the Public Health Directorate.[29] Moreover, the financing of refugee healthcare was shifted from AFAD, which is an emergency/disaster-oriented agency, to the General Directorate of Migration Management in March of 2018 (Önder 2019). While healthcare services remained covered for Syrians in line with the General Health Insurance scheme, the shift indicated a recognition of the fact that reception of Syrians was no longer an emergency action but rather a longer-term issue of migration management and integration. Moreover, in 2019, the Temporary Protection Regulation was amended to note that those under protection would have to start paying contribution fees to the General Health Insurance for treatment and medicine, but the amendment was perhaps intentionally vague about these fees.[30] The gradual shift of healthcare financing and provision for refugee healthcare signaled broader changes, and political ambivalences, of Syrian refugee reception in Turkey.

An Overview of Syrians' Healthcare Utilization

[29] The Migrant Health Directorate was established in 2016 with Ministry of Health order No. 1252. The directorate's responsibilities were laid out in the "Directive on Services and Duties of the General Directorate of Public Health," No. 934 passed on October 3, 2017.

[30] Official Gazette No. 30989, Decision No. 1851, passed December 25, 2019." https://www.resmigazete.gov.tr/eskiler/2019/12/20191225-38.pdf.

There have been few systematic analyses of Syrian refugees' healthcare in Turkey.[31] This may be in part because, according to more general surveys, healthcare is one of the services that Syrians are most satisfied with in Turkey, in relative terms (Erdoğan 2018). Along with education, healthcare is a domain in which Syrians under temporary protection have legal rights that are roughly on par with Turkish citizens. Healthcare access, however, has not been without its challenges. Research on Syrian refugee healthcare in Turkey has often looked at women's health (Ozel et al. 2018; Samari 2017), infectious disease incidences (Ergönül et al. 2020), psychosocial health (Abou-Saleh and Hughes 2015; Alpak et al. 2015; Tekeli-Yesil et al. 2018) and specific illness incidences (Güngör et al. 2018; Göktaş 2018). These studies conducted by medical researchers and public health scholars are critical to understanding health outcomes among Syrian refugees. But, necessarily, they are analyses that can only begin at and after the point of access to care services.

There is also a body of scholarship on access to care (see Alawa, Zarei, and Khoshnood 2019; Assi, Özger-İlhan, and İlhan 2019; Bilecen and Yurtseven 2018; Ekmekci 2017; Sahlool, Sankri-Tarbichi, and Kherallah 2012; Saleh, Aydin, and Koçak 2018; Sevinin 2020; Tayfur, Günaydin, and Suner 2019). Much of this research on access relies on secondary data analysis and legal analysis. Few studies systematically analyze data collected in direct contact with Syrians living in Turkey. A few surveys and studies, however, have directly harnessed responses

[31] A notable exception is Faize Deniz Mardin's 2019 dissertation *Sığınmacıların Sağlık Hizmetlerine Erişimi: Metropol - Uydu Şehir Karşılaştırması*, or *Refugees Access to Health Services: Metropole-Satellite Comparison,* completed for a public health degree at Istanbul University. The dissertation offers a comparative analysis of refugees' healthcare access between Istanbul and Eskisehir, implementing a metropole versus satellite frame as an axis of comparison. Mardin's dissertation pinpoints many of the important issues surrounding refugees' access to care, including language barriers, delays in TPR registration and resulting lack of access to care, and the general experiences of uncertainty among refugees. One key finding of Mardin's dissertation is that refugees in Istanbul face considerably more barriers in accessing care than those in the satellite city, due to long TPR registration wait times. The fieldwork was conducted before the implementation of SIHHAT and captures an important snapshot of the main problems preceding the creation of Migrant Health Centers. Many of the problems Mardin identifies persisted even after MHCs were established (Mardin 2019).

from Syrians about their health status and access to care before the point of access. Reports from government agencies are some of the most comprehensive sources that draw on survey data from Syrians. An early survey by AFAD of refugees in Temporary Accommodation Centers and non-camp refugees in areas with high refugee populations was conducted in 2013, before TPR was passed, to get a general sense of the demographics and needs of Turkey's Syrian "guests". The survey found that while nearly all refugees in camps had access to care, only 58 percent of non-camp refugees did. The report surmised that the low level of access was explained by refugees not yet having formal registration, a problem that could be bureaucratically remedied (AFAD 2014).

Another survey of Syrians' living conditions in Turkey conducted in 2016/2017 by AFAD addressed access to healthcare again, with more detail. The survey sampled individuals in provinces with large refugee populations as well as within temporary accommodation centers. The survey found that, again, while virtually all refugees staying within Temporary Accommodation Centers had access to healthcare, this figure dropped substantially for individuals who resided outside of the camp setting. Among those surveyed, 67 percent of men had access to healthcare while 61 percent of women said they had access. That left about 34 percent of refugees outside of camps without access to healthcare. It is noteworthy that even with the establishment of TPR, and plenty of time for its implementation, statistics on access were only marginally improved from the 2013 survey. This time, the survey probed the topic further. While most individuals with access noted that they were either satisfied or very satisfied with their care, these figures were systematically more negative among women, especially those who were living in non-camp settings. Moreover, among individuals surveyed who did not access Turkish healthcare services, 29 percent noted that they did not know where to go, 15 percent said

they do not have the right to care, and 13 percent noted that they could not afford care (AFAD 2017).

These figures give some preliminary, albeit incomplete insight into challenges that Syrians face accessing healthcare in Turkey. The binary question of access versus lack of access leaves little space for an understanding of how brick and mortar access may not translate into attaining requisite care, the challenges individuals face navigating the complex healthcare system, and the interpersonal challenges that individuals may face in the clinical encounter. Moreover, it is not clear what access entails in terms of the types of institutions that refugees are encountering. Individuals may have easy access to primary care but have greater difficulties in hospital settings, or vice versa. Moreover, individuals may be resorting to private services or informal services due to difficulties with the state system. In these cases, individuals may have access *in spite of* the existing government-run refugee healthcare system rather than because of it.

One other large-scale survey conducted in 2017 by the WHO in coordination with the Ministry of Health and AFAD and published in 2019 provides a detailed look at Syrian' healthcare utilization in particular. The survey, entitled "Survey on the health status, services utilization and determinants of health of the Syrian refugee population in Turkey," is the first to delve deeply into different facets of healthcare access among Syrians throughout the 15 provinces with the highest numbers of Syrian refugees, in addition to previously surveyed topics on demographics and health status. The survey provides critical insight into broader trends of healthcare service utilization. It finds that overall, Syrians are most likely to visit hospitals (66.9 percent), with 31.6 percent utilizing family health centers, 15.6 percent utilizing emergency services, 14.5 percent using migrant health centers and 7.3 percent using outpatient services.

These general results are notable for a number of reasons. For one, the findings indicate that the majority of Syrians are likely to skip primary care services altogether, going instead directly to hospitals for their care. This behavior is at cross-purposes with the signature healthcare project for refugees, which concentrated the lion's share of resources at building up primary care centers with Arabic language care. Given that this survey was conducted while MHCs were still being established, however, it is unclear what the effect on service utilization will have been once they became fully operational. Nevertheless, it is worth noting that, in total, 57 percent of respondents had never accessed primary care services in Turkey.

Another notable finding within this survey is the wide geographic variation in the ways that Syrians access services. For example, almost eighty percent of refugees in Mardin had accessed Migrant Health Centers, whereas in neighboring Şanlıurfa, barely three percent of refugees had done so. In comparison, in Istanbul, Gaziantep, Şanlıurfa, and Hatay, the provinces with the highest numbers of Syrian refugees in the country, fewer than 16 percent of those surveyed were utilizing Migrant Health Centers. These statistics may be a function of where MHCs first became operational or the effectiveness in spreading information about MHC availability in localities. It could also have something to do with the relative availability and accessibility of other types of services where refugees could access care. Finally, it could be related to the ways surveys were conducted in various regions—it appears that Mardin recorded systematically markedly higher access to all types of services than other regions.

Finally, the survey also accounts for patient satisfaction with available services. In general, Syrian refugees are "very satisfied" or "somewhat satisfied" with most services, rating FHCs, MHCs, hospitals, outpatient services, and pharmacies as such between 82 and 93 percent of time. Yet of note is a particularly high rate of dissatisfaction in Istanbul with MHCs at 14.8

percent, and 14.2 percent in Istanbul also dissatisfied with emergency services. Other pockets of marked dissatisfaction occur with outpatient services in Gaziantep at 31.7 percent, hospital services and pharmacy services in Bursa at 14.2 percent and 20.7 percent, respectively, and emergency services in Izmir at 10 percent. These variations underscore the need to understand the full landscape of available care within specific localities as well as the particular kinds of barriers—or notably effective institutions--within these different landscapes. The results also beg for longer, qualitative analyses that examine what types of experiences animate dissatisfaction and satisfaction across space and time.

One additional aspect of the healthcare system that is left out of this detailed analysis is the breakdown between utilization of private and public services. "Outpatient services" as a category may partially get at this, though the rest of the categories are ambiguous about what types of hospitals or clinics individuals are utilizing. Indeed, the category of "refugee health center," which is taken as synonymous with Migrant Health Centers in the report, could in fact be interpreted by respondents as private refugee-run clinics outside of the state system. These are a different category of provider worth accounting for separately in an analysis of refugee health care, given that it is fee-for-service and often unregulated by the state. Part of the reason for this gap in the analysis is that the Temporary Protection Regulation technically does not allow those under protection to access private care except through referral or in emergency situations.[32] This is, in practice, a rule that is not enforced.

A handful of studies have probed the issue of healthcare access on a more local level. A general survey conducted jointly by the Support to Life NGO and Ayhan Kaya of Istanbul Bilgi University in 2016 in Istanbul asked refugees in high refugee population municipalities about

[32] Article 27, Item d, TPR.

their access to care. In general, the survey found that access to services, including healthcare access, is not seen by Syrians as one of the main problems they face in Istanbul, with only 6 percent of men and 8 percent of women saying that it was a main problem. Unemployment, labor exploitation, discrimination, poverty, and the inability to speak Turkish ranked as more acute problems in the survey, though the latter three directly affect individuals' ability to access health care (Kaya and Kıraç 2016). Nevertheless, when asked specifically about healthcare access, 25 percent of respondents in Istanbul noted that they did not have any access to care. The remaining 75 percent noted access, but the report characterizes this as "access, albeit partial" due to the difficulties of getting the requisite care (Kaya and Kıraç 2017: 28). Among those who could not access any care, the language barrier (26 percent), financial barriers (22 percent), lack of registration (16 percent), and perceived unwillingness of health personnel to provide care (13 percent) were the main barriers reported. This survey quantifies some of the anecdotal data captured in news reports and qualitative studies about refugees' barriers to access and demonstrates persisting issues with access in spite of the implementation of TPR.

An even more localized, but more richly qualitative study conducted in 2015 captures some of the nuances of healthcare access among Syrians residing in the Zeytinburnu municipality within Istanbul. Using 111 household interviews with Syrian women for the survey, including 31 semi-structured interviews, the study finds that, while 80 percent of the women interviewed had temporary protection IDs, half of them did not know about their right to free access to healthcare. Among those interviewed, within the last month, 40 percent had accessed care at a government hospital, 34 percent at a family health center, and 17 percent noted that they had received some sort of care at a pharmacy. According to the report, a small number had gone to private clinics as well. Respondents to the qualitative interviews noted that the lack of female

doctors, difficulties making appointments, long waiting times, and challenges obtaining medicine led to dissatisfaction with the healthcare system. The report also notes that distrust of Turkish doctors had led individuals to utilize informal Syrian clinics. These clinics have only received a passing glance in the scholarship on access to care, though their importance as Arabic-language care providers for individuals who face obstacles in the Turkish care system has been recognized (Cloeters and Osseiran 2019).

The studies briefly summarized in this section provide some of the few analyses of Syrians' access to healthcare using either large-N samples or systematic qualitative interviews directly with Syrian refugees. Numerous studies exist that outline the basic barriers to care—language barriers, bureaucracy, and discrimination—and these will be addressed in concert with the analytical chapters of the dissertation. Nevertheless, the lacunae in refugee perspectives on the complex and changing landscape of healthcare access, particularly as it pertains to care beyond the public system, remains. The remainder of the dissertation examines how the field of refugee healthcare has institutionalized over time, accounting for Syrian refugees' access needs, Syrian doctors provision efforts, and shifting laws in both access and provision.

Chapter 3: Hybridizing Humanitarian Care

The entrance to the Shifa Clinic is on a side street branching off a bustling artery of Istanbul. On the main drag, the Arabic language interweaves with Turkish on business placards and in the conversations of passersby. Eager employees on the sidewalks cajole pedestrians to enter their businesses using both languages, young women in long dresses saunter in and out of modern coffee shops in large groups, and men smoking cigarettes sit on stools outside the more traditional tea houses. The street is dotted with shops, medical supply stores, and cafes. Every third building reads: ECZANE - الصيدلية - PHARMACY. There is a distinctly visible commingling of Arab and Turkish Muslim life on the streets--on its walls, in its businesses, and among its people.

Unlike most of the medical establishments concentrated in this neighborhood, the Shifa Clinic had no exterior labels in 2018. Signs that previously demarcated the entrance to the health center were taken down by management out of fear that too much visibility might attract unwanted attention. From whom, it was not entirely clear. Perhaps regulators from the Provincial Directorate of Health, perhaps the police, perhaps nearby healthcare providers, perhaps neighborhood denizens. The only hint that there was a health clinic in the building was the steady stream of people, often women with strollers, entering and exiting the building. After navigating the congested narrow hallway and advancing past the payment and scheduling desk, the crowds would multiply, stretching into the main waiting room, upstairs, and into the second floor.

The Shifa Clinic was a healthcare clinic run by Syrian doctors who live in Istanbul. It provided Arabic-language care to migrants and refugees looking for convenient, accessible care. A consultation with a physician cost the equivalent of about $5. There were, at its peak, over

fifty doctors working at Shifa, covering most specialties. The doctors, however, could not perform any complex procedures—it was "standing patient only". The clinic first opened in 2012 as a small medicine dispensary but had since grown into a four-story enterprise. Yet, despite persistent efforts to formalize, it still did not have the necessary permissions to function legally in 2018. Although the Ministry of Health was well aware of its operations by then, even working in collaboration with the clinic at times, the pathway to formalization remained unclear. The Shifa Clinic, along with dozens more informal Syrian refugee-run clinics like it across the city--around 40 to 50, by multiple accounts--continued to see tens of thousands of patients a month. These operations continued despite the availability of free state healthcare for Syrian refugees under temporary protection in Turkey, and despite the fact that they were informal. How and why did these clinics survive?

This chapter examines the operational strategies of seven refugee-run health clinics in one neighborhood of Istanbul. The seven clinics were all operating in a grey area of informality in 2017, during my first foray into the refugee healthcare field in Istanbul. By the summer of 2018, one had been shut down by the police, while the other six had adapted various survival strategies to perpetuate their operations, with various degrees of stability. The chapter draws primarily from interviews conducted with Syrian managers of these clinics, as well as doctors working in them, conducted both during their struggles with organizational survival and retrospectively a few years later, as they made sense of the trajectories of the organizations they worked at. These interviews are supplemented with interviews with other actors in the healthcare field, including NGO employees, Turkish doctors, and Ministry of Health officials. Interviews were conducted over a series of visits to Istanbul between 2017 and 2022, as both laws and enforcement practices evolved across a number of domains affecting refugees' lives. These

included refugee health care provision policies, individual registration policies, employment policies for doctors, and deportation policies. This chapter focuses on the period before government Migrant Health Centers that employed Syrian doctors started operating to provide linguistically competent care for refugees.

Applying the organizational concept of hybridization, it examines the relative success or failure of strategies refugee-run health clinics used to survive in an uncertain regulatory context. The chapter finds that in the temporary policy contexts of refugee reception, immigrant organizations survive when they can situate themselves in politically favorable networks that allow them to (1) legitimize themselves and (2) garner resources. This, critically, extends beyond the host state "context of reception." It includes embedding into favorable geopolitical and international networks that align with host government political aims.

Hybridizing immigrant organizations are able to accomplish the two interrelated goals of legitimization and resource accrual by strategically aligning themselves in what I call the "humanitarian niche". The humanitarian niche is an organizational niche that opens with the shock of refugees' arrival in a new location. This niche is typically filled by NGOs, international organizations, and grassroots organizations that are meant to operate as temporary stopgaps to cope with refugees' needs. Though temporally unstable, the "humanitarian niche" is formed by the demands of a newly arrived immigrant population as well as a variety of political and practical institutional needs in the host state context. In this empirical case, refugee-run health clinics combine humanitarian activities--often in a religious idiom—with fee-for-service healthcare services; while the latter meet patient demand, the former is the key factor in organizational legitimation in the context of Turkey's temporary protection policy, which is explicitly predicated on a logic of humanitarianism and implicitly driven by Turkey's

geopolitical interests in the region. More broadly, I argue that in contexts of migration policy turbulence, immigrant organizations can extend their survival in a host community by combining their more legally precarious services with (geo)politically palatable programming.

Hybridization and the Humanitarian Niche

In sociology, a "niche" refers to a constrained environment in which organizations can draw on resources and thrive (Popielarz and Neal 2007). This environment includes the social, economic, and political conditions that both sustain organizations and limit operational possibilities (Hannan, Carroll, and Pólos 2003). Immigrant entrepreneurs often identify or carve market niches in their adopted communities, drawing on group resources and untapped demand in a locality (Zhou 2004). Niches may form gradually, as sustained immigration leads to a critical mass of demand for a service or good, as does the accrual of social capital, economic resources, and local know-how among entrepreneurs. Yet, niches can also open suddenly. Swift refugee migration to a specific locale is a profound exogenous shock to an existing organizational terrain of service and goods provision, straining existing organizations and opening up space for the emergence of new organizational forms. This shock creates the "humanitarian niche".

Organizational theory provides useful tools to account for the processes through which new organizations form and attempt to stabilize in the aftermath of profound jolts. Destabilizing shocks, or "punctuated equilibria," often lead to the creation of new hybrid organizations that may be temporary or unstable (Krlev and Anheier 2020: 496). Hybrid forms attempt to reconcile competing environmental pressures as they cobble together organizational elements from different sectors (Minkoff 2002; Pache and Santos 2012; Smith 2010, 2014). They may combine different "logics", such as market, state, community, family, and religion (Skelcher and Smith

2015). They may also span more specific organization-level categories (Hsu, Hannan, and Koçak 2009).

The "humanitarian niche" that is forged in the immediate aftermath of refugee migration to a locale provides an analytically rich site to analyze dynamics of organizational emergence, hybridization, and survival. In the context of temporary protection, migration policy itself is motivated by a logic of humanitarianism. Yet organizations must contend with multiple state institutions that may circumscribe organizational activities. These include rules in a variety of domains, including employment laws, organizational registration laws, healthcare laws, and education laws, which are enforced at different levels of governance. There may be changes in these rules, both in terms of their substance and their enforcement, over time. Organizations the emerge in the humanitarian niche, then, must cope with profound institutional, scalar, and temporal uncertainty.

Canonical work in neo-institutional theory posits that in contexts of uncertainty, organizations will generally mimic organizational forms they perceive as successful (DiMaggio and Powell 1983). Yet when organizations are subjected to multiple pressures from different constituents, this path toward institutionalization can make imitation or conformity to all pressures impossible (Pfeffer and Salancik 1977). In cases where organizations face pressure from multiple constituents, Oliver (1991) suggests that organizations may compromise, avoid, defy or manipulate various pressures in order to reduce uncertainty and resolve conflict.

When organizations hybridize, they seek legitimacy not through imitation, as neo-institutional theory would predict, but by adapting themselves to specific tasks for which they are uniquely suited (Krlev and Anheier 2020). Moreover, hybridization can continually beget both innovation and stasis as organizations try to make sense of their performance in the face of

internal and external pressures and ambiguous outcomes (Jay 2013). Hybridization is not uncommon among service providing nonprofits, which must cope with competing pressures to provide for a community while participating in market exchanges (Brandsen, van de Donk, and Putters 2005; Hustinx and De Waele 2015).

The humanitarian niche, then is an institutional environment in which immigrant organizations emerge to meet co-national needs, where existing organizations in the host community cannot. Service provider organizations must adapt their operations to appeal to a variety of host society audiences, leading many to hybridize their operations as a means of survival. Unlike more typical product niches, humanitarian niches are defined by initial urgency and, typically, gradual narrowing as a population's pressing needs are met. While the *field* of humanitarianism may institutionalize (Barnett 2005), organizations that emerge to meet specific needs will, at best, eventually render themselves unnecessary. At worst, they may run out of resources over time, as political mobilization and donations die down and funding spigots turn toward more recent humanitarian emergencies elsewhere. This means that specialized organizations that emerge in a humanitarian niche may be simultaneously writing their organizational death knell. Alternatively, they may prepare to adapt their operations based on new environmental conditions. Hybridization is one way that organizations build in this organizational agility (Nijssen and Paauwe 2012).

What, then, does "survival" look like in this humanitarian niche? In order to answer this question, it is important to account for the political nature of refugee humanitarianism as shaped by regional and domestic politics. While humanitarianism may be a legitimizing logic for an organization, it also matters whether the type of humanitarianism projected by the organization aligns with state interests, particularly in non-democratic settings (Kayali 2023). The

humanitarian niche in which immigrant organizations emerge is politically inflected in ways that directly affect survival. Syrian refugees running health clinics are keenly aware of the politics of their reception, thereby shaping their efforts to perpetuate their clinics within the unpredictable environment of a humanitarian niche.

The Humanitarian Healthcare Provider

For Syrian refugees looking for an appointment with an Arabic-speaking doctor in Istanbul, the best place to start is by asking a fellow Syrian. Word travels swiftly about good Syrian doctors in the city. There are some doctors who are like local celebrities--an acclaimed Damascus pediatrician, for example, is known across Syrian households all around Istanbul. But if references from friend and family networks are not enough to find a particular type of specialty, the next best option is to head over to Facebook, where groups for Syrians in Istanbul abound. A post in a "Syrian Women in Istanbul" Facebook group along the lines of, "Does anyone have a gynecologist they can recommend near Bağcılar?" for example, will quickly receive numerous responses with phone numbers and clinic addresses.

Once Syrians become aware of the Syrian-run clinics throughout the city, they can head straight to the Facebook pages of the clinics for relevant information. Like many of the clinics, the Khayr Clinic would update its page every day with its daily schedule, which operated from morning until late in the evening. The daily schedule includes the names of the specialists who would be in the clinic, as well as the times of their availability and their phone numbers. This is important, because many of the Syrian doctors who work at the Khayr Clinic also work at other clinics in Istanbul. Their slots are relatively short, and many do not work at Khayr every day. Patients could contact doctors directly for appointments, or they could show up to the clinic and

wait. Once a patient arrives, they go to the front desk, pay the 25 to 50 TL[33] cash fee, and take a seat in the waiting area and wait to be called. Across most clinics, half of that fee will go to the doctor they see, while the other half will go to the clinic.

When I first arrived at the Khayr Clinic to meet the manager, I was shocked by the sheer size of the organization--multiple stories, with modern wooden paneling inside and black leather chairs lining the waiting room. The inside of the managers' office was similarly sleek. The most striking feature of the office was a massive banner taking up an entire wall, directly above the head of the manager with whom I was speaking. It was a banner for a school the organization used to run in Istanbul, which had by then been closed so the organization could focus on its newer health clinic. The banner was written in both Turkish and Arabic. It read, "In history, there has never been another country like Turkey that has taken its Syrian brothers into their arms in hard times." On the sign was the officially registered Turkish name of the organization. The manager assured me that, with this *dernek* registration, they were a legal clinic. This was despite the fact that a school and a health clinic should have different types of registration. A few minutes later, sure enough, he explained that they were actually still working with the Ministry of Health so that they could operate as an official clinic soon, hopefully. Yet, due to "political standstills", they did not know what was going to happen.[34]

Refugee-run health clinics started emerging in Istanbul soon after Syrians started to settle in Turkey's urban centers. The first movers started as small, ad hoc organizations providing donated medications they cobbled together for patients in need. These medicine dispensaries gradually built networks among doctors who could assist newly arrived refugees with healthcare

[33] Clinics increased their prices with rapid inflation in Turkey, but throughout my research the fees for a check-up never exceeded the equivalent of around $5.
[34] Interview, Khayr clinic manager, Aug 5, 2017.

needs unmet in state facilities. As the number of refugees coming to Turkey continued to increase, these needs became more pronounced rather than less. Refugee-run clinics mushroomed as doctors congregated around one another in densely populated parts of cities like Istanbul. The Khayr Clinic was a relatively late arrival to the mix in Istanbul, given that it focused on educational projects before the managers decided to open a clinic employing Syrian doctors, a need they saw as more persistent than the need for schools for Syrian children. It also offered a new avenue for work--Syrian schools had been systematically shut down by the Turkish state in 2016. Despite its late start, Khayr quickly grew into one of the biggest clinics in the city, even though it was lacking the elusive official license to provide medical care.

Clinic managers were aware of the precariousness of operating unlicensed clinics. At any moment, they could be shut down by authorities, as schools were. At best they would be asked to close—at worst, their employees risked arrest or steep fines. Doctors and managers dealt with this uncertainty in variable ways. While smaller operations of just a few doctors generally kept working quietly, the larger clinics—those with doctors in the double digits, sought institutionalized pathways to remain operational. This inclination is reasonably intuitive—when large informal organizations are visible to regulators, organizations often look for a means to formalize or register with state agents likely to enforce the existing rules (Cling, Razafindrakoto, and Roubaud 2012, Tam and Hasmath 2015). It is little surprise that research shows that informal organizations which formalize are ultimately more successful than those that remain informal (Assenova and Sorenson 2017). For informal health clinics, this meant trying to find ways to register with the state.

The first step to partial legitimacy for larger clinics was to register as *derneks*, or "associations". This made them legible to the Interior Ministry's General Directorate of Civil

Society Relations. *Dernek* registration is a simple and common process in Turkey that a broad array of voluntary organizations undertake. This only gave the organizations a modicum of legitimacy. The more important task was to couple this status as a nonprofit, voluntary organization with an identity of humanitarianism palatable to regulators who might grant organizations leeway in their semi-legal activities. Despite having a registration which stipulated that they could not collect fees from beneficiaries, organizations continued to collect what they referred to as a "symbolic" amount for care. Fees never topped about $5 for a checkup across clinics, accounting for inflation over time.

In 2015, the Ministry of Health introduced legislation that would provide a pathway to humanitarian legitimization for select clinics registered as associations. The Ministry released a circular detailing the rules and regulations that nonstate organizations providing healthcare to refugees would have to follow.[35] They would be required to provide free care to those under temporary protection, rendered in regulation-compliant buildings, provided by doctors licensed in Turkey. Approved clinics would then have to reapply for renewal every six months. Seventeen healthcare organizations in Turkey received this initial approval from the Ministry of Health in 2015 (Yıldırım, Komsuoğlu, and Özekmekçi 2019).

The manager of the Shifa Clinic described this law as a victory of organizational lobbying to the Ministry of Health. "You know the law that said NGOs could give health services? That law came out because we and some others fought for it." He continued: "When we first entered the field, Turks were saying, 'Are you crazy? You're a *dernek*, why are you giving healthcare?' *Derneks* collect aid, give food, why would they do healthcare? They didn't

[35] Official Gazette, Nov 4, 2015. No: 9648 "Amendments in the Principles of Healthcare Services Provided for those under Temporary Protection" http://www.madde14.org/images/5/56/SagBakYonergeDegisiklik54567092.pdf.

see healthcare as aid."[36] Once this collection of *derneks* coalesced to meet the clear and persistent demand for refugee healthcare, they were able to partially legitimize themselves rather than operate in the shadows. The clinics, in effect, seized on an incipient opportunity structure and carved a regulatory pathway to create a viable organization within it. An official at the Ministry of Health reinforced the usefulness of this healthcare law that allowed NGOs to provide health services: "We had limited resources, both human resources and financial resources. In this situation, NGOs in the field truly produced great work, and we even coordinated with some."[37] In this sense, clinic administrators themselves helped define the contours of the humanitarian niche in which they situated their organizations.

The informal clinics that made themselves legible to the state both gained an ambiguous sense of institutional legitimacy and exposed themselves to the possibility of regulatory action if they did not abide by the law's parameters (which was virtually impossible for organizations operating with Syrian doctors, who could not get Turkish certification at the time. The clinics also depended on fees to survive). The decision to register for legal status can, paradoxically, produce more uncertainty by making individuals legible to the state in a context where enforcement is piecemeal and unpredictable (Asad 2020).

This uncertainty was realized when the 2015 Ministry of Health law on NGO health provision was not renewed in 2016. All the clinics thus lapsed back into informality. They were still registered as *derneks*, but the scope of health-related services that *derneks* were allowed to provide was narrowed to psychotherapy and physical therapy, leaving these clinics in a legal no man's land. The same Ministry of Health official noted that "the NGOs served their purpose, but

[36] Interview with Shifa Clinic manager, Sept 2, 2021.
[37] Interview with Ministry of Health official, Sept 8, 2021.

we had to standardize these services, we would take over the role."[38] In her formulation, the humanitarian niche was closing, and the Ministry of Health would provide a more lasting alternative to the clinics. While the Ministry of Health did indeed take on this role through the establishment of European Union-funded Migrant Health Centers employing Syrian doctors, these centers would not be operational for another three to four years. The clinics continued to draw on the once official recognition of their humanitarianism as a legitimizing principle even after the formal permission lapsed.

In fact, this continuation of operations under a rubric of humanitarianism was legitimized among some clinics by continued coordination with Ministry of Health officials. Coordination was evident in vaccination campaigns for children. Both the Shifa Clinic and the Khayr Clinic ran multi-week campaigns supervised by the Ministry of Health to reach populations that had not approached government clinics for their required (and free) vaccinations. These collaborations, advertised widely on Facebook, were happening as late as 2017, well after the expiration of the Ministry of Health circular. Continued bouts of collaboration provided tacit permission for informal clinics to keep operating in the humanitarian role they had carved for themselves.

Hybrid Syrian-run clinics contrasted markedly from the "pure" humanitarian organizations that had also been providing healthcare to Syrians under the same 2015 Ministry of Health circular. One Turkish healthcare NGO had received European Union funding disbursed through the International Organization of Migration (IOM) and the Humanitarian Aid and Civil Protection Department (ECHO) to provide care to Syrians in Turkish cities with high refugee populations. Their clinics were free for Syrians, and Syrian doctors had received Ministry of Health training to work in them. Their formal permissions also expired when the Ministry of

[38] Interview with Ministry of Health official, Sept 8, 2021.

Health circular lapsed, and many kept operating with uncertainty about when they would be formally shuttered. But unlike the Syrian-run clinics, these clinics were just biding time until the signal came from the Ministry of Health to wind down the project.

Their administrators used much clearer international humanitarian language to describe their role in the healthcare scene. One noted that, despite the uncertainty plaguing its operations, it was right for the clinic to eventually close given that, ultimately, countries must find "durable solutions" for refugees. He directly drew from the UNHCR toolbox of terminologies to explain his organization's impending closure. Comparing Turkey's support for refugees to other refugee reception contexts he had experience in abroad, he mused, "Is it too much? This is a hectic job for the [Turkish] government, everything refugee related needs to be done with government protocols, but they don't actually know how to deal with the situation because they've never had such a big refugee influx. I don't understand why Turkey isn't resettling refugees, resettlement is the best solution."[39] The organization, by 2018, had closed its health clinic and had shifted to supporting the Ministry of Health in bolstering refugee healthcare services. As this NGO official mused about durable solutions and resettlement, Syrian-run clinics continued positioning for their survival in a hybrid, informal space.

The hybridized associational providers also differed from small "pure" private clinics set up by Syrian doctors throughout Istanbul. While many doctors sought out the relative stability of working in the partially registered *derneks,* there were also doctors—sometimes the same ones working in large clinics—who worked in small clinics tucked into apartment buildings throughout the city. These ventures, commonly called *merdiven altı,* or "under-the-stairs" clinics, had no guise of formality. While they had the advantage of limited visibility, they also

[39] Interview with NGO manager, August 1, 2018.

experienced heightened precarity given that they had no institutional legitimacy. This lack of legitimacy also affected their ability to survive financially. One dentist I spoke with explained that she had to draw patients only from her immediate network of friends and family, given that she wanted to ensure that she could trust her patients not to report her.[40] Two other Syrian doctors noted warily that a local licensed doctor was specifically looking for Syrians he could report to the Health Ministry. These doctors kept their ventures small and unidentifiable—the only way they could survive. This also meant limited business, and therefore shaky financial footing for longer-term survival.

Informality and Hybridization Strategies

The expiration of the Ministry of Health law in 2016 allowing *derneks* to provide healthcare posed registered clinics with a strategic challenge. By virtue of their registration, they were known to at least some regulatory bodies. Information about their addresses and some of their basic healthcare provision practices had been documented by regulators from the provincial health directorate. Yet once the law lapsed, so too did the legality of the clinics. This did not, however, lead to immediate closures. Instead, it made their continued functioning more precarious due to the uncertainty surrounding their future. Clinic managers tried to perpetuate their clinics by occupying a humanitarian hybrid space, despite the lack of legal legitimization of this organizational form. For most clinics, this meant highlighting their humanitarian practices to potential audiences—regulators, neighbors, or other providers--relative to their more pragmatic informal business activities. While it was not clear to clinic managers which audiences would actually assess their legitimacy, it was always best to err on the side of a humanitarian venture.

[40] Interview with dentist, August 28, 2018.

Scholars of organizations have identified different types of hybridization. These include compartmentalizing or segmenting different organizational elements, assimilating one identity into a dominant identity (Skelcher and Smith 2015), decoupling an outwardly appealing identity from the actual activities of an organization, or selectively coupling different organizational identities to appeal to various audiences (Luo, Wang, and Zhang 2016; Pache and Santos 2012). Within a volatile and complex context with changing regulations and enforcement, organizations faced challenges of how to hybridize, and to what degree (Krlev and Anheier 2020). The most successful clinics were able to assimilate their business practices into a broader organizational identity of humanitarianism that maintained some degree of legitimacy despite lapsed legal status. This created "tolerated truces" between organizations and regulators, at least for a time (Raynard 2016: 325).

Organizations hybridized their humanitarian practices and discourses with fee-for-service activities with varying degrees of success. All of the organizations underscored their important role filling a gap for refugees with registration issues and language barriers who continued to face challenges within the Turkish system. Yet not all were able to substantiate this in humanitarian terms. The first clinic to be shut down had a *dernek* registration but no humanitarian activities beyond cheap healthcare services for Arabic-speakers. The remaining clinics assimilated business practices into a broader humanitarian identity. Below is a table including the seven clinics examined in the rest of the chapter. All registered as *derneks* between 2015 and 2016 and, after their status lapsed, continued operating in a state of uncertainty.

Table 3.1: Key Characteristics of Syrian-run Health Clinics

Clinic	Size*	Humanitarian Activities	Islamic Humanitarian Organizational Networks
Shifa Clinic	Large	Vaccination campaigns, camp support in Northern Syria, material aid in Istanbul, support for orphans	American, European, Gulf, Southeast Asian, and Turkish organizations
Hayat Clinic	Large	Camp support in Northern Syria, material aid in Istanbul	Turkish and Syrian organizations
Rafah Clinic	Large	Quran courses, material aid	Turkish and Syrian organizations
Khayr Clinic	Large	Vaccination campaigns, Arabic language school (closed)	European, Gulf, and Turkish organizations
Bilad Clinic	Medium	Camp support in Northern Syria, orphan sponsorship	Gulf and Turkish organizations
Shams Clinic	Small	Camp support in Syria and Lebanon, youth activities in Istanbul	European and Gulf organizations
Safa Clinic	Medium	None	None

* Large: 25 or more doctors
Medium:10-25 doctors
Small: Fewer than 10 doctors

Of the seven clinics, the Safa Clinic was the only one closed by 2018. Safa opened in 2016, as the number of Syrians arriving in Turkey was peaking. The manager used to work at the Shifa Clinic, though over time he had become disillusioned with the administration there and decided he would try setting up his own operation. His clinic was one of many entrepreneurial ventures he dreamed of. The manager spoke of establishing a university in Turkey, or a medical training center. But given the knowledge he had gathered about running a clinic in Istanbul from his previous workplace, he opted for that route first. He invested his sizeable savings, pooled with his sister's—also a doctor—into the establishment of the Safa Clinic.

The first time I ventured to the Safa Clinic, I did a double-take when I saw the sign hanging above the entrance. It appeared to be a Ministry of Health building. It had the standard light green and red thematic, with a crescent and moon symbol characteristic of Turkey's government ministries. I pulled out my phone to double check the address. I was at the right place. I glanced at the sign again and realized that the name of the organization on the sign did not appear to be government related. I warily walked in with my translator, unsure how to greet to receptionist in case it was actually a Turkish government health clinic. The last thing I wanted to do was out a Syrian clinic operating a stone's throw away from a Turkish clinic.

Our anxieties were immediately quelled when we began talking with the receptionist, who was the sister of the manager we had been in contact with. It seemed the sign had been designed precisely so that the building would fit into its surroundings in the neighborhood, without inspiring the skepticism of Turkish passersby. After chatting with the receptionist about our appointment to see the manager, we sat in the bare-walled waiting room in black chairs lining the hallway, alongside a few patients. A few minutes later the manager came and beckoned us into his office and examination room. The space was large and messy. Old medical equipment littered the counters lining the room. Two microscopes stood out among other paraphernalia including test tubes, medicines, and various labels. It seemed that the clinic had enough resources to cobble together some medical equipment, but none of it appeared new or pristine. It was, it seemed to me, getting by as best it could with limited resources.

We discussed the doctor's journey to Istanbul, his career aspirations, and his decision to open this clinic. It was operating, at this point, with twenty specialists who rotated through the clinic on a part-time schedule—most also worked in other clinics. He was proud of his clinic, but also wary of the legal uncertainties surrounding its operations. He had already borne the stresses

of some encounters with street-level enforcement. When he first opened a clinic in 2015 under a medical tourism license, he was immediately told to close. He was informed, however, that he could reopen if he registered his clinics as a *dernek* rather than as a business. The second time around, the associational status worked, and the clinic continued to operate. But this label worried the doctor. He said, matter-of-factly, that this was not a humanitarian organization. The label had no real meaning in terms of the actual operations of the clinic. In this sense, the *dernek* label had little to do with the actual day-to-day activities of the clinic. The doctor was pretty sure they would be shut down soon. He just did not know when.

In preparation, he had already started diversifying his investments. He took us around the corner to another part of the building. In the dark space, he showed us a variety of new medical equipment. Except these were not microscopes--they were laser hair removal machines, dermatological contraptions, and other aesthetic care implements. He told us that he and his sister were planning to open a cosmetic health center, just in case the association was shut down by regulators. He gave me the business card he had made for the beauty clinic, though it was not yet open. He would wait and see.

A year later I met the same doctor in a coffee shop down the street from where Safa used to be. It had, as he had suspected, been shut down by the provincial health directorate during the intervening year. Officials from the Ministry had come to the clinic and taken photos of everything, giving him two months to get rid of all the medical equipment he had purchased with his personal savings. I asked him why he thought his clinic was targeted for closure, even as many other *dernek*-registered clinics continued to operate around the corner.

At this point, the doctor launched into his theory about why other clinics were surviving. He explained that these clinics were religious humanitarian organizations that were able to align

themselves with the ruling party's religious humanitarian inclinations. He complained about the saturation of these organizations with religion. "Science is one thing and religion is another" he grumbled, noting that healthcare clinics should not be religious organizations, but rather should be devoted to health as a medical and scientific pursuit. "These guys are Brotherhood," he noted. He was alluding to the Muslim Brotherhood in Syria, a religious political group that had a strong presence in the opposition movement against Bashar Al-Assad's regime as well as transnational connections to other Brotherhood affiliate parties across the region. He then pulled out his phone and brought up photos to show me. He explained that in these photos were some of the administrators of these clinic organizations alongside Turkish officials from the Department of Religious Affairs. "Why are these clinic managers posing with a Sheikh?" he asked rhetorically. Clinic ties with politically connected religious cadres, he mused, were the reason those clinics were able to survive while his was shut down.

This manager's argument that organizations that operated in Islamic humanitarian networks were more likely to be tolerated appeared to have some resonance. His explanation signaled the broader organizational form that I had observed: that many of the bustling healthcare clinics assimilated healthcare provision into a broader religious humanitarian organizational form. What, then, did this hybridization look like in these organizations? Most of the clinics with the *dernek* distinction did some humanitarian work outside the realm of healthcare. The clinics, though programmatically central to every organization, were discussed as one piece of a larger humanitarian project. This allowed organizations to assimilate their fee-for-service healthcare into a broader humanitarian identity.

Organizations had a variety of supplementary humanitarian programming. The Bilad Clinic had its roots in educational programming and support for orphans, even though by 2018 it

had transitioned fully to healthcare. Many of the organizations helped run camps in Syria for internally displaced individuals. Within these camps, organizations provided educational materials, food aid, and health services. The Shams Clinic had a similar project aiding Syrian refugees across the border in Lebanon. The Istanbul-based healthcare clinics were all the central components of these organizations. But they were not the only components. This helped maintain a humanitarian identity for all the *dernek*-registered clinics I followed, aside from the Safa Clinic. Opposition-friendly aid in Northern Syria, in particular, aligned well with Turkey's geopolitical goal of displacing both Assad's influence and Kurdish influence in the areas of Syria near Turkey's border. These types of aid projects fostered collaboration between the *derneks*, Turkish aid organizations, and Turkish governmental agencies.

Humanitarian networks among these organizations extended beyond the region. Syrian healthcare *derneks* made active use of global humanitarian networks for resource acquisition and organizational legitimacy. This included forging relationships with organizations both within Turkey and beyond. Clinics brought in funds and equipment from religious humanitarian organizations in countries including the United States, England, France, Kuwait, Thailand, and Malaysia, among others. In particular, most of the clinics that had continued to operate were linked to Turkish religiously-oriented charity organizations[41], either through funding, donations, or logistical support.

The Hayat Clinic was one of the larger *dernek* clinics with a multiplicity of humanitarian linkages. When I entered the manager's office on my first visit, I was struck by the religious

[41] Ipek Göçmen (2014) refers to these organizations as "religiously motivated associations" that rose from "a sense of intra-community trust and solidarity based on the ideals of Islam" (p. 97). RMAs became increasingly prevalent in Turkey with the rise of political Islam after 1980, when welfare and solidarity were re-conceived in terms of obligations of trust and loyalty among Muslims. The largest RMAs, formed in the nineties, have become sizeable welfare providers in Turkey, with budgets as high as $100 million USD. Cihan Tuğal (2017) discusses these same organizations forged in Islamic networks. He demonstrates the variability in the degree to which their services aim to create more pious beneficiaries but groups them all as religiously motivated.

iconography and framed calligraphic artwork enveloping the space. On a later visit, a manager offered me bottled zamzam water, holy water he had brought back from his pilgrimage to Mecca. Walking through the clinic with a nurse, I noticed stickers with another organization's English name dotting the walls: "Sunrise". I asked the nurse what the stickers were. He said that they were the emblem of a humanitarian organization that had helped fund the establishment of the clinic, though it did not have any connection to the clinic any longer. When I got home, I googled Sunrise, which turned out to be a US-based Islamic humanitarian aid organization run by Syrian Americans.

When I met with another manager in 2018, I found myself encountering an employee from a different humanitarian organization in the manager's office. As I was escorted into the room, the manager was finishing up a conversation with a man wearing the insignia of the Foundation for Human Rights and Freedoms and Humanitarian Relief (IHH), a religiously motivated NGO with close ties to the ruling party in Turkey. After some small talk, the IHH representative left, and I started my interview with the manager. I asked him about the man who had just been in the room. In describing the relationship with the IHH, the manager explained: "We get donations—some drugs, we also get logistic support."[42] Later, when we were discussing the uncertainty surrounding the clinic's survival, he invoked their connections to IHH again. "We are not officially registered. Healthcare should be registered, it should do a lot of things, but we can't…we need connections...we have good connections with them," he noted. It was clear that the clinic had a close relationship with the IHH, and that this benefited the clinic's resource acquisition and stability.

[42] Interview with manager of Hayat Clinic, September 5, 2018.

The same clinic noted that they received medications from another one of Turkey's large religiously motivated charity organizations. This general practice of medicine donation between organizations was corroborated in an interview with an administrator working in that national charity. She noted that their organization received donations of medicine that they redirected to Syrian organizations to disburse to Syrian refugees.[43] These networks between large Turkish aid organizations and Syrian health clinics were a common thread that kept surfacing throughout interviews. The Shifa Clinic had the densest and most variable humanitarian networks. One of their partners was Kızılay[44], the Turkish Red Crescent, which operates under state control. As the manager explained, "We work with Kızılay…because they know us, for example, they'll send us computers…if I bought all of those with money we'd go out of business. Another example, they send us an ultrasound machine, normally it would cost 2000 Euro, but we get it for free."[45] A connection with Kızılay is both a resource and an acknowledgment of organizational legitimacy in the eyes of at least some state bodies.

Clinics also bolstered their resources by forging connections with key individuals, donors, and beneficiaries in religious networks with political linkages. A closer look at the Rafah Clinic's operations uncovers how some of these religious humanitarian networks functioned to help keep organizations running. A former technician who worked in the Rafah Clinic's lab described some of the reasons she thought the clinic was able to survive informally: "The founder of the [Syrian] NGO that funded the clinic is a cleric with a lot of connections in Turkey

[43] Interview with staff member at Turkish NGO, August 2, 2017.
[44] Despite the fact that Kızılay is registered as an association, it functions as and is largely perceived as an arm of the state in humanitarian aid. Paker (2007) provides a wide range of evidence of the state cooptation of Kızılay. For example, legally, harming Kızılay property is akin to harming state property, the association president is government-appointed, and, as one Kızılay senior administrator told her, Kızılay cannot criticize the state because it carries out state duties.
[45] Interview with manager of Shifa Clinic, Sept 2, 2021.

and in Syria. He is [affiliated with] the Syrian Coalition."[46] She described how politically powerful this person was both in Syria, and now in Turkey. The cleric was a major figure in the Syrian opposition fighting Bashar al-Assad's regime in the Syrian War. Turkey had aligned itself with the Syrian opposition early on, supporting the Syrian Coalition and the ouster of Assad. The cleric was on the Syrian Islamic Council, the Syrian opposition's main religious body. This affiliation and the general sympathy the organization received from Turkish government actors, the technician suggested, was central to the clinic's ability to survive.

The phenomenon of religio-political proximity to the ruling party leading to organizational success resonates with the findings of other work on refugee service provision in Istanbul. Danış and Nazlı (2019) find that religious civil society actors that are loyal to the state have been systematically favored as service providers. The authors further note that in organizations deemed loyal, officials adopt "deliberate ignorance" about informal activities, including healthcare provision (Danış and Nazlı 2019: 151). More broadly, the humanitarian concept of *ensar*, or temporary humanitarian aid to fellow Muslims, became the Turkish state's preferred metaphor for providing protection for Syrians. Reference to *ensar* created a discursive space for faith-based organizations to take a prominent role in aid provision for Syrians (Akcapar and Simsek 2018). This follows a broader trend in which religiously motivated welfare provision has gained prominence in Turkey since the 1990s (Göçmen 2014). The Syrian War has led to increased aid activity among such organizations both in Turkey and across the border in Syria in opposition-held areas, making Syrian opposition NGOs a likely beneficiary of state support (Çelik 2021).

[46] Interview with former Rafah technician, Oct 1, 2021.

In the case of these organizations, their politics and their humanitarianism were deeply linked. This provided the requisite resources and legitimacy to continue operating healthcare services within a precarious context. Another former employee of the Rafah Clinic elaborated on how the prominent cleric's networks helped sustain the organization, beyond just providing political legitimacy. He specifically noted that the top administrators of the clinic were well-connected with potential benefactors through religious networks. "They use their power to collect money to pay for the apparatus…if I come from a religious family, I will believe it when [the organization leaders] say 'we need your support', so they collected money from Syrian businessmen that way."[47] The religious humanitarian organization thus perpetuated itself through donations from those who were ideologically aligned with a broader organizational mission.

Refugee-run organizations' ability to harness resources through networks of humanitarianism was acknowledged by many managers. In particular, one brought attention to why operating as a hybrid humanitarian organization, rather than as a private health clinic, was critical to his clinic's survival. The manager of the Shifa Clinic explained, "Opening a clinic is hard, a lot of the clinics went out of business…it's the business-minded clinics that couldn't survive. We went in with an NGO mindset, and so, for example, we got a lot of donations [from other NGOs]…but the businesses had to buy their equipment, and they couldn't afford it."[48] Here, the manager underscores the central importance of hybridized humanitarian identity--an "NGO mindset" to help defray costs--as a survival strategy. The strategy, he argues, works both in terms of maintaining organizational legitimacy and acquiring the requisite resources to survive.

[47] Interview with doctor in the Rafah Clinic, October 23, 2021.
[48] Interview with Shifa Clinic manager, September 2, 2021.

The hybrid form was maintained even throughout the gradual transition to a for-profit orientation. The technician who worked at the Rafah Clinic summarized this hybridization that veered over time toward privatization succinctly. "The donors of the association said that they should open a health clinic that was free of charge. But after just two months they started taking money, a very small amount, but that started going up and up. It turned into something commercial. In the beginning they were a charity. Then they became a business."[49] While the quote identifies an organizational transformation, it also sets up an oversimplified binary between charity and business. In fact, for most of its existence, the clinic remained in a hybrid space between the two forms.

The same technician later reframed the clinic's activities in a way that suggested an assimilated hybridization model, in which for-profit healthcare activity is couched within a broader humanitarian practice. She postulated, "I think that when they opened the Quran courses and other humanitarian activities, their goal was to attract people to the clinic to be patients, because that is how they made their money."[50] This approach allowed some clinics to leverage their humanitarianism toward more profit-oriented ends over time. It was not just employees who became somewhat disillusioned about the privatizing direction of some of the clinics. Over time, some patients also became increasingly skeptical of these clinics as prices crept up. Gradually, negative murmurs spread about the perceived goals of the organizations as profit-seeking rather than refugee-supporting. Yet, by and large, patients continued to make regular use of their expanding services.

[49] Interview with former Rafah Clinic technician, Oct 1, 2021.
[50] Interview with former Rafah Clinic technician, Oct 1, 2021.

The Local Limits of Legitimization

An air of mistrust percolated in the neighborhoods where informal clinics operated. Clinics were nervous about neighbors' complaints, and residents were suspicious of mysterious neighborhood activities. Informality is nothing new in Turkey specifically, nor in cities across both the developing and the developed world. Indeed, part of Turkey's "successful" reception of over 3.6 million refugees has been the magnitude of absorption of labor into the informal sector, estimated to make up nearly a third of the country's economy. Informal modes of organization and service provision are ubiquitous globally, and informality can provide a source of relative stability for both migrants and non-migrants. In fact, individuals may utilize informal channels of work and service access even when formal channels are available (Cammett and MacLean 2014; Maloney 2004; Sudhinaraset et al. 2013). People who are immersed in informal work are typically well-versed in the ways that formal and informal rules interface and may navigate and cope with informality in their daily lives in routinized ways (Bayat 1997; Roy 2005; Roy and AlSayyad 2004).

Yet ad hoc policy creation and uneven enforcement complicates the operations of informal ventures. Indeed, the state may use institutional ambiguity and arbitrary enforcement as a tool of governance aimed at destabilizing refugees' lives (Biehl 2015; Nassar and Stel 2019, Stel 2020). In this context, state action as well as deliberate state inaction can render refugees' lives precarious (Mourad 2017). This case-by-case enforcement produces precarity through its seeming arbitrariness (Horst and Grabska 2015; Sanyal 2018). For informal activities specifically, decisions about organizational closure may not be rooted in informality as such, but in the differentiations that regulators or street-level bureaucrats make *between* informal organizations (Roy 2009: 80). It often takes an additional complaint, like the designation of an

informal activity as a "nuisance," to trigger legal action (Ghertner 2008). As a result, organizations must be mindful not just of regulators but of broader community elements that could report them.

Managers situated their clinics as humanitarian hybrids with specific audiences in mind. Legitimacy, after all, is a condition that emerges through the alignment of an object (the clinics, in this case) with the norms or expectations of a specified audience which evaluates the object (Schoon 2022). The clinics' legitimization was directed primarily at government officials and street-level enforcers of rules around healthcare provision, such as police, health directorate employees, and local municipal officials. Through their registrations as *derneks,* they, for a time, attempted to both influence and abide by Ministry of Health rules around humanitarian healthcare provision. By forging network connections with Islamic aid organizations favored by the regime, as well as aid organizations from around the world, they were able to both enhance their legitimacy among politically well-positioned aid networks and acquire critical material resources. And by virtue of their affiliation with Syrian opposition politics, clinics had garnered political legitimacy among the ruling AKP, whose Syria policy mirrored the interests of this particular opposition class.

But these strategies faced three key problems. First, these various audiences were not consistent in determining what features of an organization made it liable for closure, making any legitimation strategy risky. Second, the "humanitarian niche" in which they emerged was constantly evolving as a result of policy changes and the attendant changes in enforcement practices, making organizational strategies that were legitimate at one point become less legitimate over time. Third, state officials and street-level bureaucrats were not the only actors in

the field of refugee-health provision. When community elements got involved, clinics had to adjust accordingly.

I met Dr. Ertürk, a Turkish doctor, at a government-run Migrant Health Center in 2018. He had spent much of his career as a primary care physician in a Family Health Center serving Turkish citizens. After the arrival of Syrian refugees, the Ministry of Health started establishing Migrant Health Centers (MHCs).[51] Early on, before the infusion of European Union funding and a reconfiguration of the project under the rubric of SIHHAT, these MHCs were functionally similar to Family Health Centers. The main differences were that they were designated for use just by migrants and refugees in Turkey, and that they were not integrated into the national online healthcare system MEDULA. When they were established in 2015, these clinics--of which there were very few--did not meaningfully alter the landscape of care for refugees. Given that the doctors working in the centers were still Turkish, like in the Family Health Centers, communication barriers were left unbridged.

When I visited the Migrant Health Center in 2018, Dr. Ertürk and one nurse were on duty. Neither Dr. Ertürk nor the nurse spoke Arabic, or any other language other than Turkish. Moreover, Dr. Ertürk was exuberantly anti-refugee. Throughout the afternoon we spent together, I listened to a stream of vitriol about Syrians in Turkey. The women have too many children. The men should have stayed home in Syria to fight, like the Turks' ancestors did in Gallipoli in World War I. The women are too conservative. There was no conversation that Dr. Ertürk did not end up diverting into an anti-refugee diatribe. "Three million…" he would periodically say with a sinister look, apropos of nothing, dramatically emphasizing the number of Syrians in

[51] Ministry of Health Law No. 49654233/703.99, passed September 3, 2015, available here: https://hsgm.saglik.gov.tr/dosya/mevzuat/genel_nitelikli_yazilar/toplum_sagligi_db/GOCMEN_SAGLIGI_MERKEZLERI-BIRIMLERI.pdf.

Turkey. These stage whispers continued as refugee patients entered the clinic for appointments. Eventually, Dr. Ertürk brought the conversation to Syrian doctors working in illegal clinics. I noted that many of the doctors are qualified and skilled, but do not have a pathway to practice legally in Turkey.

"I don't believe they are doctors," he snapped back. "Do they have a diploma? They may be swindlers."[52] He then described how he would ask patients who came to his office with prescriptions written in Arabic where they received them, in order to report the clinics. He had no sympathy for the plight of Syrian doctors. While not every Turkish doctor or professional harbored such motivation to make sure Syrian clinics were shut down, it was certainly the case that one of the biggest threats to clinic survival was the possibility of complaints from the community, including either beneficiaries or neighbors. The Hayat Clinic had been shut down multiple times due to community complaints to the Health Ministry. One of these complaints, the Hayat Clinic managers were told, was brought by a pharmacist complaining that they were distributing unofficial prescriptions, like those Dr. Ertürk was identifying in his office.

Local actors in the healthcare domain posed a persistent challenge to informal clinic operations. Rather than trying to get them closed, some Turkish clinics tried to coercively arrange unequal business partnerships with them. The Shifa Clinic had to deal with overtures from a local Turkish private clinic, which had proposed a deal where Shifa would send them refugee patients' whose conditions were too serious to be treated in the Syrian-run outpatient clinic. The Turkish clinic promised reduced costs for these patients. While at first glance the offer seemed practical as a service to Syrians, the administrator noted the overt pressure they felt

[52] Interview with Turkish primary care doctor in Migrant Health Center, January 4, 2018.

in receiving the offer—if they refused, the Turkish clinic strongly intimated that they would report the clinic to officials.[53]

With this fear of community-level reporting, clinics had to make sure they were doing everything they could to remain under the radar, despite the fact that they had previously registered as associations. This meant removing external signage and limiting publicity to social media, where information about the clinics was routinely shared on their own pages and through dense Syrian networks. It also helps that most Turks cannot read Arabic script, making it hard for Turkish observers to decipher social media posts or signs. Even sympathetic government officials sometimes gave the clinics a nudge about remaining incognito. While the humanitarian niche was wide enough for organizations to forge connections with Turkish NGOs and government officials, it was considerably narrowed by the communities in which they were embedded. These communities also exerted pressure on their elected representatives, who could not be perceived as tolerant of illegal refugee activities.

A gastroenterologist who used to work across numerous clinics explained how the uneasy peace between enforcers and clinics could be tilted by community members. Referring to Health Directorate employees, he said, "It was like, 'I'm letting you go if there are no complaints, either from other doctors or neighbors, it's fine.' But then in some places it was getting crowded, neighbors were getting disturbed from having so many people outside their buildings, so the Ministry of Health closed the clinics."[54] These types of temporary clinic closures were relatively common among the clinics I visited. Some officials who visited the Rafah Clinic told them that they could "no longer close their eyes" to the crowds gathering around the clinic. The managers

[53] Interview with Shifa Clinic administrator, August 9, 2018.
[54] Interview with gastroenterologist, Nov 28, 2021.

decided they would distribute their operations from one large clinic into three buildings within the neighborhood, thereby downsizing and distributing their crowds.

Ultimately, refugee-run clinics could more convincingly signal their religious humanitarian commitments to receptive parties in Turkish government positions with regulatory sway than to Turkish members of their immediate community. Partial registrations, humanitarian activities in connection with well-connected domestic organizations, and politically advantageous positioning in geopolitical matters between Turkey and Syria provided some legitimizing cover. Yet this legitimacy remained precarious in the day-to-day operations of the clinics in an increasingly hostile neighborhood. The more abstract legitimacy gained through embedding in protective networks came into direct tension with local grievances about the clinics' visibility in the community.

Conclusion

Refugee-run healthcare clinics emerged in Istanbul in a humanitarian niche shaped by a variety of institutional factors. At first clinic managers were able to help carve the niche from below and advocate for legal registration status for humanitarian clinics. But this formalized source of legitimacy lapsed with change in the landscape of refugee healthcare policy. Clinics nevertheless forged on by hybridizing their fee-for-service healthcare operations with a broader organizational identity of humanitarianism. This hybrid humanitarianism aligned with Turkey's geopolitical interests in Syria as well as its domestic interest promoting government-aligned religious humanitarianism. Alignment with the Syrian opposition, aid to Turkey-controlled Northern Syria, and partnerships with Turkey's powerful religiously-motivated NGOs shaped the contours of informal fee-for-service clinic survival in an otherwise institutionally precarious landscape.

The competing pressures of Ministry of Health rules and the state's humanitarian framework for Syrian refugee reception created a highly unstable institutional context, as healthcare personnel attempted to create viable organizations. The market imperative to survive in an increasingly competitive field and the community imperative to provide affordable and accessible services came into tension for clinics serving Syrian refugees. Emergent clinics found themselves at an organizational crossroads in terms of how to register and how to operate. Hybridization of for-profit healthcare activities within a humanitarian framework served a self-preservation function for clinics suspended in a regulatory fog. Clinics strengthened their precarious footing in the healthcare provision terrain by maintaining a hybrid form that drew on both humanitarian and market logics. In particular, the way they leaned into their humanitarian activities critically shaped their ability to stabilize their operations in two main ways. First, humanitarian activity delayed or softened regulatory intervention, given shared religio-political values and goals. Second, it helped garner extra resources that a pure business would not have been able to attain.

More broadly, this chapter emphasizes the importance of network-based resource acquisition to facilitate organizational survival in a market—or humanitarian—niche. Moreover, the chapter further elaborates how organizations can operate strategically such that they make advantageous political appeals within a (geo)politically fragile context. While immigrant entrepreneurship looks at the importance of networks beyond host state national boundaries through the lens of networked resource acquisition, this chapter has sought to emphasize how (geo)politics also shape the opportunity structure in which these clinics emerge. That is, an advantageous position vis a vis the Turkish government's Syria politics in particular, and Islamic

humanitarian networks in general, can earn clinics legitimacy and resources that buy them critical time as they contend with an unstable humanitarian niche.

The chapter also brings to light the institutional effects of ambivalent refugee policy. Temporary protection regimes undoubtedly produce uncertainty in the lives of migrants. The contingent nature of migrants' access to work, services, and other basic rights in the polity make the prospect of stable belonging elusive. Temporary statuses can take a substantial toll on individuals' lives. Organizations, of course, do not experience the same affective instabilities wrought by temporary status, and indeed often serve to reduce these stressors in the lives of individuals. But the same uncertainties make managing an emergent immigrant organization fraught. Positioning organizations as hybrids in order to appeal to multiple stakeholders is an active form of reducing uncertainty and altering the institutions of refugee reception. The Syrian-run health provider shows how unstable immigrant organizations may forge ahead and survive in ambivalent institutional contexts. In doing so, immigrants and immigrant organizations can take an active role in shaping their institutional contexts of reception. They can both meet the immediate needs of refugees in the host city while building the groundwork for more permanent organizational forms that cater to immigrant populations.

This chapter has analyzed how clinics survived *before* the restrictive turn in refugee reception in Turkey, which began in earnest in late 2018 and 2019. Once European Union-funded Migrant Health Centers employing Syrian doctors began to open, regulators' enforcement of these clinics tightened. The organizational transformations undertaken by clinic managers and doctors, as well as the broader field of Syrian refugee-provided healthcare, are explained in Chapter 6.

Chapter 4: The Enduring Appeal of Syrian Care Providers

Leila and I arrived at the pediatrics department of Çapa Hospital together. Leila is Syrian, a university graduate, and speaks fluent English. Her son, Kareem, is in a stroller with us. He is three years old and noticeably large for the stroller, but Leila feels more comfortable with him staying put rather than traversing the chaotic Istanbul streets on tottering toddlers' foot. Kareem has hemophilia, and even a slight knock or fall can cause life-threatening internal bleeding.

Leila is an expert at navigating Turkey's healthcare system. Kareem received his diagnosis in Istanbul, where he was born, after Leila left Homs to flee the war in Syria. His condition has forced her to learn the intricacies of the system, hopping from specialist to specialist in the early days of diagnosis. Miscommunications have led to incorrect treatments, where the medications that help Kareem's blood clot were given in the wrong quantities. They finally found a hematologist they trusted at a local hematology association with a caring and attentive staff. On this day, however, the doctor is on vacation. So, Leila and Kareem have come to the local public hospital instead. I came along to help Leila with any Turkish translation that might be needed when dealing with a staff that is unfamiliar with Kareem's condition.

When we get to the registration desk, Leila is informed that she does not have the necessary paperwork indicating the dosage and method of treatment. Leila had forgotten that at a new clinic, she would need to bring this documentation. We are sent downstairs to get the correct form filled out and signed. The man there also says he cannot fill out the form without official dosage information, and that we would need the original document or a photo of it. Leila calls her sister to bring the form, which she left at home.

As we wait in the waiting room, Kareem is walking around a little. Leila follows close behind him, always at the ready to intervene if he looks unstable. We are chatting and laughing.

Then, despite all our precautions, Kareem takes a tumble on the waiting room chairs. The mood immediately shifts from playful chatter to crisis mitigation, as Kareem's knee appears to be bruising. We run to the desk and ask for medical assistance. A doctor rushes over. Leila is in tears, trying to maintain composure and communicate with the doctor. The doctor is bellowing at her in broken English as I try to help as a Turkish translator, my purpose for coming along. For some reason, he is ignoring my Turkish translations and insisting on yelling at Leila in broken English. He turns to me and coyly says, in Turkish, "She doesn't speak much English, does she?"

At least he is treating Kareem. As he prepares forms with instructions for treatment for the nurses upstairs in pediatric oncology and hematology, he writes down Kareem's information from his temporary ID card. KAREEM AL-WAZIR, he says out-loud. Changing the pronunciation from Arabic to the Turkish transliteration, he repeats the name: KERIM VEZIR. He writes "Kerim Vezir". This is not how Kareem's name is spelled on his Temporary Protection ID. I wonder if this will have bureaucratic consequences.

We get in the elevator to go upstairs. A man in the elevators is playing with Kareem, making faces and laughing. After hearing Leila speak, he exclaims in Turkish, "Ah, this kid we have here is an Arab! Now I can see it, he has those Arab eyes!" He continues talking, expressing shock at how light Leila's skin color was, but then attempts to make some sense of the situation. "The dad must be darker, because the kid does look a little more Arab." When we got to the nurses in the pediatric hematology clinic, they were also surprised when they realized Leila and Kareem were Syrian. Chatting among themselves in Turkish, they said that Syrians are typically much darker. When I told Leila later that the nurses were saying this, she scoffed. "Turks have no idea what Syrians look like, they have no idea that we can have blue or green eyes, they just lump all Arabs together."

Thankfully, at least, the nurses were kind to Leila and gave Kareem the treatment he needed. Things calmed down a little after he got his injections. We left the hospital together to check in with the on-duty staff at the hematology association in another part of the neighborhood. After the check-in there with the on-duty staff, they suggested we go back to the hospital and have Kareem monitored there overnight, just to be on the safe side. We re-entered Çapa Hospital in the late afternoon, as the pediatric oncology wing was winding down most routine services for the day. The security guard at the entrance of the hospital barked at us as we entered, asking what we were doing coming at this time. I explained that we were coming to stay overnight in the pediatric oncology ward to have Kareem monitored, out of precaution. Begrudgingly, the security guard let us in. But as we walked by, English and Arabic permeating our conversations, he grumbled with palpable annoyance, "This is Turkey." We went upstairs.

This one day in the Turkish healthcare system reveals many of the quotidian struggles—as well as some of the benefits--of being a Syrian refugee navigating the Turkish healthcare system. Of central importance is the fact that Kareem's overnight stay in Çapa Hospital that evening did not cost Leila's family any money, including the blood-clotting factor treatments he received. Turkey's Temporary Protection policy is expansive in its coverage of refugees' healthcare expenses. For that, Leila has expressed gratitude. But the challenges of navigating the system peek out in numerous interactions throughout the day. The day began with some bureaucratic confusion about missing paperwork. With a language barrier, even small oversights--forgetting necessary paperwork, for example--can prove both inscrutable and insurmountable for many refugee patients.

Communication barriers can also turn aggressive. Doctors might yell at their patients, a manifestation of either frustration with communication difficulties, racist impulses, or often a combination thereof. But discriminatory encounters are not just with doctors, and they are not always aggressive. Nurses or fellow patients may comment on the Syrian identity of the patients, sometimes insidiously, sometimes without any awareness that their comments are racist. Discrimination in healthcare spaces is pervasive and referenced often by my Syrian interlocutors as well as Turkish doctors themselves. Finally, the fact that the pediatric wing of the public hospital was winding down its non-emergency services by late afternoon is another challenge. Many Syrians work long hours during the week. For them, free public healthcare services are available, but can be difficult to access in practice due to public healthcare institutions' limited working hours.

These are just some of the many barriers that Syrians face in the Turkish healthcare system. The challenges Syrians face in Turkey align in many ways with those that immigrants and refugees face in host countries around the world. It is often the case that, while refugees have legal access to healthcare services in a host state, practical access remains a challenge. These obstacles often include language, logistics, poverty, cultural differences, discrimination, and insufficient availability of services. From Canada (McKeary and Newbold 2010) to the European Union (Mestheneos and Ioannidi 2002) to Australia (Murray and Skull 2005), scholars observe a similar combination of these barriers in healthcare access for refugees.

This chapter does not intend to reinvent the wheel by explaining these barriers. Rather, it aims to elucidate how individuals facing these barriers in their encounters with the healthcare system navigate the terrain of available providers. While the previous chapter examined the supply side of refugee healthcare, this chapter shifts analytical focus to the demand side.

Building on existing studies of Syrian refugees' access to healthcare in Istanbul specifically, and Turkey more generally, the chapter analyzes interviews with Syrians living in Turkey about their healthcare practices. How do Syrian refugees use available healthcare providers in Istanbul? More specifically, if Syrian refugees have free legal access to state healthcare rendered in their home language, why and under what circumstances do they choose to pay for care? By exploring this question, the chapter sheds light on the dynamics of demand that perpetuate healthcare provision by refugees, for refugees.

Despite a flagship European Union-funded healthcare project aimed at easing Syrian refugees' access to linguistically and culturally competent care, Syrians continue to seek out fee-for-service private, at times informal, healthcare. This behavior is shaped by (1) the structural limitations of a primary care intervention (2) the reverberations of negative interactions and experiences with Turkish state providers and (3) the bureaucratic and political ambivalence built into a temporary protection regime in which laws determining access to healthcare are unclear, shift frequently, and are unevenly enforced. The chapter argues that within the shifting policy and institutional landscape wrought by a temporary protection regime, refugees opt for relative constancy and reliability afforded by services from co-national refugee providers. While the previous chapter details how refugee healthcare providers cope with an uncertain regulatory and geopolitical context, this chapter emphasizes how those providers absorb uncertainty as organizations but remain comparatively stable as a field--though not as individual organizations—when viewed from the demand side of beneficiaries. While Syrian doctors' informal work is legitimized in humanitarian terms to regulators, refugees often do not conceive of this care as aid, but rather as a practical private care choice.

"Patchworking" Care in a Turbulent Context

When immigrants and refugees face barriers to healthcare access, they often turn to brokers who can assist them. Professional interpreters can be a key institutional solution in these contexts, but their availability may be limited or costly. In these cases, immigrants often turn to informal brokers like family members, including children who have acculturated to the host community in schools and can act as linguistic and cultural mediators (Cohen, Moran-Ellis, and Smaje 1999; Katz 2014). Brokers may also fall somewhere between professionals and family members. They may be self-appointed or community-recognized third-party "experts" in navigating structures of care (Hunter 2018), volunteers (Berenschot, Hanani, and Sambodho 2018), or community health workers (Schaaf et al. 2020). They may also be professionals who lie wholly outside the healthcare field. For example, school employees (Campbell-Montalvo and Castañeda 2019) and even researchers themselves who have accumulated relevant information in the field and can help the immigrants with whom they are working. Immigrants facing difficulties with access rely on informal networks to create a "patchwork" of care (Kibria 1995). This can include cobbling together prescription, nonprescription, or traditional medicines, as well as availing themselves of select formal services depending on the illnesses for which they need treatment. They can access these various resources through "informal ties" (Menjívar 2002).

When Menjívar (2002) refers to informal ties, the analytical focus is on the familial, neighborly, and community-mediated relations between individuals--women, in her empirical case. These networks are forged outside of formal healthcare contexts that facilitate access to a collection of healing practices. But "patchworking" care also often incorporates informal care in another sense--care from healthcare providers that is rendered through extralegal means. Raudenbusch (2020) describes how poor populations in the United States combine informal and formal care to meet their health needs. This includes receiving medicines and treatment through

friends, family, and doctors that have formal access to care and resources and can acquire items on behalf of those excluded from or avoiding care. Raudenbusch calls this a "formal-informal hybrid system" and notes that these strategies are often utilized even when individuals may not be legally excluded from formal care (Raudenbusch 2020: 8). It should come as little surprise that individuals are creative in the way they cobble together formal and informal healthcare practices. Indeed, this occurs across a range of socioeconomic and legal statuses, given the bureaucracy of formal healthcare and the availability of a sea of alternatives to formal care. It is also the case that the particular ways in which individuals navigate formal and informal services and networks both *shapes* and *is shaped by* the legal and institutional terrain of care providers.

When immigrants or refugees arrive in large numbers to a host community, their healthcare demands may stretch or challenge the capacity of existing providers. For forced migrants in particular, early and urgent healthcare needs may arise from the violence of war or the deprivation of care during flight from conflict. Typical institutional responses at this acute stage of displacement include humanitarian organizations (Ager 2014). But over time, refugees' healthcare needs in a host context may shift with the resumption of a relatively more settled life. With this transition come new healthcare demands on existing providers, which may need to be adapted or supplemented. Depending on the particular immigrant group's challenges, interventions may include instituting interpreters (Vange et al. 2023) or navigators (Shommu et al. 2016) in healthcare settings, or fortifying existing providers to better serve immigrants (Kay, Jackson, and Nicholson 2010). It can also include establishing targeted healthcare clinics for immigrants or refugees, whether as nonstate organizations (Hoekstra 2021) or as state clinics (Kohler et al. 2018).

Patient demand and provider supply are therefore in constant interplay, as formal and informal modes of both healthcare-seeking behavior, brokerage, and provision come together to meet healthcare needs of individuals in general, and immigrants in more particular ways. For immigrants, there may be demand for linguistically appropriate, culturally competent, logistically streamlined, bureaucratically comprehensible, and/or legally accessible care that is not readily met by institutions in place for host community nationals. Whether there will be attempts to meet these needs will depend on a variety of factors: migration policy at the national level, local implementation, and bottom-up entrepreneurial or organizational mobilization to facilitate access.

It can also be shaped by specificities of host country migration policies and home country dynamics. Ukrainian refugees, for example, sometimes choose to return home for their medical care rather than to navigate what they see as more expensive yet poorer healthcare systems in their European host states. Legally, their host countries afford them this mobility, and they deem Ukraine safe enough for this quick journey back (Méheut 2023). In the Turkish case, Syrians forfeit their temporary protection if they cross the border to go back home. In a policy context of protracted temporary protection, the broader institutional imperative to forestall refugees' long-term incorporation abuts practical healthcare considerations. The remainder of this chapter examines how the institutional flux of migration policy change is experienced and mitigated by refugees themselves as care-seekers.

Healthcare Access in the Aftermath of the SIHHAT Project

After the initial announcement of the SIHHAT Project, Syrian doctors were invited to apply for a training program to work as primary care doctors in Migrant Health Centers. They were to gather all of their certifications and undergo an interview-based vetting process to confirm that they

were doctors. The training program combined five days of theoretical training to acquaint doctors with the Turkish healthcare system in addition to six weeks of practical, on-site training in a Turkish primary care clinic. After the training, doctors' names were placed in a lottery, and selected doctors were assigned to Migrant Health Centers.

As MHCs opened beginning in 2018, Syrian doctors were placed into their general practitioner roles and began working their 8:00am to 5:00pm schedules. News about the new clinics would, hopefully, spread to Syrians through word of mouth. Some learned from Syrian doctors themselves--the doctors they used to see in informal clinics now had day jobs in the state centers. Others learned more abruptly. The Family Health Centers they used to go to alongside Turkish neighbors began to redirect Syrians to MHCs, which had been created specifically for them. In some cases, the FHCs that they had begun to utilize no longer accepted them. Some, still, never heard about the MHCs and continued to go to other providers, cobbling together their own strategies to get the care they needed.

Meanwhile, the SIHHAT Project was touted by Ministry of Health officials as the answer to the issues that Syrians faced in the Turkish healthcare system--namely, a salve to deal with the difficulties that emerge from a language barrier. In addition to Migrant Health Centers, the SIHHAT Project supported the placement of Arabic-Turkish translators into public hospitals. Each public hospital was to have at least one translator whose services would be free of charge to patients. This massive project was supposed to be the institutional answer to Syrian patients' troubles. How did these institutional changes in the terrain of refugee healthcare providers affect dynamics of access?

The remainder of the chapter takes a broad view of how Syrian patients utilized the various providers available to them in Istanbul. It draws primarily on 44 interviews conducted

with Syrians living in Istanbul in 2020-2021, after the Migrant Health Centers were established, though the chapter is also informed by interviews with Syrians in Istanbul conducted before the Migrant Health Centers were established. The latter interviews provided the requisite context to understand how healthcare seeking behaviors shifted (or not) after European Union funds fortified the refugee healthcare system in Turkey. I find that a combination of institutional, interpersonal, and legal challenges led Syrians to both utilize *and* strategically avoid MHCs, specifically, and state providers more generally. The MHCs shifted the dynamics of demand by meeting the most basic healthcare needs of Syrians with Arabic doctors. But they did not eliminate the need for Arabic-language specialized care beyond the primary care provider. The combination of structural barriers led individuals to cobble together both formal and informal providers in their efforts to be cost-effective, time-efficient, and efficacious in solving their health problems.

The Migrant Health Centers provided a critical service: healthcare provided by Syrian doctors who speak the Arabic language. As primary healthcare facilities, however, they provide relatively little in the way of substantive healthcare. Like their Family Health Center counterparts, they are merely a first point of contact in the health system. Individuals go for basic health concerns, to get prescriptions filled, and to get health reports for bureaucratic reasons--wedding registrations, school enrollment, sports team registrations, and other mandatory health checks. Throughout conversations with Syrians, many noted that these clinics were useful but peripheral to the ways they utilized the Turkish healthcare system. Much more frequently, and as the Ministry of Health's own surveys indicated, Syrians would approach secondary providers like hospitals directly, seeking out the specialists who could help them with specific healthcare concerns. The SIHHAT Project's own survey, which was conducted with temporary protection

ID holders across a range of provinces, found that while 35 percent of Syrians interviewed had utilized a Migrant Health Center, almost 75 percent had utilized a state hospital.

Despite the centrality of the MHC intervention in Turkey's refugee policies, the fact that the MHCs are not frequently utilized is unsurprising to most Turks. This is because Turks also use Family Health Centers episodically, and typically not for serious healthcare concerns. A survey conducted in 2012 among Turks found somewhat comparable results, despite asking a slightly different question. When asked what their predominant choice for a healthcare provider was, just shy of 32 percent said family health centers, while 54 percent said state hospitals (Hone et al 2017). These results suggest less of a preference for providers than a structural imperative; Turkey's healthcare institutions are set up such that primary care is a useful resource but is not a central component of people's typical healthcare seeking behaviors. Unlike in other referral-based primary care systems, a referral is not required to seek out specialists in the Turkish healthcare system.

So, how do Syrians actually use this system? A first methodological note calls into question some of the SIHHAT Survey results cited in the background chapter. Many of the Syrians I interviewed were not familiar with the term "Migrant Health Center" or "Göçmen Sağlığı Merkezi", even if they had been utilizing these providers. I often had to describe the differences between the providers I was asking about—primary care facilities with Syrian doctors versus primary care facilities with Turkish doctors versus NGO-run or private providers with Syrian doctors—to specify the types of providers individuals were using. This is because respondents commonly referred to both the Migrant Health Centers and the Family Health Centers as the *mustawsaf,* or "clinic". Significant descriptive follow-up was often necessary to pinpoint which type of *mustawsaf* individuals were referring to. Moreover, when asked if they

used private or nonstate providers, often individuals would say no, only to later clearly describe Syrian-run health clinics as a frequented provider. This is likely because these clinics occupy an ambiguous space between private provider and humanitarian organization, as the previous chapter describes. Questions about specific types of care sought--such as vaccinations or gynecological care or pediatric care--would also trigger anecdotes of going to a wider range of providers than initially mentioned early in interviews. As such, interviews, were methodologically useful to getting an in-depth understanding of utilization practices among the Syrian population.

Where Informal Care Meets State Care

The MHCs operating with Arabic-speaking doctors were opened gradually between 2018 and 2020, as the Ministry of Health found appropriate buildings in which to house the clinics and then deployed trained healthcare personnel. As these clinics were established, their existence was largely communicated to Syrians through word of mouth. Many discovered their existence once they were turned away from the Family Health Centers that they had been utilizing for some time.

Hala, a 32-year-old woman from Damascus, explained her introduction to the MHCs. She had been in Istanbul since 2013 and settled in Fatih, a central neighborhood of Istanbul with one of the highest concentrations of Syrian refugees. She explained that, when she first arrived, before she had a daughter, she would only seek out healthcare on "random occasions" at the informal Syrian-run clinics. But once she was expecting, she needed more regular care both for herself and, eventually, for her daughter. She explained how her healthcare utilization practices evolved over time.

> I only started going to doctors once I got pregnant…I would go to Syrian clinics because it was easier to talk in Arabic, and I went every two weeks, or every

> month, and everything was going well…but when the delivery time came, I started to panic because my doctor was not licensed for childbirths.

Hala ended up finding a hospital where she could have the baby, and despite the language barrier, the delivery went smoothly. Afterwards, she needed to continue to seek out healthcare providers for postnatal care.

> I was told to bring my daughter to the Family Health Center for her check-ups and vaccinations. But when I went in September of 2018, I was told that I cannot come in, that I have to go the Migrant Health Center. I had no idea what that was. I was forced to go there…We don't know the doctors, and when we went honestly it was not fully equipped, the Syrians all seemed lost, there was no official announcement about the MHC. It's hard to know by yourself what's going on, we didn't know.

Hala ended up getting the vaccinations that her daughter needed, without too much difficulty. She continued to describe the MHCs.

> They were always crowded. I didn't trust the clinics…There was only one nurse and one doctor for everyone. We had a three hour wait because there was no appointment system…My sister is married to a Turkish man. Since the beginning she has been going to the Family Health Centers. It's really organized, the doctors are organized, it's very clean…Here, even the building is worse, there are lots of stairs and it's difficult to go up--you have all these moms with strollers struggling to get into the building.[55]

Hala's descriptions of her experiences with healthcare providers in Istanbul reveal a number of common themes encountered by members of the Syrian population in Istanbul. Hala's introduction to the MHCs was, perhaps paradoxically or perhaps by design, bundled with an experience of exclusion from Turkish providers where she had once been welcomed. Her analysis of the MHCs, therefore, was also through a lens of separation between services for Turks and services for refugees, which she described through direct comparison as inferior in terms of equipment, environment, and system. There are both advantages and disadvantages to having separated services for immigrants and refugees--specialized services for populations with

[55] Interview with Hala, January 16, 2021.

particular needs--including linguistic, cultural, or specific medical needs--can be useful. But siloing them from mainstream services can also serve to exclude populations from integrating into health systems (Healy and McKee 2004).

Not every respondent had a negative analysis of the MHC system. Indeed, it is worth noting from the SIHHAT survey that 70 percent of Syrians under temporary protection surveyed in Istanbul were either "strongly satisfied" or "satisfied" with MHC services. Nineteen percent, on the other hand, were either "strongly dissatisfied" or "dissatisfied" (with another 10 percent neither satisfied nor dissatisfied). The much more frequent commentary I heard about MHCs in my interviews was that they were adequate, but not necessarily a key service.

Nadia, a 22-year-old student from Aleppo who lives in Küçükçekmece, had sought out care for a persistent health issue in her stomach with no clear diagnosis and no resolution, despite multiple interventions. When I asked about where she went first, she responded that--as intended by the SIHHAT Project's design--the MHC was her first stop.

> We went to the *mustawsaf* for Syrians [MHC], but to be honest I never got what I needed. I had something in my stomach that needs special care, and when I went to the *mustawsaf* I got medicines but I was never improving. So I tried to go to the [public] hospital and it was so crowded, I couldn't get my appointments. It's been a year and a half and I still haven't been able to go. I don't know why, it's always crowded. I've tried going to private doctors at the Syrian clinics too but they said I needed a more advanced test and they said, "You need to go to the hospital, we can't give you the medications you need."

Nadia's problem is a scenario that Syrians experience frequently. The MHCs are there to help them but are not sufficient to assist in the navigation of a complex health system that can involve months-long waits to see specialists. With many options available, including Syrian doctors, Syrians often try to figure out their problems without having to fully engage the state system's slow-moving bureaucracy. They often end up at a crossroads where none of the providers they seek out are getting to the fundamental health problems at hand. I asked about her

symptoms, which sounded quite severe, then followed up to see if she had ever tried going straight to the emergency room.

> I tried to go and they would make me wait for hours and then would tell me to transfer to another department, but that I can't just directly transfer. They said I would need a referral. One of the doctors saw me and told me that I really need to go to the surgical department, and they need to really check me quickly, but the hours were over so I had to leave. Now I'm trying to make an appointment.[56]

At this point, Nadia had visited over four hospitals, both private and public, on the European side of Istanbul. Her eagerness to have her condition treated quickly was at odds with the typically long appointment waits--a feature of health systems around the world, not just in Turkey. While Nadia's exasperation with the health system may not be unique to Turkey or the refugee experience, the frequent circling back to Syrian doctors who could only advise but could not treat her symptoms created a unique problem. The option of seeing Syrian doctors led her to prematurely exit the Turkish public system where she would have been able to receive the care she needed, albeit with a wait. While Syrian doctors were often critical brokers or providers of care to refugees, they could only be so helpful to patients who needed more involved interventions.

Preferences for care from Syrian doctors in private care settings was more tenable for minor health concerns. Farha, a 43-year-old woman from Daraa, the origin site of the Syrian uprising in 2011, fled to Istanbul with her family in 2015. As a family, they generally avoided primary healthcare providers. When I asked about where they would go first in the event of a health problem, she noted that they would either stay home and cobble together medicines or go directly to hospitals. I asked if they ever considered an MHC or an FHC for more minor issues

[56] Interview with Nadia, March 21, 2021.

instead of acquiring medications on their own. It turned out that they had some experiences with the centers but did not consider them particularly useful.

> No, we don't use the clinics at all. We tried once to enter a Family Health Center, they didn't let us in, I still don't know why. We tried to go for over three years, and even though we have our names in the center, they didn't accept us. I took my daughter even to help translate but they said, there are Syrian centers, you should go there…We would visit the MHC centers for general cases, but they don't have any specialists. For specialists we go to the Syrian clinics like Hayat and Shifa [I asked Farha to describe her experience with the MHCs a little more.] The MHCs are good, but they're not useful for actual problems. If I want to see a gynecologist, if I want to see a heart doctor--my husband has a heart issue--I go to the Syrian private clinics, MHCs can't help us.

I then asked about her experiences with the Syrian private clinics.

> They're really, really crowded but they're really good. We have to wait an hour, two hours, but it's good. They're much faster than the appointments in the Turkish hospitals…We really try not to go to the Turkish hospitals…There's no translator. Even when we have my daughter as a translator she can't understand, she doesn't know what the Turkish doctors are saying. Nothing. The doctors just give very brief attention, very short.[57]

She specified after that they would go to Turkish hospitals for x-rays and blood tests or anything that would have an added cost at a Syrian clinic beyond the 50TL appointment fee. But she further specified that she will immediately take those results to a Syrian private clinic to show Syrian doctors the report for a more thorough explanation. Her observation that there are no translators in the hospitals may be a vestige of her experiences before the SIHHAT Project was rolled out, given that the assignment of translators to state hospitals was a key element of the policy. Yet, it is also possible that she was not able to see a translator given that demand for translators in hospitals often outstrips their supply. It is far more common practice that Syrians bring a family member or friend with Turkish language capabilities as unofficial translators they can trust.

[57] Interview with Farha, November 18, 2020.

Together, these preceding examples show how Syrians weave private and public services, including the more recently established Migrant Health Centers, into complex healthcare seeking behaviors. MHCs as a refugee healthcare intervention had a clear and limited effect on simplifying healthcare access for Syrians, but they did not displace Syrian informal care as allegedly intended. Syrian doctors working outside the state system remained a steady resource throughout these bureaucratic changes, but unwittingly sometimes created complications for individuals. The ease of access could have a complementary effect on healthcare practices, where individuals would get particular services from Syrian doctors even as they took advantage of free healthcare and MHCs. But it could also lead individuals to opt out of free care they had available to them for quicker, but less encompassing care.

Interactions in Care

Since Syrians arrived in Turkey, journalists, academics, and NGOs have emphasized the challenges that refugees face in Turkish healthcare providers. Ayşecan Terzioğlu (2017) conducted interviews with a range of Turkish healthcare professionals who express politically and culturally inflected discriminatory sentiments toward the Syrian population. Racist tropes about their religious and social conservatism, their propensity to have many children, and their cowardice in fleeing their revolutionary struggle abound among healthcare workers, as well as the larger population. In fact, Dr. Ertürk in the preceding chapter hit every single one of the tropes Terzioğlu identifies within the course of one afternoon with me. These sentiments are felt by Syrians themselves and shape their healthcare-seeking practices. In this section I examine how a combination of negative interactional dynamics in Turkish state healthcare settings re-route Syrians toward private providers, even when the financial costs are steep. My goal is not to

rehash the variety of negative experiences individuals face, but rather to explain how these interactions affect individual decision-making about provider selection in the healthcare field.

Across countless conversations, Syrians told me about their experiences being yelled at, handled roughly, and dismissed without explanation from state providers. Many of these individuals also had good experiences with state providers, and therefore became careful about going to specific doctors, hospitals, or Family Health Centers where they felt comfortable rather than avoiding Turkish state providers as a whole. Still others only had positive experiences. Some had heard about others' bad experiences but never felt discriminated against by doctors or other healthcare personnel. Yet anecdotes of negative experiences like discrimination, exclusion, and poor treatment kept recurring throughout interviews with Syrians in Istanbul.

Fatima, a 42-year-old woman from the suburbs of Damascus, first settled in the Esenyurt neighborhood of Istanbul and then moved to a basement apartment in more central Fatih so her husband could be closer to his job painting houses. They did not have registrations until Fatima realized that having a child in a hospital without one could pose bureaucratic problems and possible financial costs. Instead of going to antenatal visits in Istanbul, Fatima relied on medicines she had brought along with her from Syria. When the time to give birth arrived, Fatima went to a state hospital. Afterwards she was sent to the local Family Health Center to get vaccinations for her baby.

> The center was near my house but the nurses are not competent…it seems like they don't like Syrians. The doctors try to talk to [the nurses] to make them help, but it doesn't work. They act like they are forced to help but aren't actually helpful at all. Maybe other places are different, but the one by our house is terrible…I had to memorize all the words [in Turkish] that I needed before going to the center. I even had to argue with the nurse and was saying the words I memorized in the argument. It actually worked, even though it was really difficult.[58]

[58] Interview with Fatima, December 20, 2020.

Fatima persevered with the center in her neighborhood because it was free and just two minutes from her house. She came to like the doctors despite her bad experiences with the nurses. For her, finding her place within the Family Health Center despite the language barrier and discrimination was a personal triumph. Nevertheless, for issues with her children, she would still take them to the Khayr and Hayat centers. When her daughter was late to speaking and she became concerned, she sought out Syrian doctors in private clinics. Fatima had found a way to combine free care with more convenient fee-for-service care.

When health problems become more complicated, the stakes involved in navigating different providers become larger. Miscommunications can lead to adverse health outcomes, long waits at public providers can prove dangerous, and opting for quicker, private hospitals can become financially onerous. In these cases, individuals often cobble together a variety of insights from different doctors and try to make the best decisions they can with incomplete information and limited time. Syrian doctors often emerge as key mediators in these efforts, even if they cannot perform the complex in-patient procedures themselves.

Sara, who moved from Aleppo to Istanbul in 2013, was 39 years old when we met. She had moved from Zeytinburnu to Bağcılar with her family, and her husband worked as a tailor in a textile workshop, one of the more common jobs among Syrians in Istanbul. She had navigated the health system for herself and her children and recounted a variety of her experiences. They had some confusion with the MHCs and FHCs--she was able to register her children at the FHCs with the help of the kids' school but was rejected herself, so she would go to the local MHC. But she had to go beyond the primary care system when she started having gynecological problems.

> I saw Turkish doctors at Haseki Hospital and Samiha Şakır Hospital[59] in Zeytinburnu…I also tried a hospital in Bakırkoy. I went to a lot of Syrian doctors as well but they all told me that I needed to get surgery. When I went to Samiha

[59] Samiha Şakır Hospital is a gynecology and pediatrics public research hospital in Istanbul.

> Şakır I had a female doctor who, from the way she acted, you could just tell she didn't like Syrians. I even took a translator with me and she made her wait outside and was rude to us. She then said that she wouldn't do the surgery, that I didn't need it, and let me out without even a report of the visit. I did need surgery and ended up getting it at a private hospital. Then afterwards I returned to Samiha Şakır but made sure to make an appointment with a different doctor and that one was fine. I think it was just that one doctor.

I asked Sara about how she made the decision to get the procedure done in a private hospital, noting that it must have been a large expense for a family that relied on a single income. She explained how she ended up at the hospital.

> I went to a Syrian doctor in Esenyurt at a clinic there, she told me about a [private] hospital in Beylikdüzü. She actually worked there [part-time] and helped with the surgery….They were good. Of course, whenever you pay money, they will treat you well. The doctor was Syrian, the manager of the hospital was Lebanese. And it was 3500TL [cheaper than 5000TL quoted at another private hospital] so I did it there.[60]

It was expensive but a cost that Sara and her family were willing to bear to have the comfort of being able to communicate with her doctors and feeling cared for.

Very few Syrian families are able to shoulder the costs of private care. They may end up in difficult financial situations when they opt for the ease and comfort of a private provider instead of a free state hospital procedure. Dina, 43, had settled in the Sultangazi neighborhood with her husband and two children after fleeing Aleppo. She recounted the traumatic experiences she had with the health system at length. She arrived in Istanbul with a heart issue that she needed treated.

> I used to go to public hospitals at the beginning and get my medications there, but that didn't solve the problem--I needed surgery. So eventually I went to a public hospital that specializes in heart issues, Mehmet Akif Hospital[61]. I did my first surgery there, but it wasn't successful. They did the surgery entering the heart through the arteries instead of the veins, it was a big mistake, my life was endangered and I had to stay in intensive care for two weeks. When I got out, I decided I would never go to a hospital again. After a while I met a Syrian private

[60] Interview with Sara, April 7, 2021.
[61] Mehmet Akif Ersoy Hospital is a public thoracic and cardiovascular surgery teaching and research hospital.

> doctor who was really good…I went to the private Syrian doctor and showed him all the reports and he said, "You survived death, you're very lucky." They told me to come back to the hospital to repeat the surgery but I didn't go back anymore.

I asked Dina if this fear was general to all hospitals or just the one where she had the bad experience. She responded:

> In general I now fear the public hospitals. I don't want to go anymore. I stayed in intensive care for a week. When they discharged me, I went home and slept one night. I woke up the next day and I looked at my legs and they were entirely blue. I went back to the hospital and they said the arteries in my legs had fully constricted so they put me back in intensive care [for another week] and treated me again…It was so dangerous. I really hated it. I would never go back. [We kept talking about her follow up treatments.] [The Syrian doctor] told me about a good hospital--a private hospital--but I needed to pay 30,000TL. So we started to gather money, borrow money from people we knew, and I did the surgery 2.5 months ago...The Syrian doctor came with me and helped me and there was also a translator…I'm doing better now but I still have the debts. The money is the biggest problem.

Dina was grateful to the Syrian doctor and the private hospital where she had her surgery corrected. But she was also consumed by the debt she now had and was unable to pay. She recounted going to organizations for help but being scolded by the organizations. They would tell her, "Why did you go to private hospital, even Turkish people go to public hospitals, why did you put yourself in that position?" And so, given her fears of the state system, Dina ended up instead with a mountain of debt. "I'm so tired. Just because of this medical issue. It's been so exhausting."[62]

Ultimately, many Syrians were practical about which providers they would use for various healthcare needs. But when negative experiences compromised Syrians' ability to get safe or dignified treatment, they often turned to Syrian doctors who would point them toward private alternatives. While these options could be potentially lifesaving, they also could be financially crippling. For Syrians with limited information and income, this could lead to

[62] Interview with Dina, March 24, 2021.

extreme long-term stress. As Dina learned firsthand, NGOs that provide assistance to refugees cannot help Syrians who have incurred costs at private hospitals.

The Legal Bureaucracy of Care

Negative experiences at Turkish state providers are just one reason that individuals divert away from state clinics and hospitals toward private doctors. One of the main reasons that Syrian clinics initially emerged was that individuals were experiencing long lags in attaining their temporary protection IDs. When large numbers of Syrians were arriving in Istanbul, state offices could not keep up with processing, leaving many Syrians without the access to care they would become entitled to with an ID. Other bureaucratic hurdles included the transition from 98 to 99 numbered IDs and the formal end of registration for Syrians in Istanbul in 2018. These changes meant that there have always been a considerable number of Syrians who do not have the requisite temporary protection IDs for care. In many cases, individuals who registered in other provinces and then moved to Istanbul for work or through family networks were also left with statuses that prevented them from accessing care.

These difficulties were experienced vastly differently by Syrians depending on when they arrived, where they first registered, and how they decided to register. While most Syrians registered under temporary protection, others wary of temporariness applied for residency permits, complicating the services they had access to. In a system designed specifically for holders of temporary protection IDs, variations in registration type created persistent challenges for a host of Syrians typically left out of analyses that focus by default on temporary status holders. The ways that individuals navigated periods without legal registration also affected the ways they would utilize services once they had it.

Jiyan, a Kurdish woman from Damascus who came to Istanbul via Dohuk, Iraq, explained her registration struggles.

> Wallahi it was so hard…I suffered a lot to get the *kimlik*[63]. I stayed here for more than three years without a *kimlik*….but my husband was ill and we didn't have the ID, and we knew we would have had to pay too much for the doctors, so I went to Rafah association and asked them for help--they really helped me and we finally got it, and they also provided us with medicines. [Jiyan then explained her attempts to get care without the ID.] I only needed a doctor when I was pregnant, I never needed anything else really. Except once when I went to a hospital in Zeytinburnu. I had someone else's *kimlik*, a friend I knew lent me hers. I went to the hospital and they discovered it wasn't me, it didn't work! But I was forced, I had to try. Otherwise I would have to pay, and I couldn't.

I asked Jiyan why she had not registered for the temporary protection ID when she arrived in Istanbul in late 2015, back when the process was relatively streamlined. "At first, when we arrived, we didn't actually know about the *kimlik*. That's why we didn't get it right away. By the time we knew we needed it [in 2018], it was really difficult." Once Jiyan finally got her ID, she was able to figure out the state system, and now utilizes the services that she is entitled to, both at MHCs and hospitals. Until then, however, she had to rely on Syrian organizations and networks of friends to help navigate the system.[64]

When Jiyan mentions registration difficulties, she is referring to the restrictive turn in Istanbul's registration enforcement in 2018. Refugees have been barred from registering for TPR in Istanbul since early 2018, but for exceptional cases that often require advocacy by an NGO or bureaucrat. This has led to a large number of undocumented Syrians in the city. Moreover, according to the governor's office, nearly half of the 500,000 registered Syrians in Istanbul had their registrations processed in other provinces, which has made them liable for deportation to

[63] *Kimlik* is the Turkish word for ID and is used synonymously with the temporary protection IDs among Syrians.
[64] Interview with Jiyan, December 4, 2020.

their province of registration after October 31, 2019.[65] At this political juncture, Human Rights Watch documented an increase in deportations, as well as the unlawful denial of education and healthcare services to newly arrived refugees (Human Rights Watch 2018a).

In the summer of 2018, the governor of Istanbul Province issued a memorandum calling for all refugees who did not have Istanbul registrations to leave the province.[66] Those with registrations in other provinces were advised to return to their province of registration, and unregistered refugees were threatened with deportation. During this period, Syrian refugees experienced a flurry of illegal deportations to Syria, often without any notice or explanation of where they were being taken (ibid.). Those who remained unregistered feared deportation to Syria.

Numerous respondents had registration-related difficulties in healthcare access during and after this restrictive turn. The most common scenario was that individuals with registrations in other provinces would realize that they would need an Istanbul registration if they needed to access care within Istanbul. According to my interviews with Turkish social services experts in Istanbul-based support NGOs, this was an incredibly common problem specifically for pregnant women. Before 2018, childbirth was considered a healthcare emergency, so pregnant refugees who did not have local registrations could approach hospital emergency rooms and get the care they needed for free.

This understanding was reversed after 2018. At this point, the Istanbul Health Directorate's general stand was that pregnancy is not an emergency, given that unregistered refugee women have many months from the realization that they are pregnant to arrange their

[65] This was covered widely in the media, including Selcan Hacaoglu's December 2018 article in *Bloomberg News* entitled "A Flood of Refugees Tests Turkey's Tolerance."
[66] For the press release of the governor's statement, see "Düzensiz Göçle Mücadele İle İlgili Basın Açıklaması," T.C. İstanbul Valiliği, 22 July 2019, http://www.istanbul.gov.tr/duzensiz-gocle-mucadele-ile-ilgili-basin-aciklamasi.

birth plans in other provinces where they can register for temporary protection. In interviews with NGO workers in Turkey who provide support to Syrian refugees, they noted that since 2018 they have advised individuals to return to their provinces of registration for childbirth so they could have the procedure done for free. For middle class individuals with some means, they would also communicate that private hospitals were an option. The NGO social workers would recommend purchasing inter-city bus tickets to pregnant women as a last-ditch effort to help them avoid paying for private hospitals. Inter-city bus tickets in Turkey typically run at a fraction of the cost of a childbirth procedure in a private hospital, making travel to their original province of registration a financially—if not logistically—viable option for a birth plan. What that would mean in practical terms was left to Syrians to figure out.

Even after the registration crackdowns in Istanbul in 2018, there were some ways that individuals could register or switch registrations to Istanbul from other provinces. If they registered for K-12 school, if they had a nuclear family in which statuses were mixed among different provinces, if they produced a formal work registration in Istanbul, if a student was registering at a university, or, in rarer cases, if a patient who needed specialized healthcare locally could make this known to officials at the Directorate of Migration, they could apply for Istanbul registrations. Interviewees who had registered for university or had applied during their pregnancies for provincial transfers had in some cases been successful in their local re-registration efforts.

Janah, 23 years old when we met in 2021, had left Idlib in Northern Syria and crossed the border on foot to Reyhanlı on the Turkish side of the border while she was one month pregnant in late 2017. She and her husband came straight to Istanbul, where Janah's uncle had already settled. The timing of their attempts to register corresponded to Istanbul's move to strictly limit

registrations for temporary protection. She recalled: "It wasn't easy, we had a lot of problems …they only gave [the ID] to me because I was pregnant in my last month and was going to have a child." During the interim months before she was registered, Janah exclusively went to informal Syrian clinics for her prenatal care. For the birth, she went to a public Turkish hospital. She still prefers the Syrian clinics and goes to three different ones in the neighborhood for her various healthcare needs.[67]

Aya, 50, her husband, and their three teenaged children also came to Turkey from Idlib when the security situation deteriorated in 2017. They spent six weeks in the province of Kayseri in central Turkey, where they registered for their temporary protection ID cards, before continuing to Istanbul's Güngören neighborhood. Their family experienced the gradual tightening of registration restrictions. When I asked Aya whether they were able to access healthcare services or other social services with their Kayseri-registered IDs in Istanbul, she explained: "At the beginning it was easy and normal. We would go to the hospitals, we registered [for aid] from Kızılay[68]. But when the problems started, we tried to go to the hospital and they told us 'no'. Things were fine at first but then it got much worse with the changes."[69] Ultimately, they were able to change their registrations from Kayseri to Istanbul in 2020 when her husband got a formal work permit in Istanbul. Only then could they access the state providers comfortably, and they have since adjusted to the state system. The only family member that was still regularly going to private Syrian clinics was the daughter, by choice, for her antenatal care.

In 2022, it was unclear how many completely unregistered Syrian refugees there were in Istanbul. But conversations with NGO workers suggested that there were likely tens of

[67] Interview with Janah, February 4, 2021.
[68] Kizilay, the Turkish Red Crescent, has an EU-funded cash assistance program for Syrian refugee families that meet specified criteria for aid.
[69] Interview with Aya, March 2, 2021.

thousands. I did not interview any refugees after 2018 who lacked any form of legal registration. (Individuals I contacted through snowball sampling all ultimately declined interviews. Understandably, the unregistered population tries to stay below the radar.) In order to understand the experiences of the unregistered, I relied instead on interviews with the doctors who treat them, NGO officials who dealt with their protection cases if they have reached out to NGOs, and secondary journalistic reports.

Unregistered refugees face immense difficulties in access to services in Turkey in general, and in Istanbul in particular. Strictly speaking, all individuals in Turkey can access emergency care for free. This includes unregistered refugees. Yet in practice, there are two main adverse outcomes that unregistered refugees fear in accessing public providers. The first is a generalized fear of being reported to authorities and deported, much like undocumented immigrants in strict enforcement contexts around the world (Cervantes and Menjívar 2020; Natta 2023). In the aftermath of Istanbul's enforcement crackdown in 2019, unregistered refugees were, in some cases, deported back to Syria. Local police started doing identification checks in the streets, and unregistered individuals retreated away from spaces in which state bureaucrats might report them (Karakas 2020). More often, doctors would refuse to provide care and send unregistered refugees away from the hospitals. Rather than refusing service, however, it also became increasingly common for public hospitals to charge individuals for services rendered using the state's established health tourism prices. While these individuals were not deported or reported, they sometimes ended up leaving public hospitals with onerous debts (Sevinin 2020: 13).

One social worker at a national refugee support NGO in Istanbul described some of the cases he had encountered.

> We get cases where people go to the state hospital, and they tell [the hospital workers] they're unregistered. In those cases they'll sometimes leave with a bill of 8000 Turkish lira, even though it's a public hospital. In that case, we send them to our lawyers, and we've had some cases where that amount will be halved by the General Directorate of Migration...Or, if someone has a bill from a state hospital, but then they go and get an ID, we can have that bill erased. They can make the claim that they were originally unregistered but they have the right to care now. This is really hard, because they need to get an Istanbul ID, they can't register in another province and get the bill erased.[70]

Syrian doctors in the Migrant Health Centers also lamented the difficulties that unregistered refugees faced, even as they tried to help individuals. The rules that dictate access to Migrant Health Centers are ambiguous. While in theory all migrants, regardless of registration status, should be able to go to MHCs, practices vary across centers. There is no written rule in any Turkish legislation about whether unregistered migrants can avail themselves of services at MHCs, even though Ministry of Health officials and SIHHAT Project supervisors affirmed in interviews that they have this right. Through word-of-mouth, refugees and NGO employees learn which MHCs will accept unregistered Syrians and which will not. When I asked one Syrian general practitioner working in an MHC about how their center dealt with migrants without registrations, he let out a big sigh before explaining:

> The patients who don't have IDs come to us. For me and my colleagues here, in our municipality, a normal health complaint is not a big problem. The local municipal health directorate here allows it. We make a physical examination and we write some medication, but if the patient has a big problem we have to send them away. We can only do physicals…in emergency cases we call the ambulance and they come to us and they take the patient…but when its not an emergency, for people without IDs, or those with IDs from another city, this is a big problem. The hospital can't accept them…they can only go to a private hospital or clinic.[71]

[70] Interview with social services worker at NGO, October 18, 2021.
[71] Interview with MHC doctor, January 11, 2022.

Another doctor from a Migrant Health Center explained the bureaucracy of how they dealt with unregistered patients. Showing me the online patient registration portal, he explained that they are entered into the system as *vatansız,* or "stateless", rather than as individuals with a Temporary Protection ID number, Turkish ID number, or foreign passport number. These individuals can be referred to the hospital if they need to be but may end up having to pay medical tourism prices.

Essentially, only some MHCs examine unregistered refugees if their local municipal health directorate allows it. But even so, the scope of what service they can provide is circumscribed and doctors end up exercising considerable discretion depending on their workload and the health situations of particular cases. Most MHC doctors accept individuals from other municipalities outside the one they work in, but matters become more complicated for patients registered in different provinces. Another MHC doctor explained:

> From other cities, they say it is forbidden. We can only accept them if they have travel permissions…from the Directorate of Migration…Once in a while, we will see that there is a family, and the husband is from Istanbul but the wife is from Urfa, and she is pregnant. There is a lot like this. It is very difficult. We accept it, we do the check-up…We accept pregnant people every time, no matter where they came from.[72]

Often, unregistered Syrian refugees are among the most vulnerable refugees. Yet there are also Syrian refugees who are registered with the Turkish state under alternative statuses other than the temporary protection statuses that can still produce vulnerability in access to services. Syrians who come from middle class families would often come to Turkey by plane rather than on foot and would enter with tourist visas. Once those tourist visas ran out, some opted to pay the fee for a residency permit rather than obtaining a free temporary protection ID card. This was typical

[72] Interview with MHC doctor, November 20, 2021.

among people who had means and intended to continue to travel across provincial and state borders, or those who were otherwise skeptical of the temporary protection status as a legal tool.

Farid, a thirty-year-old journalist, was emphatic that he would not take a temporary protection ID: “The ID is a short-term protection, this sentence scares me, what is the meaning? Whenever you want you can say no to me, we saw this happen last year, a bunch of people with IDs were sent from Turkey to Idlib. I need to go outside to see my parents, and the ID doesn’t let you travel.” Given his family’s reasonably comfortable financial situation, this was tenable for Farid for a time. Then, however, he had a seismic health event. After having some odd sensations in his head, he went to a private hospital for medical attention. A scan revealed that Farid had a six-centimeter-long brain tumor and would need surgery to remove it.

Had he been under temporary protection, the surgery would have been free. Residence permits, however, afford no such benefit, as individuals must purchase insurance on their own. Often, this insurance is quite limited in coverage. Farid went to five different health centers to try to find an option that was both affordable and could perform the complex surgery. Many refused due to the difficulty of the procedure. Farid went to a radiology center with a Syrian doctor for advice and was spooked when the doctor suggested that their center could do the surgery, saying it was simple enough. Farid was aghast. “What the hell are you talking about? I visited five hospitals and they all rejected doing this surgery…I felt like he saw me as a pocket of money or wallet, and he was calling me several times, like when do you want to make this surgery, we can do this, I have friends who can do this surgery.” Farid was alarmed by the insistence of the Syrian doctors and opted instead for a Turkish private hospital in Kirazlı, where he had to pay $5000 out of pocket for the procedure, an overwhelming sum for his journalists’ salary.

Late into our interview, he circled back to the topic of finances. “I should have made a second surgery two years ago, but I don’t have that money, so I postponed it until I can get a formal work permission. Because work permission has insurance included, it will cover most of the surgery. But now I can’t with the card I have, even though it’s so critical, it’s so important but I can’t do it because I don’t have $5000.”[73]

Farid had not been able to avail himself of the healthcare services available to registered Syrians. Opting out of temporary protection, he had needed employment that could provide adequate health insurance. Yet, given that he was employed by a Syrian media association that could not provide insurance, he could not cover his medical costs. His goal, however, was to get Turkish citizenship rather than to apply retroactively for temporary protection. His application was underway at the time of the interview, though in the process he had encountered some detours, including being scammed by people pretending to be from the Directorate of Migration Management. Finally, it seemed, things were on track and the approval process was progressing. Until the citizenship determination and subsequent employment process, however, his brain surgery would have to wait.

Conclusion

This chapter has sought to show how institutional, interactional, and legal dynamics lead Syrian refugees to opt for care from Syrian doctors in private, sometimes informal healthcare settings despite access to free public healthcare. By “institutional” I refer to the limitations of the free state providers--most centrally the fact that Arabic-language care for refugees is limited to primary care, leaving a persistent demand for linguistically and culturally competent secondary care. This demand is also fueled by other institutional features of the Turkish state system that

[73] Interview with Farid, February 20, 2021.

can require long waits for appointments and have limited working hours. By "interactional" I refer to refugees' negative experiences in Turkish state healthcare providers. These may be experiences of discrimination or racism, miscommunication, or poor treatment, which coalesce together into a general distrust of state providers among some Syrians. Finally, by "legal" I refer to the ways that the temporary protection regime's limitations and uneven application over time structure the ways individuals with a variety of legal statuses navigate available providers.

These three admittedly broad dynamics together can make navigating free state providers logistically onerous, emotionally fraught, and legally precarious for Syrian refugees seeking healthcare. The persistence of Arabic-language care in informal or semi-formal arrangements poses a convenient alternative in cases where health interventions are minor. Syrian doctors can also act as brokers for individuals seeking specialist care, though often this leads individuals toward private providers. These private alternatives are often financially onerous for refugee families. Yet in matters of health--which are sometimes matters of life and death--the pursuit of reliable care may trump the appeal of free care. As a result, the demand for secondary care services from Syrian doctors persists despite the Turkish state's massive investment in Arabic-language care through state-run Migrant Health Centers. Moreover, when institutional changes to refugee healthcare are combined with changes in legal status enforcement practices, nonstate providers appeal to refugees as a relatively stable source of care. The following chapter examines the role that Syrian doctors play in perpetuating nonstate Arabic-language provision despite state attempts to circumscribe these semi-formal activities.

Chapter 5: Global Talents, Local Limits

On May 3, 2022, a short film called *Sessiz İstila*, or "Silent Invasion," was released on Twitter and Youtube. Funded by Ümit Özdağ, the fringe Victory Party's virulently anti-refugee leader, the film draws on some of the worst anti-refugee impulses of the Turkish nationalist imagination. The video presents a racist dystopian vision of Turkey in 2043, when Syrians have become the majority in Turkey and the country is run by Syrian politicians. The video begins in 2011, with a couple expecting a child watching a news report about the Syrian revolution and subsequent arrival of refugees at Turkey's southern border. The couple expresses sympathy for the refugees, who have lost everything and have little choice but to seek safety across the border.

The couple is looking forward to their child's birth, whom they dream will become a doctor and make his grandmother proud. "Nothing will stop him if he studies," they muse. When the video jumps ahead to 2043, the 32-year-old son is, indeed, working in a hospital. But he is not a doctor. He is a cleaner in a hospital run by a Syrian doctor. He complains to his parents. "Remember I was going to be a doctor? Remember my grandma was going to be proud? What was that magic formulation—everyone who works will achieve their goals, nothing can stop them. I worked but what happened in the end? They won." He complains that his parents did not stand behind the Turkish doctors who were resigning, that they did not raise any alarm about the demographic changes in Turkish society. He describes the hospital he works in. "It is illegal to speak Turkish in Zeynel Bey's hospital. Why? Because neither the doctors nor the patients know Turkish." He says that even the Turkish employees speak Arabic amongst themselves. "They can't say my name so they call me, 'Hey, Turk!'"

The short film draws on racist tropes from start to finish. It taps into deep-seated fears nationalist Turks have about a "demographic shift" with the increasing Syrian population. The

town is noticeably poor and ramshackle, Arabic music emanates in the background, and Arabs are depicted as bullying thugs. The creator of the video was, perhaps surprisingly, taken into custody briefly for distributing a video that manipulated facts about the refugee crisis, but she was released shortly thereafter. Within 24 hours of its release, the video had over 2 million views.

What is most interesting about this film from the perspective of this dissertation is that the main site of contestation depicted is the healthcare provider. Healthcare for refugees has been a societal sticking point for Turks since temporary protection was established. As Selin Siviş's interviews with Turks about their attitudes toward Syrian refugees show, Turkish citizens often understood the right to free healthcare for Syrian refugees as an undeserved privilege because they did not have to pay a contribution fee to the Social Security Institution like Turkish citizens did (Siviş 2022). The misconceived notion that Syrians get to "jump to the front of the line" at the hospital has been a recurring trope among disgruntled Turks dealing with a struggling health system.

Interestingly, in the short film, it is not *access* but rather *provision* that is highlighted as a site of tension between Turks and Syrians. The dystopia depicted is one where Syrian doctors reign supreme, and healthcare is rendered in Arabic, leaving no work for qualified Turkish citizens. This is striking for numerous reasons. First, between 2011 and 2018, Syrian doctors under temporary protection had no legal means of working in the Turkish healthcare system. This included being administratively blocked from pursuing a standard equivalency process, which other foreigners were allowed to apply for. If anything, Turkey's refugee policies have made it quite difficult for Syrian healthcare workers to gain a professional footing in the medical field, pushing them into informal work.

The second thing that is striking about the video is that it briefly alludes to the fact that Turkey *does* have a crisis in healthcare provision currently. Turkish doctors are leaving Turkey in droves. This exodus has nothing to do with the Syrian doctors who have arrived in Turkey. Rather, Turkish doctors are leaving behind stagnant salaries that do not keep up with rampant inflation in Turkey, long work shifts, and a general loss of respect for doctors coupled with an alarming increase in violence toward doctors. This exodus has been documented in the global press frequently since 2022, from *The New York Times* to *BBC World* to *France 24* to *The Guardian.* In 2021 alone, more than 1400 doctors left Turkey, with 4000 leaving over the previous decade (Gall 2022). In 2022, that number soared to over 2600 doctors who left Turkey (Yaşar 2023). Many of these doctors are leaving for Europe, with Germany as the preferred destination. Syrian doctors are not filling in those gaps. Instead, throughout the country, hospitals lack integral specialties, and patients of all backgrounds—citizens and immigrants—suffer.

Sessiz İstila paints an invented mechanism of the replacement of Turkish doctors by Syrian doctors. Yet it is true that Syrian healthcare professionals have been trying to gain a foothold in the Turkish healthcare terrain as providers. As the chapter on the emergence of refugee-run clinics demonstrated, this often meant working in the informal sphere, lest they wanted to switch careers and work in office jobs or manual labor. While many Syrian doctors sought out Istanbul specifically as a place with more job opportunities, these jobs varied in their reliability and availability, leaving many doctors in professionally precarious situations.

Formalizing Work for Syrian Doctors

The first attempts to provide a systematic pathway to employment for Syrian doctors began with the influx of funding from the European Union in 2016. After the EU-Turkey Deal was negotiated and the SIHHAT Project established, Syrian doctors were given the opportunity to

apply for jobs in Migrant Health Centers. As described in chapter 2, these centers were established in 29 provinces across Turkey with large Syrian refugee populations. According to a Ministry of Health Report published in 2021, 712 Syrian doctors, 977 Syrian nurses, and 1148 "patient guides" (translators and auxiliary staff) were employed by the SIHHAT Project by June 2020. After having their Syrian healthcare certifications confirmed by the Ministry of Health, these healthcare professionals were given a five-week training to become acquainted with the Turkish healthcare system, including a week of practical on-site training in clinics. These trainings were held across seven provinces--Ankara, Gaziantep, Hatay, Istanbul, Izmir, Mersin, and Şanlıurfa--in Refugee Health Training Centers. Once doctors completed their trainings, their names were entered into lotteries within their provinces of registration. As MHCs opened, doctors were placed into centers by lottery. Thirty of these Migrant Health Centers are located in Istanbul within municipalities with large Syrian populations (Zikooska et al 2020).[74]

The MHC system presented the only pathway to legal employment for Syrian refugee doctors until 2018. It was designed specifically for Syrian refugees and touted as the solution to two problems: first, the MHCs would provide the linguistically and culturally competent care that Syrians needed in Turkey. Second, they would provide a work opportunity to the Syrian doctors who had been shut out of legal employment in the field of healthcare. The preceding chapter details the limitations of the first expectation. This chapter explores the contours of the latter.

While the Ministry of Health touted the SIHHAT Project as the solution to legal employment for Syrians in Turkey, a second pathway to legal employment was finally allowed

[74] Turkey has also established separate Foreign National Polyclinics (*Yabancı Uyruklular Poliklinikleri)* in areas with large immigrant populations, including but not limited to Syrian nationals. These clinics provide primary care in languages suited to the primary beneficiary population in the area.

for Syrians through the standard equivalency process for foreigners. Before 2018, the Turkish government provided no equivalency process, arguing that the freeze in diplomatic relations between Turkey and Syria prevented the Turkish government from verifying that Syrian diplomas were legitimate. Syrian doctors were frustrated by this posture, given that other countries like Germany and the Gulf Arab states were accepting Syrian diplomas without Syrian governmental verification (Ileri and Tokcan 2017). In 2018, Turkey decided to accept general practitioner equivalency applications without verification from Syria's Ministry of Education, opening up a second route to legal employment. This one, unlike the SIHHAT Project path, was not designed specifically for Syrian refugees. Rather, the general pathway for foreign doctors' certifications became available. Full equivalency requires passing the *Seviye Tespit Sınavı (STS),* or placement exam, and then doing a 6- to 9-month training in a hospital once certification documents are reviewed by the *Yükseköğretim Kurumu (YÖK),* or Council of Higher Education. After this process, Syrian doctors, like other foreign doctors, could attain their general practitioner equivalency.

This chapter examines how healthcare professionals approached the professional options available to them within a broader temporary protection system designed to keep refugee integration at bay. The logic of temporary protection manifests in doctors' lives most clearly in two main ways. First, seven years passed from the start of the Syrian War to the beginning of legal work options for Syrians, as the state hedged on what to do with this highly-skilled population. Second, the main policy intervention to follow was providing work in EU-funded clinics that are institutionally outside the permanent structures of care in Turkey. The chapter asks: How do Syrian doctors integrate professionally, and what are the implications of these employment processes for the terrain of care available to refugees? Moreover, how and why do

some doctors continue to work in precarious informal arrangements once formal pathways become available to them?

The chapter traces how doctors' considerations of legal and economic factors surrounding their work lead to configurations of care provision in increasingly privatized environments. It finds that this preference for private practice is spurred in large part by skepticism about the lack of long-term stability for doctors within the SIHHAT Project's limited jobs. Faced with low pay and professional temporariness in the SIHHAT Project, doctors find alternative pathways to incorporate into the terrain of healthcare provision. These pathways take on a distinctly entrepreneurial valence: Syrian doctors know there is demand for their skills, and they search for institutional structures in which they can most effectively supply medical services. We have already seen how this entrepreneurial approach manifests in the creation of Syrian-run healthcare clinics. Here I elaborate on the expanding entrepreneurial strategies employed by doctors trying to legitimize their work.

The chapter argues that doctors situate their work in Istanbul's healthcare terrain by discursively recasting their skills and resources to justify filling specific opportunity structures in which they can both meet healthcare demands and institutional gaps in provision. They do this by discursively placing themselves within an *international* and *multiethnic* field of providers in contrast to the nationally delimited welfare state in which they must contend with intractable employment processes. This propensity to bypass state rules remains despite the fact that the vast majority of interviewees had, by 2021, received Turkish citizenship. Rationalization of their semi-formal and increasingly privatized work draws on distinct framing strategies that renegotiate and justify their place in healthcare provision in multiple ways.

First, they compare Turkey's relative delay in recognizing Syrian doctors' competencies to other countries around the world, notably Germany and Gulf Arab states. By invoking their peers who continued on to practice in other countries, they affirm their own competencies and frame the Turkish state and its policies as uniquely harsh for Syrian healthcare professionals. Second, they point to their bilingual English and Arabic language competencies as a way to criticize the Turkish equivalency process, which must be navigated in Turkish only, as provincial and short-sighted. They note that their added value in the Turkish system is precisely their multilingualism and their ability to reach a growing Arabic-speaking patient base, as well as their ability to fill increasing specialist gaps in Turkey as Turkish doctors leave for other countries. Finally, they articulate complex critiques of Turkey's temporary protection policies in general, and equivalency limitations in particular, within the broader geopolitical context of intractable war.

Scholarship and policy reports on Syrian doctors tend to focus on the doctors who work in the SIHHAT Project's Migrant Health Centers. In 2020, the World Health Organization, in partnership with the Ministry of Health, conducted a survey of job satisfaction among the Syrian healthcare professionals employed in the SIHHAT Project. Of 1577 total healthcare workers in the system at the time, 891 of them completed the survey. Of those surveyed, 62.3% were nurses or midwives, and the rest physicians. In their sample, 47.3% of participants had received Turkish citizenship. Most of these were doctors as opposed to nurses (Zikooska 2020: ix).

A few basic but important findings are worth highlighting. First, Syrians doctors who work as specialists are generally dissatisfied with work as general practitioners. Syrians who had been practicing as specialists in Syria but now worked as general practitioners in the SIHHAT Project had statistically significant lower job satisfaction than general physicians and nurses and

those very few specialists who had been able to find SIHHAT Project jobs as specialists (only pediatricians and gynecologists) (Zikooska 2020: 19). Finally, doctors were most dissatisfied with the income of their Migrant Health Center jobs. Only 11% of general physicians and 14% of specialists thought their incomes were "good" with 45.6% and 29.9% respectively saying their salaries were poor. Perhaps unexpectedly, de-professionalization through assignment to general medicine and stagnant incomes were the biggest complaints that Syrian doctors have in the SIHHAT Project jobs. These findings were clearly reflected in my interviews, both by those who worked within the system and those who had intentionally avoided it given these known shortcomings.

Recasting Opportunities for Work

For highly skilled migrants with specialized degrees and certifications, migration can initiate a blow to professional dignity and social prestige in the community of settlement. Whereas immigrants who are not forced from their home countries may be able to choose destination countries where their skills match work opportunities (Malkki 1995), or at least make cost-benefit assessments about migrating and forfeiting their educational credentials in the new destination (Kawashima 2021), refugees are often focused on attaining basic security and family safety first. Only later do the more quotidian struggles of settling into work or a career follow. When it comes to matching skills with available work, bureaucratic barriers to degree recognition or equivalency conferral may lead refugees to be under-employed (Krahn et al. 2000) and to become "de-professionalized" (Smyth and Kum 2010) or "deskilled" (Siar 2013).

When faced with the bureaucratic employment strictures of a receiving state, immigrants often turn to entrepreneurial ventures to try to gain a living (Siar 2013). Immigrant entrepreneurship has received sustained analytical attention from immigration scholars who have

sought to explain the socioeconomic mobility of immigrant groups. Often shut out of jobs that require educational degrees and certifications, occupational closure may direct immigrants toward comparatively flexible small business enterprises (Waldinger 1989). Entrepreneurship may be a compelling pathway for immigrants due to the emergence of immigrant-specific demands unmet by local businesses in a destination community. This demand may present a "protected market" to immigrant entrepreneurs that will sustain business (Light 1972). Emergent demand for goods and services, as the previous two chapters have demonstrated, can lead to the entrepreneurial creation of new organizational forms to meet those specific demands.

As scholars of immigrant entrepreneurship have also noted, it is not just demand that drives entrepreneurial activity. The market, the regulatory context, and the broader institutional context of the receiving state shape the "opportunity structure" for emergent businesses in distinct ways. Immigrants need to be able to create businesses in the host community in order to exploit contingent market demands (Aldrich and Waldinger 1990; Light and Rosenstein 1995; Waldinger 1989). This time- and place-specific opportunity structure is shaped by not just the product market (Kloosterman and Rath 2001) but also by the human capital and social capital needed to start the business at the micro-level, as well as the economic and regulatory institutional landscape at the macro-level (Kloosterman 2010).

The institutional forces that shape the opportunity structure are not always stable. Indeed, uncertainty in a market can produce opportunities or niches for immigrant businesses to emerge. This is because larger, more institutionalized firms or organizations may be less nimble in dealing with the caprices of the market (Waldinger 1989). Yet uncertainty may also be a feature of the complex institutional environment in which the entrepreneurial ventures are embedded. Changes in rules and regulations may expand, constrict, or transform opportunity structures. For

example, previously tolerated informal immigrant businesses may face tightening state enforcement and business closures (Kloosterman et. al. 1999: 262).

Chapter 3 of this dissertation examines how regulatory as well as political uncertainties shape immigrant organizational emergence and survival in the "humanitarian niche" created by the swift arrival of refugees to a host locale. This chapter shifts focus to the professional motivations of individual doctors as the institutional context continues to constrict work opportunities. Unlike chapter 3, which focuses on the material and political strategies organizations employ to sustain themselves, this chapter focuses on individuals' discursive strategies as they criticize and discredit the existing institutional context in which they work. These discursive moves both highlight the structural limitations of work opportunities while allowing doctors to reframe and renegotiate opportunity structures that shape their day-to-day work. I conceive of Syrian doctors in Turkey as entrepreneurs who create new organizational combinations (Swedburg 2000), rather than merely as business creators or profit seekers. I analyze how doctors navigate changes as well as stubborn continuities wrought by the temporary protection regime, and the shifting institutional landscape that emerges out of the policy.

Entrepreneurs may deploy particular rhetorical strategies to both discredit the existing institutions that structure a field as well as to justify or legitimate new forms of organizing (Suddaby and Greenwood 2005). These discursive practices recall social movements scholars work on "framing". Political opportunities, organizational resources, and discursive framing processes precipitate what social movements scholars refer to as political opportunity structures (Koopmans and Statham 1999: 203; McAdam, McCarthy, and Zald 1996). Entrepreneurs similarly discursively situate their work in particular opportunity structures they have identified as legitimate, an element of entrepreneurship often left unexamined in the migration literature.

By making analytical space for a discursive analysis, scholars can better understand why entrepreneurs mobilize in specific organizational configurations within complex fields (Koopmans and Statham 1999).

The opportunity structure, then, is more than an institutionally structured space of interaction between market demand and feasible supply. Rather, it is institutionally structured but also discursively justified and legitimated based on shifting political, economic, and organizational dynamics in the field. These shifts allow entrepreneurial ventures to adapt within the capricious institutional contexts in which they are embedding. Individual entrepreneurs' vernacular practices of defining their own skills and potential contributions to the community in relation to other points of reference serve to reorient their work toward alternative opportunities, explored in chapter 7.

Doctors During Wartime

The Syrian war thrust doctors into the frontlines of a brutal conflict. When the protests against Bashar Al Assad's government were violently repressed by the regime, the ensuing conflict would lead to over half a million lives lost over the next decade (SyriaHR 2019). As cities became battlegrounds between the regime and opposition fighters, individuals caught in the crossfire desperately needed medical attention. From the beginning of the revolution, Syrian doctors played a key role in providing care to individuals injured in the protests and the war. While a handful of doctors were recruited by the regime to carry out torture in detention centers (Alkousaa and Uhlig 2022), far more doctors became the targets of state violence and torture. A report from Physicians for Human Rights (PHR) details systematic state violence against healthcare facilities and workers from the beginning of the war. According to their research, 90% of the 583 documented attacks on healthcare facilities had been carried out by the Syrian

government and its allies. This was a part of a broader effort to systematically deprive civilians in opposition-controlled areas of medical care (Koteiche, Murad, and Heisler 2019: 3). Between 2012 and 2021, Physicians for Human Rights calculated that 3,364 healthcare workers were detained or forcibly disappeared, and 945 were killed in attacks on health facilities (Hunter and Youssef 2023).

In this context, many Syrian doctors attempted to provide nondiscriminatory healthcare to whomever was injured and needed care. Providing healthcare was both physically and politically dangerous. This meant that doctors would provide care to individuals in opposition held territories, including those fighting against the regime. Syrian doctors set up field hospitals in areas where hospitals were destroyed and supplies were lacking in order to provide basic emergency care. In the midst of these efforts, a range of healthcare workers--from physicians to nurses to pharmacists to physical therapists--were detained by state agents, imprisoned, and tortured (Koteiche et al. 2019). Healthcare workers, some of whom were still in the midst of their medical training when the war began had to learn emergency care on the fly and worked in brutal field hospital conditions with limited supplies and the risk of shelling.

Many of the doctors I interviewed had spent time in field hospitals in opposition-controlled areas before deciding it was too dangerous for them and their families, then deciding to come to Turkey. Many stayed and worked in harrowing conditions until the hospital they worked at was bombed, or their homes were bombed, or until the areas they were working in fell back into government hands. Dr. Hassan, a surgeon, described in detail his work trying to provide care in a modest field hospital, where he became an impromptu obstetrician, psychiatrist, and infectious diseases expert. This work, at least, was normal, he said. He then described working in the field hospital in the aftermath of a chemical attack, which he said killed almost

1400 people in one hour. “The massacre of the century”, he called it. “We couldn’t do much…if we thought they could survive we would give them support, but if it seemed like they couldn’t we’d just try to make them a little more comfortable, that’s it, we couldn’t afford to give them more medication if they’re not going to get better. That was really hard for us. That’s what we had to do in war conditions. We felt helpless.”[75]

Physicians like Dr. Hassan were referred to as “terrorists” by the regime for providing healthcare in opposition areas. Risking arrest for carrying out their duty to provide care for individuals regardless of their political alignments in the war, these doctors had few options but to flee across borders. Many had developed prodigious emergency care skills as well as a knack for resourcefulness in the face of chronic medical supply shortages. Their retraining as humanitarian emergency medics and their role as key figures in sustaining the health of the Syrian population was suddenly obviated in Turkey, where there was no place for them as healthcare workers. Aside from the informal humanitarian and NGO clinics described in chapter 3, Syrians had few professional options.

Making the Case for Integration into the Turkish System

Once Syrian doctors arrived in Turkey, they had no legal professional pathways available in their field. As chapter 3 details, many of these doctors transferred their humanitarian role in helping Syrians from war-time field hospitals to humanitarian clinics in Turkey. Given the acute need for Arabic language care and the strain on the Turkish healthcare system, Syrian doctors were given leeway in working without their equivalencies. As enforcement tightened in 2018 and 2019, doctors reoriented themselves toward more long-term work options within Turkey. The SIHHAT Project’s Migrant Health Centers posed one viable option, as a legal government job with a

[75] Interview with Dr. Hassan, November 17, 2021.

stable, if somewhat low, income. Yet the uncertainty of the SIHHAT Project's future made many Syrian doctors uncomfortable. Syrian doctors working in MHCs do not get equivalency, so doctors worried about what their professional fate would be if EU funding for the project ended or if temporary protection policy was summarily reversed and the project shuttered. The other option was to undergo equivalency, which posed onerous challenges to doctors who had spent the last years working in Arabic-language settings and had not yet acquired the requisite Turkish language skills to successfully complete the STS exam.

Doctors became quite frustrated that barriers to professional entry still remained steep ten years into Turkey's opening of its borders to Syrians. These professionals, who had become intimately acquainted with the Turkish healthcare system but could not work in it, articulated clear structural arguments for why they should be integrated into an ailing provider terrain. These doctors used arguments about the Turkish system's personnel shortages to critique and therefore delegitimize Turkey's employment policies for refugee doctors. By doing so, Syrian doctors established the Turkish policies as narrow, unreasonable, and self-defeating while reaffirming their specific qualifications and positioning themselves as untapped assets in the broader healthcare terrain.

Many doctors referred directly to the shortages of Turkish doctors in the healthcare system. The recent wave of departures to Europe have come hand in hand with decreasing numbers of people seeking out careers in what is now perceived as a field undergoing a devaluation of societal respect. Pointing these dynamics out, Syrian doctors positioned themselves as potential assets to help relieve these personnel shortages. Dr. Ramzy was a dentist who had lived in Istanbul for eight years by the time we met in 2022. When he first arrived, he worked at the Rafah charity clinic for three years. He would commute from Başakşehir, a

periurban municipality close to the Istanbul Airport with a large middle class immigrant population, to work in the clinics. As time went on, he wanted to leave the charity clinic and start his own clinic with a friend, which he did for a little while. But he felt uneasy working informally without the relative stability the charity clinics were able to provide. So, he ended up looking for work in a Turkish polyclinic that was willing to take him on as he worked toward his equivalency. I met him there, where he had a glassy office in the top floor of a large private clinic.

Since beginning the equivalency process, he had faced barrier after barrier. First, after he registered for a program in orthodontics and completed two years of the three-year program, the university froze his registration because he had not yet taken the equivalency exam. He had to hire a lawyer to fight the freeze and won. But the university management reopened the case, saying that he could not get a masters in orthodontics without passing the general dentistry equivalency. At this point, Dr. Ramzy argued that there is no reason for him to get equivalency, as he is ready to leave Turkey and head to the Gulf, where he would be able to work legally through a simpler equivalency process.

Dr. Ramzy leveled a harsh critique of Turkey's system, which he pointedly argued failed to support Syrian talent in Turkey.

> Here we even tried to unite the doctors, dentists and pharmacists--we made a *dernek*, we held meetings. I was one of the representatives. We had 250 doctors. We went to the Ministry of Health and told them we need to fix the situation. They told us, yes, we will help…They took some doctors and put them in the EU Project. But they don't have equivalency either, they just can give primary care. This is so bad because Turkey needs specialists. I go to the Cam and Sakura Hospital in Başakşehir, patients come and they need services but the hospital says we don't have those specialists here. Yet we have Syrians with a lot of experience, why don't you benefit from them? Why don't you ask them to treat these patients? Turkey doesn't benefit from the Syrians' specialist experience. This is very wrong in my opinion.[76]

[76] Interview with Dr. Ramzy, March 2, 2022.

Dr. Ramzy drew directly on the gaps in the Turkish system to point out the shortcomings of the attempt to integrate Syrian healthcare professionals into the Turkish system. This sentiment was echoed by Dr. Ahmed, a pediatrician from Aleppo. He noted, "Unfortunately for Syrian doctors, the equivalency process is a huge struggle. And that's too bad because Turkey has a shortage of specialist doctors, we only have 32% of the specialists we need, so the Syrian doctors could be really helpful. But, of course, the language issue is big." Here, Dr. Ahmed notes that full integration of the Syrian doctor cadres would necessitate language acquisition that can be challenging in mid-career.[77]

Syrian doctors also pointed out that their integration into the Turkish healthcare system would have benefits beyond filling gaps in specializations. Dr. Farid, who first left Homs for Lebanon and then came to Turkey to be able to work, albeit informally, reflected on his circuitous professional path since the war started in Syria. Upon coming to Turkey, he had worked at Khayr Clinic for a while. Then he had started working alongside a naturalized Palestinian doctor in a dental clinic. He was incredibly frustrated with the system as he continued to navigate the equivalency process. When discussing Syrian doctors' benefits to Turkey, he said:

> If Syrian doctors were employed here legally they would also relieve pressure on the Turkish hospitals and centers. You always hear complaints about the serious amounts of pressure on these places, the severe crowding and lines. We would help relieve these Turkish doctors. And it's not just about Syria. There are refugees here from almost every Arab country, we have so many Arabs in Istanbul. Turkey should facilitate our work here. They should let us formalize, and it would benefit them! We would pay taxes, we would relieve them of burden, we would help economically. The laws should work for people, not against them. They should benefit people, not take away from them.[78]

[77] Interview with Dr. Ahmed, January 27, 2022.
[78] Interview with Dr. Farid, January 11, 2022.

Dr. Farid extended the argument about an institutional need for Arabic language speakers from an issue of manpower to an issue of domestic economic vitality. Unlike informal clinics, legal clinics must pay taxes to the government. Moreover, private healthcare provision to Arab migrants and refugees in Turkey could become a thriving niche for Syrian doctors. Dr. Farid's multifaceted analysis of Turkey's healthcare system draws attention to the losses Turkey bears by not integrating a well-connected and skilled group of Syrians.

Moreover, the doctors who were integrated into the SIHHAT Project's MHCs universally pointed out the structural shortcomings of their inclusion in the Turkish healthcare system. Just as the WHO survey of job satisfaction among MHC doctors indicates, Syrian specialists working in MHCs find their de-professionalization and assignment as generalists frustrating. While the WHO survey frames this concern in terms of personal dissatisfaction, Syrian doctors in interviews often linked this frustration with the fact that they were being de-skilled in a healthcare context where their skills are actually acutely needed at the specialist level.

Dr. Hamza first noted that he was frustrated professionally before expanding on the problems with the MHC focused healthcare intervention. When I asked him if he liked his job as a general practitioner in an MHC he said, "It's fine but it's not my job. As you know I'm specialized in internal medicine. I used to work in a hospital, I like hospitals. But in Turkey I can only work in this clinic." He then went on the explain how this reproduces a structural problem in healthcare provision. "In our center here we speak Arabic, English and Turkish, so [the Syrian population] doesn't have trouble here. But our healthcare here is not enough, it's just primary, not secondary--just vaccination, clinical exam, some blood tests, just that. If they want to provide

more we would need to provide [Arabic-language] clinics with specialized care. The [Turkish] specialists can't provide good care for the Syrian population."[79]

Syrian doctors positioned themselves as essential actors in a healthcare terrain with structural problems that they are uniquely suited to help fix. This positioning served to both critique Turkey's refugee employment policies while underscoring the breadth of potential contributions that Syrian doctors can make to the healthcare system in Turkey. By pointing out the seemingly obvious discrepancy between supply and demand for specialized healthcare in Turkey—for Turks as well as Syrians—doctors discredit what they see as policy intended to exclude them from Turkey's institutions of care. These doctors are keen to note that Turkey has benefitted economically from Syrian labor and Syrian capital in other domains. As Dr. Farid mused, "A lot of factories moved from Syria to Turkey and they allowed that no problem. But when it comes to doctors, they don't let us work. How is that fair?"

The persistent mismatch between Syrian doctors' skills and the narrow types of jobs available to them created pointed frustration at national policies. These include the SIHHAT Project's MHC system, and, more broadly, the temporary protection policy that shapes the contours of the SIHHAT Project as the singular healthcare intervention buttressed by EU funding and perpetuated through short-term contracts. These frustrations led Syrian doctors to draw on their knowledge of bureaucratic equivalency processes around the world to level critiques at Turkey, thereby discrediting Turkey's policies.

Global Talents, National Barriers

Syrian doctors are keenly aware of healthcare systems around the world. Among the doctors I spoke to, there were individuals who had completed part or all of their medical degrees in Egypt,

[79] Interview with Dr. Farid, January 11, 2022.

Yemen, Hungary, and Russia, along with other supplementary programs completed in the United Kingdom and the United States. Even before the Syrian war, many doctors were considering possible international migrations to pursue what they thought would be better personal and professional lives abroad. Some had begun multi-step equivalency examination processes in the United States, Canada, and Australia. These aspirations shifted when the war in Syria broke out. With a passport that suddenly lost its value, migration plans stalled. Some pathways--like those to the United States in the wake of Donald Trump's "Muslim ban"—were blocked for Syrians, while other countries began to look relatively more welcoming. Many of the Syrian doctors in Istanbul considered numerous migration trajectories to Europe--most often Germany--but ultimately chose to stay in Istanbul. Their peers, in many cases, took alternate pathways and ended up in countries across the Middle East and Europe. As these professional networks and friendships maintained close contact over the post-2011 years, Syrian doctors began to gain a clearer image of how different countries' reception policies and field-specific employment policies shaped professional integration.

Syrian doctors in Istanbul increasingly critiqued Turkey's healthcare employment policy through direct comparisons to other countries throughout the world. In doing so, Syrian doctors positioned themselves as a part of a global professional elite that was being unfairly hobbled by Turkey's national policies. This strategy served to rationalize protracted informal and semi-formal work as the only economically viable option available to qualified professionals in Turkey. Comparing themselves directly to their Syrian peers, most often in Germany, they directed attention not toward their precarious work but toward the ambivalent national policies that served to exclude them from the healthcare terrain. They diminished Turkey's rules as provincial and short-sighted in contrast to their globally relevant skills. Repeatedly, Syrian

doctors drew direct links between policies in other countries, policies in Turkey, and the limited types of work to which they were constrained.

Dr. Ziad worked as an endocrinologist in a private clinic that he set up after gaining his primary care equivalency. This was the end of a long and circuitous journey towards trying to begin his practice as a doctor. He was due to graduate from his specialty at Damascus University in 2011. He had already secured a job offer in Saudi Arabia that he would have taken after his graduation. But right as he was planning to leave, the Syrian revolution broke out. Intent on participating, Dr. Ziad stayed put. "We would not leave the country at such an important moment like this," he said. "For our lives it has always been 'yes, yes, yes, yes'. Finally, we had the chance to say 'No!' to the government." He ended up opening a practice in Syria while also participating in the protests. He was arrested for his protest activities in 2013 then released a year later in 2014, after which he went to Lebanon for a few weeks before deciding to come to Turkey. He noted that he had considered Germany as well but decided, for the sake of his family, that Turkey would be more culturally comfortable. Yet being in Turkey had made work more challenging than he had anticipated.

> We have been here since 2015. In Europe you can start the equivalency process from Day 0. There are many ways to do this, to check the validity of certification…Here from 2015 to 2018 there was nothing. So most doctors will not stay here. Doctors can only work in medicine. They are not like engineers who can do lots of different work. They will do medicine, so they start to work illegally. Then once the law allowed us to apply for equivalency most of us were busy, there wasn't enough time for us to undertake the process. This makes it harder. If it started Day 0 you will program your day around the equivalency training. The three-year gap complicated things.[80]

This critique of Turkey's delay in establishing a pathway to employment was repeated across virtually all interviews with Syrian doctors. The delay is a product of Turkey's temporary

[80] Interview with Dr. Ziad, February 23, 2022.

protection policy, which set out a particular set of rights for Syrians while blocking professional pathways available to other foreigners in applying for equivalency. It is a lag that is built into the temporary protection policy, which itself has served as a hedging mechanism for the state where it does not have to make commitments to refugee integration. The promise of employment through a special project for Syrian doctors kept individuals in a professional no-man's-land for years, during which many sought out informal work rather than to switch fields. As another doctor noted, "Here in Turkey we have an equivalency process for many doctors from other countries, and a lot of people come to study from other regions, but as Syrians we were suspended from this--if they allowed us to do it in the beginning it would have been easier."[81] The temporary protection policy that was often touted as an inclusive policy for Syrians vis a vis other refugee and migrant groups was, in the case of professional re-certification, exclusionary for Syrian doctors in relation to other healthcare professional immigrants in Turkey.

Respondents addressed the fact that it was this time lag in Turkey's healthcare employment policies that led to the creation of a persistent informal terrain of providers. Dr. Mohsin, a dentist whose extended family has settled all over the world since the start of the Syrian war, summarized the effect of Turkey's ambiguous policies on healthcare provision succinctly.

> The system in Turkey is grey. This is good and bad. In Germany for example you could never work without a license. Here you can do it if nobody complains, but it's not suitable for a lifetime job, to work under the stairs like this. Every day I come to work feeling I'm committing a crime. And if the patient is rude, I have to still be polite, and if they decide the care is bad and they're not paying for it I can't do anything about it. Also, at the end of the treatment, they can say, "You are illegal, I won't pay, and you can't do anything because I will report you." Turkish people have learned that they can blackmail us. They pretend they are the police, or they are the Ministry of Health. And then they extort money.[82]

[81] Interview with Dr. Daoud, November 28, 2021.
[82] Interview with Dr. Mohsin, January 14, 2022.

Twice Dr. Mohsin had encountered swindlers who tried to extort his clinic by pretending to be Ministry of Health bureaucrats. He learned over time that this was a racket and realized that he did not actually have to pay these extortionists. He was both resentful of the "grey" system Turkey had allowed to proliferate but also thankful to be able to practice his trade as he progressed through the equivalency process. Soon, he figured, he could formalize his still semi-formal work.

Others, however, were less hopeful about the prospect of formalization for Syrian doctors once informal care provision was normalized, in part by the state's toleration of these activities. Dr. Ahmed had trained in Turkey and therefore could open a fully legal private clinic without needing to go through an equivalency process. His pediatric clinic was the ideal of what many Syrian doctors were striving for but unable to achieve without access to equivalency certification. Dr. Ahmed was critical of Turkey's policies as well, in solidarity with his colleagues who could not practice as he could.

> They made a mistake here with the Syrian doctors. They should have immediately set up a special course for them, that's what they did in Germany for Syrian doctors. Then in 2-3 years they could have just thrown the doctors into the Turkish system. Syrian doctors don't have any issues in their medical knowledge, it's really just the language. But they didn't do that and now the doctors have to work informally, and the government just looks away.[83]

With his fluent Turkish and connections in the Turkish healthcare system, Dr. Ahmed had done what he could to help advocate for a clearer employment policy for Syrian doctors. He organized an association of Syrians in Turkey and met with government ministers, he presented to the Turkish Medical Society, and he went to parliament to speak on behalf of his peers. The policy change they were able to muster through this advocacy was modestly lowering the score needed

[83] Interview with Dr. Ahmed, January 27, 2022.

to pass the equivalency exam. Institutionally, however, the SIHHAT Project's Migrant Health Center program remained the principal refugee healthcare intervention.

Dr. Hamid began working in a Migrant Health Center just two months before we met in late 2021. He had applied to the SIHHAT Project three years prior, after six years working odd jobs in Lebanon because he could not work as a doctor there. Complications with his paperwork led to years of uncertainty about whether he would actually get assigned an MHC position. In the interim, he had worked in a laboratory in the Southeastern province of Siirt, where a Turkish hospital paid him minimum wage for his technically informal work. Finally, he was assigned to an MHC in Istanbul, and made his way to the bustling metropolis with his wife and children.

But, just two months in, the MHC work was already frustrating to him. He complained about patients coming in with no real problems, just trying to get prescriptions to stockpile various medicines, especially antibiotics, which are not disbursed in Turkey without a prescription. He complained of the crowds and decided that the problem with the system was that it was free. A little cost, he argued, would keep families from coming constantly with mild problems. He laughed as he described all the excuses people would come up with to get medicines. "They say, 'I woke up in the morning, and the cough started.' I'm like, 'OK, why don't you wait a little?'" He was already trying to pass the equivalency exam so he could bow out of the SIHHAT Project, but he had failed his first attempt.

> It's really easier in Germany. In Turkey, my friend--he's a Turkmen[84]--he didn't succeed. He went to Germany and passed on the first try. Even in the US, in Canada, my friends pass on the first try…here there is no direct path…In Germany, there are 4000 more Syrian doctors. Turkey was too late. The things they say are going to happen don't happen. And then in the airport they don't allow the doctors to leave the country…In England, Germany, they immediately accept them. They slowly help them. In the health system, they slowly rise up through the ranks…there was nothing here…They say they help. Slowly, slowly.

[84] Syrian Turkmen often grew up speaking Turkish in Syria and typically have had an easier time integrating in Turkey due to the ease of language mastery.

Dr. Hamid emphasized the time lag in Turkey produced by the ambivalence of temporary protection, where policy is created in an ad hoc manner. Among respondents, there is also a clear propensity to paint Western equivalency programs as easier and more straightforward. The reality is that those processes are difficult and frustrating for immigrants as well. What Syrian doctors overwhelming emphasize, however, is that at least these countries had clear policies set forth from the moment of arrival. Turkey, in comparison, was a clear policy failure.

How, then, did Germany's system differ from Turkey's? Germany, unlike many other countries receiving Syrian refugees, began granting short-term visas to Syrian doctors to expedite their immigration process. By 2016, 1500 Syrian doctors were working in Germany. Politicians came out in favor of swiftly integrating Syrian doctors' medical skills into Germany's healthcare system, which does not have the personnel to serve the country's population (Braw 2016). Like Turkey, Germany receives many foreign doctors. But given that their Syrian refugee policy is one of asylum, which creates a pathway to permanent residency, their policies were oriented toward integration from the start. Germany accepted Syrian medical credentials to issue short-term visas, then issued student visas to those who arrived in the country to practice. As *Foreign Policy* reported in 2016, the steps included five German language certificates, a license to work under the supervision of a doctor with full German medical licensing, and then registering to work in Germany as a non-EU doctor.

This process is admittedly not easy and can be costly for individuals arriving to Germany with very little. Studies of Syrian refugee doctors' experiences in Germany describe the German equivalency process as long, complex, and arbitrary (Loss et al. 2020). But, as many Syrians in Turkey emphasized, it was a process that was available quickly. While the process itself can take a long time, and may vary by state, doctors were allowed to work in internship-like positions

during the credentialization process (Eddy and Shoumali 2018). By 2017, there were reportedly 2895 Syrian doctors authorized to work in Germany (Salameh 2017). The Syrian doctors who chose to stay in Istanbul for various reasons looked on with frustration as their peers found stable, legal, and decently paid work abroad.

Syrian doctors were not only looking at Europe when assessing their place in the global cadres of doctors trying to find work outside of Syria. Many doctors also had their eyes trained on the Gulf Arab states as well as other Arabic-speaking countries in the broader Middle East region. When looking at Gulf states, doctors weighed the relatively easy examination process with the larger issue of "permanent temporariness" engendered by insurmountable naturalization rules (Lori 2019; Vora 2013). Given that many Syrian doctors are able to get citizenship in Turkey, doctors wrestle with what is more valuable to them--stable work without legal belonging or unstable work with secure legal status. For those with families, the latter often prevailed. For single doctors, sometimes permanent guest status in the Gulf remained attractive in comparison to Turkey's professional morass for doctors.

As doctors navigated the protracted equivalency process, they often considered how they would fare within these other Arabic-speaking countries. Dr. Mohsin, the dentist who has dealt with extortionists coming to his dental clinic, seriously considered working in the United Arab Emirates. Yet he ended up deciding that the onerous citizenship regime--not to mention the relentless air conditioning--were not for him. This was in spite of the fact that he had taken the UAE's equivalency exam and passed it on the first attempt. He explained, "I have an uncle who went to the UAE in 1968, he's there until now, and he still does not have citizenship. He's always renewing his permit. I didn't want that."[85]

[85] Interview with Dr. Mohsin, January 14, 2022.

Doctors were always hyper-aware of the ways their skills were shaped by global citizenship and passport hierarchies. As members of an elite class of doctors spread around the world, they knew their skills were of high value. Yet they also had to deal with the fact that their skills were typically more easily transferrable in countries where broader life conditions would be more challenging--in developing countries or authoritarian countries with poor human rights records. They had some choice in how to situate themselves within this hierarchy but also recognized the particular challenges of each national system of reception.

Dr. Daoud, a gastroenterologist who had progressed through the first stage of his equivalency process, had decided to focus on building a life in Istanbul after considering the various options available to him.

> For doctors, it's not easy. Any place you would want to go, you have to start over. When your country is weak, when your country has abandoned you, you have no rights. Some of my friends are in Libya, Yemen, Mauritania, Qatar, Kuwait, Saudi. But you are like a slave, if they mistreat you, who is going to defend you?...That's why I'm not going to these countries. The US I considered again, but [during the coronavirus pandemic] the test was cancelled, and my first exam [which I took five years ago] just expired…As everyone is retiring, I'd be starting. I'm trying to make my stresses minimal.[86]

The countries Dr. Daoud listed were places where Syrians have a relatively easier time gaining equivalency. But for him, the political contexts of those jobs were not worth the move. So, he remained in Turkey where he was able to piece together a decent livelihood working as a specialist in Turkish private hospitals with his general practitioner certification in a semi-formal capacity.

The Global Politics of Equivalency

[86] Interview with Dr. Daoud, November 28, 2021.

Syrian doctors situated themselves as skilled actors in a global field of healthcare provision who were being unduly circumscribed by the educational and employment policies in Turkey. Turkey's equivalency process was a site of focused contestation for Syrian doctors. Language was a key point of contention in the equivalency process. Many of the complaints about the process were standard issues that immigrants attempting equivalency in a range of host contexts would face. First, doctors faced a serious economic barrier to undertaking the lengthy process. Doctors need to dedicate time first to gaining competency in spoken and medical Turkish, and then to studying for the rigorous exam. This takes time that many of these doctors do not have, given that they must work to support their families. One strategy that Syrian doctors used to simultaneously critique Turkey's equivalency system and make a claim for their integral place in the local healthcare terrain was to criticize Turkey's equivalency as parochial for not having an English language option.

Time and again, doctors reported either that they did not have the time to study, or they were studying at odd hours of the day around their work hours. Secondarily, language acquisition posed a challenge for doctors, many of whom had started working informally in contexts where they only needed Arabic skills. Even those who took Turkish courses had few contexts in which to practice when most of the day was spent with Syrian patients. These issues are unfortunate but unsurprising. Yet Syrian doctors critiqued equivalency barriers by making claims to their globally relevant skills that the parochial Turkish system was not taking advantage of.

A topic that came up repeatedly in interviews was Syrian doctors' relative fluency in English, a skill that was not serving them professionally in Turkey, where English is less prevalent than in Syria. While Turkey is seen in many ways as a more advanced country than Syria in economic and political terms, Syrian doctors were shocked that English language

competency carried no weight upon their arrival to Turkey. When I would ask doctors what concrete recommendations they had for improving the equivalency process, they regularly invoked introducing an English language option.

Dr. Ramzy portrayed the equivalency process as uniquely parochial. "They need to find a way to…benefit from the doctors. The options for us are very hard. Every year 200 doctors take the test and 2-3 are passing. In my opinion they need to do something in English, they need to do something special for these doctors…Now even drivers' license exams you can do in English, in Turkish, in Arabic."[87] These doctors were aware that critiquing a country for requiring equivalency in the country's main language sounded a bit unrealistic, but they rationalized this by emphasizing the urgency of the Syrian doctors' situation after years of uncertainty. They also pointed out that the healthcare market they were entering demanded care in international languages.

Individuals going through the equivalency process noted that Turkish language acquisition was not of central importance to the work they would do once they finished the process. "After finishing the residency [stage of equivalency] we have a lot of opportunities because most of the Turkish clinics, they want Arabic speaking doctors. English and Arabic."[88] Another dentist made the same point: "They should really allow the test in English. I'm not going to speak Turkish as a dentist, I will work with international patients! In Germany, as a doctor, you are welcomed. Here I feel like I am nobody."[89] By emphasizing their globally relevant linguistic skills in both Arabic and English, they positioned themselves as providers for an international population of patients while trying to reclaim professional dignity that has been degraded in the Turkish context.

[87] Interview with Dr. Ramzy, March 2, 2022.
[88] Interview with Dr. Maysa, March 18, 2022.
[89] Interview with Dr. Asma, October 1, 2021.

While Syrian doctors positioned themselves as global talents with skills that would benefit an ailing and parochial Turkish system, they also emphasized that global factors beyond their control were precisely the reason they could not legally capitalize on these in-demand skills. One of the single biggest barriers to Syrian doctors' legal work has been the diplomatic freeze between Turkey and Syria. As mentioned earlier in this chapter, the Turkish government lifted a restriction requiring Syrian officials to certify Syrian doctors' diplomas before applying for the equivalency process. (In Germany, it should be noted, this process was bypassed from the very beginning in order to facilitate the integration of Syrian doctors.) When Turkey lifted this requirement for Syrian doctors, it only lifted it for general medical school degrees. The requirement is still in place for specialist diplomas.

This has meant that doctors that do everything right—learn Turkish, study for the exam, pass the exam, then do their 6-8 month residency—can only advance to the point of licensed generalist if they cannot get their papers certified by the Syrian government. Aside from a handful of doctors I spoke to who had risked their lives to gather the necessary documentation in Syria, no doctors were advancing past generalist licensing at the time of research. The persistence of this bureaucratic barrier with no explicit rationale—nobody could explain why the restriction was lifted for general medicine but not specialists—contributed to feelings of powerlessness and futility among the doctors. While doctors could position themselves as a skilled global professional class, they could not overcome the protracted war that produced the system of temporary protection they had become mired in.

Syrian doctors were adept at attributing their difficulties in equivalency to the particularities of Turkey-Syria relations rather than as basic features of the immigration experiences of highly skilled migrants. They regularly drew direct links between geopolitics,

temporary protection, and equivalency policies. They also drew broader comparisons with other migration flows to underscore their unfair treatment in the Turkish context. Dr. Hisham had a series of positive international experiences before the war started in Syria. He had worked in Saudi Arabia for eight years as a dental technician before deciding that he would study for his dental degree in Yemen. He then undertook the equivalency process in Syria while simultaneously applying to immigrate to Canada. In 2009, he was approved to go to Canada, but opted to stay in Syria, where he lived a comfortable life with a thriving dental clinic.

When the revolution started, Dr. Hisham came to Turkey and started trying to cobble together work, moving between the province of Kayseri in central Turkey and Istanbul, working informally in various dental clinics. He waited the five years from his arrival until he could apply for equivalency and then immediately undertook the arduous process. Yet, in 2021, he still could not work formally. He complained about the particular challenges Syrians faced in Turkey:

> It's all political in the end. No one is willing to do anything for Syrians. But it's so simple, you would either give us a committee [to assess our certifications] or give us temporary certifications. They did a committee for Bulgarian doctors in the 1980s. They made a special committee and they modified their diplomas and they started working. But officials don't want to solve Syrians' issues. They want to complicate our issues.[90]

Dr. Hisham attributes the difficulties of Syrian doctors to intentional political decisions that were absent when Bulgarian Pomak refugees fled to Turkey 1989. These Bulgarians, who were Muslims of Turkish origin, were welcomed to Turkey as ethnic kin and integrated readily. The Syrian experience has differed markedly from Turkey's past refugee policies, which have often privileged rights for Turkish ethnic kin. Syrian doctors like Dr. Hisham astutely analyze policy differences that have disadvantaged them in the professional realm.

[90] Interview with Dr. Hisham, January 7, 2022.

Doctors are keenly aware that their professional fates are shaped by larger geopolitical conditions that define Turkey-Syria relations. These same conditions make it politically impossible for most doctors to try to get their diplomas certified by the Assad government's officials, especially for those who were active in the opposition movement. Dr. Hamza, an internist working in the Migrant Health system, has not had time to prepare for the equivalency process given the long hours in the center. He hopes to at some point but does not see it as a feasible option during his SIHHAT Project work. When I asked him what his recommendations were to improve the professional prospects of Syrian doctors, he invoked the geopolitical barriers trapping them in temporary jobs.

> It would help to make the bureaucratic procedures faster, as it takes a long time. And if you want to continue studying your specialization, they require you to go to the Syrian embassy and get the diploma signed but the embassy doesn't sign anything, on purpose, like they're humiliating people on purpose. So we're stuck. This is a big problem. If [the government] could stop us from having to go to the embassy—a lot of us can't go…But the test, no problem, we understand that we need to take this. It's right they make us take it. Just help us, make the process more manageable.[91]

Dr. Hamza here was careful not the criticize the institution of equivalency, which he respects, but rather the particular challenges they face as Syrians in an intractable conflict that trickles down into mundane bureaucratic procedures. Dr. Mansur, a dermatologist, had a similar complaint. He was hoping to open a dermatology practice in Istanbul but could not, so long as bureaucratic barriers to specialization certification remained.

> There's a problem because even after the general practitioner equivalency there is no specialization equivalency. The Syrian consulate right now doesn't want doctors to work in Turkey so they're not approving or attesting to the veracity of certificates. If I want my documents certified I need to go to Syria but I'm not going to go into Syria because I'm opposition…I would need to do my military service and serve in the war but I can't do that…many doctors are deciding to go

[91] Interview with Dr. Hamza, January 11, 2022.

> to the Gulf countries like Saudi Arabia because they can't get these papers signed.[92]

Dr. Mansur, unlike some other doctors, placed the blame squarely on the Syrian government rather than on the Turkish government, which he said was doing what it needed to do to certify Syrian doctors. Still, given these challenges, Dr. Mansur was thinking about how he might be able to move to Qatar, preferably, or possibly Saudi Arabia, the UAE, or Oman, in order to go through a simpler certification process and begin working legally. The geopolitical context that produced the temporary protection regime was, in Dr. Mansur's view, also the source of his professional woes. The state bureaucracies that upheld the enmities of the conflict closed off the potential opportunities for legal practice dangling tantalizingly out of reach for Syrian doctors.

Conclusion

Early on in Turkey's reception of Syrian refugees, Syrian doctors were able to work in clinics that filled a pressing humanitarian need. Clinics that aligned with Turkey's geopolitical objectives in Syria were able to informally employ Syrian doctors keen to work but blocked from formal work in the host country. But as the war dragged on, the geopolitics of the regional conflict, as well as the temporary policy born out of these politics, became a source of deep professional frustration for Syrian doctors. Once heroes who cared for Syrians in the crossfire of civil war, then key humanitarian brokers in facilitating care to newly arrived Syrians in Turkey, doctors now watched their colleagues abroad settle into their professional lives while they remained excluded from stable work.

[92] Interview with Dr. Mansur, March 21, 2022.

As the niche of legitimate humanitarian healthcare gradually closed, Syrian doctors faced a series of suboptimal work options: working in Migrant Health Centers as primary care providers, protracted re-certification processes where they would at best gain primary care equivalency, continued informal work, or some combination thereof. Many found venues for informal work in various types of private providers (explored in more detail in the next two chapters). They justified this work using a series of critiques of the institutions that have circumscribed their professional opportunities. First, they point out the willful avoidance of the reality that Syrian doctors could fulfil pressing doctor shortages in Turkey's healthcare landscape. This is painted as a clear domestic healthcare policy failure. Next, they fault the temporary protection policy for perpetuating informality. The lag in providing *any* formal work for Syrian doctors, they rightfully point out, was a feature--not a bug--of the temporary protection policy that attempted to prevent Syrians from incorporating swiftly into host community institutions. Through these discursive moves, they discredit both healthcare and refugee policy, two domains that long were framed by international and domestic political observers as uniquely supportive of Syrian refugees.

The next discursive move among Syrian doctors was to situate themselves within an international field of highly skilled professionals. In doing so, they again discredited Turkey's policies as short-sighted and parochial. Placing Turkey's policy within a global field of refugee employment policies, Syrian doctors underscore what they make out to be Turkey's singular failures. In countries with resettlement and asylum policies, they point out how their peers have eventually integrated into their work as doctors. In countries with more exclusionary refugee immigration policies, they nevertheless point out the relative ease of employment in the healthcare sector. Turkey, alone, is made to look dysfunctional in this domain.

Finally, Syrian doctors point to the intransigence of geopolitical conflicts that trickle down to their own mundane bureaucratic procedures for professional incorporation. Even though they are globally talented professionals, the unlucky fate of geography has left them besieged--literally, at home, and professionally, in Turkey. By laying out these shortcomings of the Turkish system, Syrian doctors lay the groundwork to justify the work that they continue doing in Turkey even as they bypass rules they might, in other contexts, be more willing to follow. The next two chapters examine the brick-and-mortar manifestations of these attempts to renegotiate their work in a national context where policy does little to facilitate their professional incorporation. Rather than waiting until they were given a legal pathway to practice, Syrian doctors negotiated their place in Turkey's healthcare landscape by making claims to their membership in a transnational professional elite constrained by a parochial host state incapable of effectively harnessing their human capital.

Chapter 6: From Humanitarianism to Hair Transplants

When I visited the Shifa Clinic in late 2021, it looked markedly different than my first visit four years prior. Most apparently, it had changed its name and had new, prominent signage beckoning patients: "Private MediPark Clinic". The entry hallway was familiar, with families huddled around the check-in desk, making their payments and being directed to the appropriate floor for their services. Once inside, upgrades were immediately visible. The clinic had digitized its check-in system, with LCD screens in the waiting rooms that would flash the numbers of the next patients on deck with the room number they should proceed to. With this system in place, the mood was less frenetic, though still imbued with the nervous energy of a crowded medical waiting room. I met the manager with whom I would talk in the entry level, and he guided me upstairs.

I had gone up these stairs many times before. On my first visit to the clinic in 2017, I had walked up the stairs to the administrative offices on the fourth floor. I had anxiously waited for them to open the frosted glass door so I could introduce myself to the managers. When I had returned to Shifa in 2018, changes were already afoot. One of the managers told me that the Ministry of Health informed them that the clinic did not comply with medical building codes, so they had begun a renovation. In order to go up to the fourth-floor offices, I had been led through a side room on the third floor, where I had glimpsed small replica models of the refugee camps they were supporting in Northern Syria on display. We had to bypass the construction by climbing outside onto a precarious balcony, only to then reenter through another door to get to the fourth-floor administrative offices. Soon, they assured me, the construction would be done and there would be no need for apartment acrobatics to get to the office.

When I returned to the building in 2021, I went up the familiar flight of stairs with one of the new, young administrators, a Syrian who was just finishing up college in Turkey. I did not have to scale the building this time. Instead, in the room that used to be the administrative office was a sleek, luxurious waiting room with cushy blue couches with gold trim. The administrative offices had moved to a new building. The old office was now the aesthetic wing of the MediPark Clinic. I sat and drank coffee with the administrator as we discussed the transformation of the space. There were no patients on this floor—the renovation and redesign were recently completed and so far, MediPark still primarily operated as a low-cost outpatient clinic for standard secondary care needs. But the manager was excited about what lay ahead for the clinic. The head manager had applied for a medical tourism license, in hopes that the clinic could eventually draw wealthier, foreign patients into a clinic already well-known among the Syrian population in Turkey.

MediPark's social media pages had, by 2023, shifted almost exclusively to advertising aesthetic procedures. These included but were not limited to non-surgical rhinoplasty, Botox, laser skin treatments, eyebrow lifts, and Turkey's signature medical tourism service--the hair transplant. Catchy videos with electronic music soundtracks advertise these procedures in place of what used to be basic clinic schedule information and health advice stock images. The clinic, it is clear, has transformed its image as well as the variety of services it offers. Back when MediPark was the Shifa Clinic, it was known among Syrians for being a dependable low-cost clinic with a humanitarian approach to helping refugees. It was one of the health clinics that Syrian patients across Istanbul trusted despite its informal status. It remains a destination for many Syrians seeking convenient care in Arabic. But any external hints of that humanitarianism have evaporated, as MediPark has become increasingly profit-oriented in its self-presentation.

MediPark was not the only clinic that had changed in form over the five years of my fieldwork. The Hayat Clinic, in collaboration with the Rafah Clinic, was reborn in a new location as the Oasis Clinic. Unlike MediPark, which had transitioned quite seamlessly by operating even as they underwent their building adjustments and registration processes, Hayat and Rafah had to close and find a new location, during the pandemic no less, delaying their reopening. The Khayr Clinic had gone through a rockier transformation: the managers had decided to shut down the health clinic rather than to try to go through the expensive and arduous process of formalization. Instead, they had established a private Arabic-language school, drawing on their original organizational mission before they had transitioned to healthcare. Yet it did not stop its medical services completely. In a new location, it had opened a private dental clinic. The Bilad Clinic had also gone down the dental clinic route—it had discontinued its secondary care services. Instead, they had renovated their previously ramshackle office into a gleaming, luxurious space.

How and why did these humanitarian clinics transform along different pathways? And what can these transformation trajectories tell us about temporary refugee reception more broadly? Accounting for dynamics identified in the previous chapters of this dissertation, this chapter examines organizational changes at the level of service provision. It extends the insight from chapter 3 that refugee service providers survived in the longer-term by channeling resources accrued as humanitarian hybrids toward formalization through privatization. A puzzling phenomenon emerges: the clinics that were regarded as the most humanitarian and charity-oriented had become the most profit-oriented private clinics. The Shifa Clinic's transition to the MediPark Clinic in the introductory anecdote is a prime example. What explains this paradoxical outcome?

This chapter finds that as the humanitarian niche narrows and hybrid humanitarianism loses its legitimacy, a move toward more complete forms of privatization becomes the most viable pathway for organizations to survive in the longer-term. The "most humanitarian" clinics become the most successful private clinics because the legitimacy and resources they have accrued allows them to transform their operations the *least.* They are able to channel their resources toward formalizing the services they were already providing. What were once clinics with fee-for-service care assimilated into a humanitarian organizational form gets reversed: clinics become private clinics with residual humanitarian activities assimilated therein. Other hybrid humanitarian clinics that cannot or do not intend to formalize as secondary care providers segment their organizations: they downsize medical care to dental clinics and then focus the rest of their organizational resources on other pursuits. Finally, the hybrid humanitarians with the least resources revert to pure humanitarian organizations.

The chapter argues that because successful hybridization strategies endow organizations with agility, the most agile organizations can cope with environmental turbulence through incremental adaptations and thereby avoid drastic operational changes. By changing less in relation to their original organizational form, these clinics retain more flexibility in rendering those services in an increasingly for-profit idiom. This leads to mission drift for once humanitarian organizations.

Organizational Survival Beyond the Humanitarian Niche

Chapter 3 detailed the hybridization tactics used by Syrian health clinics to withstand the regulatory uncertainty wrought by a shifting institutional landscape. As we know from that chapter, hybridization can be a strategy of survival for organizations that emerge in a context of institutional flux. When the external environment produces uncertainty for organizations,

hybridization allows them to "hedge their bets" between multiple audiences or organizational fields (Nee 1992). While hybrid organizations may face legitimization challenges given that they defy audiences' expectations (Hsu, Negro, and Perretti 2012; Pache and Santos 2013), environmental flux can also attenuate these challenges, given the general disarray wrought within the organizational field (Ruef and Patterson 2009). Moreover, once hybrid forms gain some acceptance among relevant audiences, organizations may benefit in ways existing "purer" organizations cannot (Pache and Santos 2013; Paolella and Durand 2016). But just as environmental uncertainty may produce and facilitate the legitimization of hybrid forms, so too may environmental changes render these forms illegitimate as the policy and regulatory contexts continue to lurch. As a result, organizations must develop institutional agility to keep up with unpredictable changes in the environment (Farjoun 2002; Mair, Mayer, and Lutz 2015; Nee and Matthews 1996; Nijssen and Paauwe 2012).

Organizations respond to environmental turbulence by hybridizing as a continual process, rather than seeking out a hybrid form as an end goal (Battilana, Besharov, and Bjoern 2017; Jay 2013). Nonprofits are often particularly vulnerable in turbulent contexts, due to the vagaries of public and private funding sources. Nonprofits--particularly healthcare nonprofits--often attempt to hybridize nonprofit and for-profit forms in order to cope with this turbulence (Smith 2014). Nonprofits may hybridize in distinct ways--some may assimilate for profit ventures into a nonprofit form, while others may segregate the forms under the umbrella of the organization. These tactics may succeed, but they may also lead to organizational dysfunction (Skelcher and Smith 2015). It remains an open question as to why organizations may implement particular hybridization trajectories, and to what end.

This empirical case allows us to consider how clinics that originally hybridized in similar ways ultimately transformed in distinct ways in a turbulent context. While they still exhibited hybrid characteristics, these largely diverged into two models: (1) assimilated hybrids where they functioned primarily as private clinics but maintained some residual humanitarian principles, and (2) segmented hybrids, where they downsized their private healthcare practices and segmented them from other activities. Across both forms, however, one thing is clear: early successes in hybridization grant organizations more agility to occupy more lucrative market niches in the private sphere, given their established local reputations and their expanding global networks. The most humanitarian organizations, therefore, become functionally the most privatized. These organizations are able to perpetuate themselves because they draw a vast immigrant clientele as well as an increasingly international tourist clientele. They are able to do this even as they continue to implement semi-legal or informal strategies within their more formalized organizations.

The Shifting Institutional Context

A key dimension in the organizational transformations I discuss is the changing policy environment. The dissertation has charted a series of shifts in the institutional terrain of healthcare for refugees. Below is a summary of the key contextual changes shaping the field in which Syrian doctors were working over the course of my fieldwork. I consider 2018 a rough turning point in the field, even though some changes happened gradually and can be ascribed to a broader shift between 2016 and 2019. Crucially, during this period, the Turkish government gradually shifted from a strategy of humanitarian reception toward a strategy of border securitization, punitive enforcement of legal status, and harmonization—*not* integration—with the existing Syrian population. Turkey's willingness to commit to harmonization was in part to

appease the European Union and take advantage of the humanitarian windfall disbursed to Turkey to externalize Europe's fear of sustained Syrian migration. This political move also gave Turkey unprecedented political leverage in its relations with the European Union, as discussed in chapter 2. Tables 6.1 and 6.2 summarize relevant shifts during this period of flux.

Table 6.1: Institutional Transformations in Refugee Policy over Time

Before 2018	***After 2018***
Provincial Migration Management	
Istanbul becomes a key destination for Syrian refugees, particularly given work opportunities relative to other provinces; delays in processing of registrations due to demand for Istanbul IDs	Governor of Istanbul issues a memorandum demanding refugees registered in other provinces return to provinces of registration; Istanbul stops registering newly arrived Syrians; policing of individuals' registration statuses is increased (especially leading up to tightly contested provincial elections in 2019)
National Policy Context	
Temporary Protection Regulation is passed in 2014 as a humanitarian legal status premised on eventual return of Syrian refugees to Syria	The Ministry of the Interior officials concertedly move toward using the term *uyum,* or "harmonization", in official speeches and policy, avoiding mention of integration or assimilation.[93]
Geopolitical Context	
Turkey actively supports Sunni opposition against Bashar Al-Assad in Syria, Istanbul is the hub of Syrian Coalition political opposition -Turkey is the main transit route for refugees fleeing Syria for Europe	-Turkey's primary strategy in the war shifts toward the creation of a buffer zone at the Turkey-Syria border to prevent the emergence of an autonomous Kurdish region -2016 EU-Turkey Deal shifts refugee burden to Turkey and gives Turkey political leverage in the region

Table 6.2: Institutional Transformations in Refugee Healthcare over Time

Before 2018	***After 2018***
Municipal Regulatory Context	
Enforcement of rules around informal healthcare provision left largely to local municipalities, and loosely applied in many locales	Heightened enforcement of all informal clinics, including those previously tolerated

[93] See the General Directorate of Migration Management's webpage "Uyum Hakkında," or "About Harmonization," for details on the official stance of the agency: https://www.goc.gov.tr/uyum-hakkinda

State Healthcare Institutions	
Syrians have access to state providers at primary, secondary, and tertiary level with referral. Small number of "Migrant Health Centers" established in 2015 that employ Turkish primary care physicians	European Union funds the SIHHAT Project, established in 2016 in partnership with the Ministry of Health, to create Migrant Health Centers that will employ Syrian doctors as primary care physicians. MHCs begin opening in 2018. SIHHAT also funds translators for state hospitals.
Certification Rules for Syrian Doctors	
Syrians bureaucratically blocked from applying for certification equivalency in Turkey, no Syrian diplomas being certified due to diplomatic freeze between Turkey and Syria	In 2018, Syrians are permitted to apply for primary care equivalency alongside other immigrant doctors; Syrian doctors may also work in MHCs with the abbreviated SIHHAT Project training. Latter job does not provide equivalency.

It is not just refugee policies that shape developments in refugee healthcare. The broader institutional context—both in the humanitarian field and the healthcare field in Turkey—are key to organizational transformations as well. Given that many clinics were working as hybrid organizations, straddling the humanitarian field as well as the private provision field, the structures of both fields were also central to organizational survival. Chapter 3 shows how Syrian clinics' orientation toward religious humanitarianism that was already politically dominant in Turkey affected clinics' ability to garner resources and legitimacy. Once the boundaries of acceptable humanitarian activities shifted with the institutional changes outlined above, organizations, and the doctors working within them, had to re-orient themselves within remaining accepted forms of work and organizing.

During this gradual reorientation, the structure of Turkey's existing private healthcare terrain became increasingly relevant for Syrian doctors, especially as they faced minimal work opportunities with unknown yet obliquely temporary time horizons within state providers. As discussed in chapter 2, the system is characterized by both universalization of access, and privatization, as beneficiaries increasingly opt into private health insurance schemes and private

hospitals for higher quality services. The government has also supported the development of public-private partnership hospital complexes (Pala et al. 2018) and has directly invested in making Turkey a global hub of medical tourism (Yılmaz and Aktas 2021). Since the universalizing healthcare reform of Turkey's Health Transformation Program initiated in 2003, expansion of public healthcare access has been accompanied by a persistent increase in privatization and marketization of healthcare services (Dorlach and Yeğen 2023). Along with the more turbulent context of changing refugee-related policies and their implementation, the gradually privatizing healthcare landscape during a roughly overlapping period has shaped the organizational outcomes discussed in this chapter.

Transforming along the Hybrid Spectrum

We return now to the clinics introduced in Chapter 3. In late 2018 into 2019, their previously lax enforcement environment became increasingly draconian. Managers who used to once cheekily speak of how the Ministry of Health "turned a blind eye" to their operations were faced with the reality that these eyes were no longer looking away. Clinics faced an ultimatum. Either they had to get their registrations in order, or they had to close. The associational *dernek* status, once a registration refuge for organizations trying to keep operating under ambiguously legal circumstances, lost any residual legitimizing force as time went on. The six remaining clinics faced a decision—would they close, or would they continue operating? And if they were to keep operating, how would they go about this process?

Among the clinics I was observing, there were two general pathways pursued. The most well-resourced clinics with the most respected reputations in the field pursued a transition to registered private secondary healthcare clinics. In essence, this meant they would maintain—and even expand—the services their clinics had already been operating. These clinics fully

assimilated private practices into their organizations, and humanitarianism became a residual part of the organization. The clinics that had moderately less name recognition and fewer connections and funds opted to downsize and segment their operations. One clinic eliminated all operations in Turkey and focused on humanitarianism abroad—becoming a "pure" humanitarian organization. The outcomes are summarized in the table below:

Table 6.3: Organizational Outcomes for Syrian-run Health Clinics

Clinics	**Humanitarian Efforts**	**Resource Acquisition**	**Health Clinic Outcomes**
Shifa Clinic, Hayat Clinic, Rafah Clinic	- Registered as *dernek* (nonprofit association) -charitable activities in locality -collaboration with Turkish humanitarian orgs -ties to Turkey-supported Syrian opposition -charitable activities in opposition-held regions	-fee-for-service outpatient care (large) -donations from NGOs abroad -donations from state-supported Turkish humanitarian orgs -private investment	**Assimilated Privatization** *large fee-for-service private outpatient clinics with residual humanitarian activities including aid in camps across the border*
*Khayr Clinic**, Bilad Clinic	-Registered as *dernek* -charitable activities in locality -episodic work with Turkish humanitarian orgs -charitable activities in opposition-held regions	-fee-for-service outpatient care (large) -donations from NGOs abroad	**Hybrid Segmentation** *Downsized private dental care + residual humanitarian projects*
Shams Clinic	- Registered as *dernek* --charitable activities in opposition-held regions	-fee-for-service outpatient care (small) -donations from NGOs abroad	**Humanitarian Consolidation** *Closed fee-for-service clinic, focus solely on humanitarian projects abroad*
Safa Clinic	- Registered as *dernek*	-fee-for-service outpatient care (large)	**Closure**

			Blocked in privatization process

The Assimilated Private Outpatient Clinics

One of the pathways that existing Syrian-run healthcare organizations pursued was to formalize as private healthcare providers that continued to provide outpatient care. While these organizations also maintained active *dernek* registrations, their health clinic operations in Istanbul were stripped of any humanitarian features or pretense. As privatization became the main focus of these organizations, humanitarian activity became the afterthought. That said, they did not eliminate humanitarianism fully, but rather made that the focus of their associational wings. The *derneks* would focus on aid, often across the border in Northern Syria, and the clinics would work as registered private providers. These organizations had benefited from their diverse resource accrual through both humanitarian and for-profit activities in their early stages. They were now able to leverage their accumulated resources to establish large private healthcare clinics with legal registrations. Moreover, they were able to maintain a steady stream of clientele given their established humanitarian reputations.

Three clinics transitioned from humanitarian hybrid clinics into increasingly for-profit private secondary outpatient clinics: Shifa, Hayat, and Rafah. As noted, these were the "most humanitarian" clinics of the bunch. I use scare quotes because they collected fees just like all the other clinics, and in fact had earlier on developed higher cost services for paying customers. Their reputations, and the institutional legitimacy they garnered in the NGO and refugee support worlds, were by far the most upstanding—these were clinics that Turkish NGOs might refer beneficiaries to, because they were perceived as more highly vetted by Turkish institutions. In my interviews with Turkish NGO personnel, many knew these clinics by name, and some were completely unaware that they were in fact informal clinics. They had essentially become

synonymous with humanitarian healthcare for Syrians in Istanbul. Perhaps unsurprisingly, these were the most highly resourced clinics in the group, save for Khayr, which I discuss as an analytically useful exception later in the chapter. Why did the "most humanitarian" hybrids become the least humanitarian just a few years later? The manager of the Shifa Clinic helps bring us closer to an answer.

The manager of the Shifa Clinic/MediPark is both savvy and well-connected. It also helps, I am sure, that he is charismatic and handsome, effortlessly commanding any room he strolls into. He was one of the first Syrian doctors to start building an organization to help refugees in Istanbul get access to medications. Since, he has seen Shifa through its expansion into a secondary care provider, its semi-legalization in 2016 after advocating for the operation of humanitarian refugee health clinics, its lapse into informality, and, finally, its registration as a private health clinic. He is now the head of the aesthetic operations in the new clinic, regularly showcasing his work on the clinic's Instagram and Facebook pages with shocking before/after visuals set to techno beats. When I asked him how his clinic, in particular, has survived such a long stretch of uncertainty, he was quick to emphasize the essential humanitarian roots of the clinic.

He described how their humanitarian orientation set them apart from all the private clinics that Syrian doctors had tried to open and operate.

> Because we're an NGO we get injectors, we get them as donations, like 1000 injectors for free. The private clinics have to pay for them so they can't survive. Also, for example, [during Covid-19] nobody could find masks, but we were getting masks as donations. No one was finding masks anywhere, a box was 110TL when it should have just been 7TL, but we were getting them for free. Also, we get patients from other NGOs. For example, Doctors Worldwide, they send us patients, and we will treat them for free. So when they get extra medicines, or extra supplies, they send them to us.[94]

[94] Interview with Shifa Clinic manager, September 2, 2021.

These donations they collected from some of Turkey's most well-resourced NGOs helped sustain their operations even as they underwent a privatization process. They were able to maintain these resource channels by fostering humanitarian relationships with Turkish organizations. They continued to reap the benefits of these connections even after they had registered as private clinics.

By coupling this organizational legitimacy with significant resources from a variety of actors, Shifa was by far the most successful refugee healthcare clinic in Istanbul. This made the costs of transition to a formal clinic less onerous. Throughout Istanbul, and Turkey more broadly, there were countless small-scale, one room clinics operated by Syrian doctors opening and closing during these years. As the manager noted, many of these clinics were not able to survive financially. This is largely because they lacked any sort of legitimacy that would allow them to operate visibly, to advertise their services broadly, or to acquire resources from avenues other than patient fees and personal savings. These smaller clinics came and went, depending on fears about enforcement crackdowns and their ability to weather the costs of operation.

The manager of Shifa Clinic, on the other hand, had been continuously expanding the organization's scope throughout these times of profound uncertainty. Formalization meant downsizing and focusing on the original clinic in Istanbul. "We had opened clinics in Antep, Hatay, and another one in Istanbul, but in this privatization period we had to make a lot of payments, like monthly taxes, we needed to be very deliberate with our bookkeeping, so we decided to close those and focus on running this one [in Istanbul]." The clinics in the other provinces never reached the level of prominence of the original Istanbul clinic, but they had provided some extra funding that helped make the transition to a formal clinic more financially feasible.

Other clinics had similar experiences of geographic expansion in the period when humanitarianism prevailed, and then later contracted under formalization pressures. The Rafah Clinic administrators had opened a second clinic in Izmit, a neighboring province to Istanbul, as well as one in another densely refugee-populated part of Istanbul. Ultimately, they shut down the clinic in Izmit. The second clinic remained in operation as a wing of a Turkish private polyclinic that took ten percent of the clinic's profits for the cover of formal registration. Resource accrual during the period when humanitarian clinics could operate with more lax registrations and rules was a direct boon to the formalization process, as managers consolidated profits they had made as larger organizations.

Opening a formal clinic, as the managers of these clinics suggested, is costly. The manager of the Shifa Clinic gave a lengthy description of how that process went for his clinic. The process he describes is challenging, but also the best-case scenario in comparison to the processes that other clinics would need to undertake if they wanted to formalize. Shifa was a well-respected organization headed by a proactive and activist leader with good relations with Turkish government officials. Nevertheless, its formalization was besieged by complex bureaucratic processes.

> When a clinic formalizes, it needs to transform the building, it needs to be earthquake-safe, the rooms need to be enlarged, I don't know, it needs to have certain devices. You have to have certain medicines. It needs to operate during certain times, you need certain documents. This transition was good for us but, at the start, [officials at the provincial health directorate] were not being helpful at all. Let me give you an example, we would tell them that we've applied for a formal certification, and then we'd give them the building plans with the sketches, then they'd look at them and give us the OK. But then they would say 'you're missing this, you're missing that' and we'd say 'we already gave you that'…They always told us we were missing things. I was approaching them with a good attitude and good intentions. They actually learned the process through us, like they learned how big an emergency exit needs to be, how many centimeters, how big the mirror of the handicapped bathroom needs to be, how slanted it needs to be. Which floor the elevator should stop on and which floor the elevator should

> not stop on. I'm convinced the Provincial Health Directorate [in Istanbul] didn't know any of this stuff, they learned it by monitoring us. Yes I'm talking about the people working in the Ministry of Health—the ones in Ankara know but the ones in the Istanbul Provincial Directorate have no idea. So they send the papers back and forth, you need to change this, you need to change that. And each form would take three months to send and send back.

Shifa was unique in that it was able to transform the building it was already in into a clinic that met Ministry of Health building codes upon inspection. Nevertheless, the costs of renovation were significant, and the slow bureaucracy of registration was frustrating. Yet the Shifa Clinic benefited from the fact that it never had to close as it went through this process. This was likely due to its especially friendly relations with a range of well-connected NGOs and government actors. These good relations derived from his organization's staunch and steady support for the opposition forces in Syria early on, and aid support in Northern Syria in Turkish-controlled territory later.

Dr. Bilal, the manager of Rafah who joined forces with Hayat Clinic in the formalization process, was met with a seemingly more challenging task—he had to find a building in a densely populated neighborhood in which he could operate a new, legally compliant clinic. Rafah's original building had received neighborhood complaints in the quieter part of the neighborhood. Dr. Bilal knew that renovating the space would not be feasible given the dimensions of the apartment building it occupied. Finding a suitable space in a central part of the neighborhood was challenging. The process took months and coincided with the pandemic, drawing out the process further. They were closed from mid 2020 until January 2021, when they reopened in a central location. "It took us five months to find a spot but look, we even have a view!" mused the manager, pointing at a park across the street.

When I visited the new spot in late 2021, its formal registration was still in progress. Dr. Bilal referred to the status himself as "semi-official" because all of the services were not yet

officially licensed. The clinic was approved for internal medicine, laboratory testing, dental care, and emergency care but had not yet had other specialties approved. They had thirty doctors working in the new clinic. Some had attained equivalencies, but others had not. Despite this early-stage semi-formality, the clinic was bustling with patients and doctors.

As these clinics formalized through registration as private polyclinics, the question of increasing prices became a sensitive subject. In interviews, managers continued to emphasize their value, eschewing the suggestion that they were trying to boost their profits. When I asked how much a typical appointment would cost, Dr. Bilal responded: "Most of our services are 50-60 Turkish lira [$6-7] per appointment. Our aim is still humanitarian, we are not business oriented." He emphasized that there is still a pointed need for these types of providers to serve the refugee population. The weekends, he said, are chaos, because patients who cannot access public healthcare providers during the week come to them during their days off. Moreover, he underscored the fact that the Turkish government still has no solution for how to provide healthcare to immigrants who do not have registrations, or those whose registrations are in other provinces. That's why, he emphasized again, they must operate.[95]

That said, it is common knowledge that the clinic has a variety of significantly more expensive services, depending on what the patients want. The manager of Shifa echoed this sentiment, while still recognizing the clear organizational transformation Shifa had undertaken to become MediPark: "We are less of a service NGO now," he noted, though he still emphasized that they are here to help the refugee community. "Let's say someone comes and says, 'I have no money, I'm in bad shape,' we always help, that's our motto. We never dropped our humanitarian side." It was abundantly clear, however, that the organization was gradually shifting its focus to

[95] Interview with Rafah Clinic manager, September 6, 2021.

more profitable endeavors. The manager of MediPark, as noted earlier, had applied for a medical tourism license for his clinic. He has since, surely, received it, based on the slew of videos he posts online of himself performing aesthetic medical procedures.

It is also worth considering what some doctors who used to work in these clinics and then left had to say about the organizational forms. It is one thing to recount the manager's tidy descriptions of humanitarianism, followed by registration and privatization. It is another to hear how the employees working within these spaces saw what was happening in the clinics. Dr. Daoud, an esteemed gastroenterologist, had worked in Shifa, Hayat, Khayr, and one other large clinic in another part of Istanbul for three to four years. He first described the clinics as charity clinics, and then corrected himself:

> When I say charity, it's not free, the person is paying a little, but it's not like a private hospital…in fact the word charity does not apply to all the clinics, it is dependent on the center, and on the doctor. Shifa is not really. It's really a difference in ethical approach. They are…more interested in how much they're able to make from the patient. For example, they have investors who helped them get a CT Scan and MRI, then they were encouraging doctors to do more of these tests, then they were giving some of the profits to these doctors. Before 2018 there were many centers working for the interest of the patients, so at that time fees were cheap and the commercial ones were not able to compete. But after 2018 most of them closed, but Shifa has some connections so they kept working. Then they won. They can charge more now.[96]

Dr. Daoud marks the "victory" of Shifa over other clinics, such that it could start increasing prices without competition for a while. Yet, he also implicitly describes another victory—the victory of a for-profit provision model that would take hold in the refugee healthcare terrain. What Dr. Daoud describes is not particularly unexpected, as private healthcare providers are often trying to find ways to make more money. Perhaps more surprising is that this was

[96] Interview with Dr. Daoud, November 28, 2021.

occurring in the clinic with the most sparkling humanitarian reputation in Istanbul, as it accrued more and more resources through charity networks.

As the managers of these clinics all said, they have aimed to maintain a humanitarian orientation toward their patients. What, then, does this actually look like in practice? Some of the doctors who worked in these clinics gave a sense of what humanitarianism meant within a more privatized context. Dr. Mansur, a dermatologist who used to work at Shifa, provided some clarification for what humanitarianism meant in the new MediPark Clinic.

> Dr. Mansur: In the first years they still had a charity orientation…they used to give out medicines like charity, but they slowly became private…Now the conditions have changed for lots of Syrians. Most of them work in commercial centers and they can pay.
>
> NK: What happens if a patient comes who can't pay?
>
> Dr. Mansur: If a patient comes and they speak with reception they'll tell them they don't have the money, and then the reception will call [the doctor] that there's a patient who cannot pay and then we decide if they can get the treatment or not.[97]

While the clinics could continue to provide care in a humanitarian idiom, this decision was left up to individual doctors rather than a policy emerging from the organization's core principles. A dentist working at MediPark told me flatly she does not provide any charity services. "We don't do free check-ups here. Maybe the doctors do, but the dentists do not."[98] The degree to which these clinics seemed humanitarian or for-profit was also highly subjective. Another doctor I spoke with specifically chose to work at MediPark rather than Oasis because he felt like MediPark was less voracious for organizational profit. "I went [to Oasis], but it felt too business-minded there. Anyway, they don't need more doctors," he lamented.[99]

[97] Interview with Dr. Mansur, March 21. 2022.
[98] Interview with Dr. Asma, October 1, 2021.
[99] Interview with Dr. Adnan, October 1, 2021.

The Segmented Dental Clinics

Shifa, Rafah, and Hayat Clinics were the only clinics of the seven original *dernek* clinics that continued to provide fee-for-service secondary care across a range of specialties. Indeed, as other clinics closed and downsized, many of the doctors that had once been distributed around Istanbul ended up working in MediPark, the new Shifa Clinic, and Oasis, the combined clinic of Rafah and Hayat. What, then, happened to the other clinics? Of particular interest at this juncture is the Khayr Clinic. Khayr had been the biggest clinic in the neighborhood—even bigger than Shifa at its peak with over fifty doctors cycling in and out—and had similar name recognition to the Shifa Clinic among Istanbul's Syrian population. It also had good relations with government officials that helped maintain partnerships with Ministry of Health personnel even after the clinic lapsed into informality. In most of my interviews, Shifa and Khayr were the two clinics that individuals would mention having visited. Khayr was large, well-connected, and generally respected among its beneficiaries. The fact that Khayr Clinic did *not* transition into a private, secondary outpatient clinic like Shifa, Rafah, and Hayat is puzzling.

This departure can be explained by Khayr's managers' existing personal networks and resources, as well as their organizational rationalizations of what services would best serve Syrians in Istanbul in the longer-term. Of particular importance was that Khayr's leadership was previously embedded in educational, rather than healthcare-related, networks back in Damascus, and later in Istanbul. I had first heard about the Khayr Clinic through a friend who had worked as a summer teacher in the organization's school in Istanbul. Khayr had run an Arabic-language school using the Syrian curriculum until it was shut down, along with countless other unregistered Syrian schools, in 2016 as part of a concerted effort to systematize Syrian education in Turkey. It was only in the aftermath of that closure that Khayr had decided to transition into

the healthcare sphere, where Syrian-run organizations could still maintain some cursory organizational legitimacy. It was not the organization's central mission to provide healthcare. Healthcare had merely been an entrepreneurial opportunity for an organization already deeply networked among Istanbul's Syrians. When I had first visited the Khayr Clinic, it still had its massive school banner left over from its education days hanging in its administrative offices, as described in Chapter 3.

Once the local government started strictly enforcing healthcare codes and closing clinics, the managers of Khayr decided not to invest in formalizing the clinic. In December of 2019, the clinic announced its closure publicly online, with a message of uncertainty about future reopening. In the meantime, the organizational leadership shifted its focus to the organization's original *raison d'etre*: establishing a private Arabic language international school. The school opened in late 2019. Though the managers were hopeful, they could not have predicted the jolt the school would experience in 2020. When the pandemic hit, the school was left scrambling for funds and students. When I spoke with the manager over the phone in 2021, he sounded resigned, talking about leaving Istanbul for London or the Gulf so he could start over. I asked if he would ever consider trying to reopen a private health clinic. He said anything would be impossible without an investor. They had run out of resources during the transition to a private school, given the unexpected shock of Covid-19 to their nascent operations.

Yet the school was not the only organization within Khayr's operations. I knew this because there was a clinic that had taken over the Facebook page of the original clinic's illustrious Facebook presence. It was a small dental clinic operating not far from the original clinic's location, in a smaller apartment marked by a toothy sign with the name of a Turkish dentist. The Facebook page still maintains Khayr's name, but now as "Khayr Dental Clinic".

When I brought up this dental clinic with Khayr's manager, he seemed to have forgotten about its existence until I mentioned it. I was surprised by his surprise, given that I had recently spoken with the receptionists at the dental clinic who had suggested I call him to discuss Khayr's recent transformations. The dental clinic was still operating with a regular clientele. When I visited in late 2021, the waiting area was crowded and the phone ringing consistently. But it became clear that the dental clinic was a residual organization that was Khayr's in name, but not particularly important to its manager's broader organizational goals.

Since I left the field, those larger goals have since been realized. The school reopened in January of 2022 and has been operating ever since. Upon the school's reopening, it attracted some unwanted attention on social media. Videos of elementary school aged children separated by gender—an educational practice prohibited by Turkish law—had been taken from their Facebook page and shared on Turkish social media. There were also videos of the students doing a reenactment of Muslims' pilgrimage to Mecca inside an Istanbul mosque, sparking social media ire among Turks who see Syrians' as bringing an ominous strand of conservative Islam into Turkey. National news outlets then got wind of the fact that the school did not have official certification. But that was rectified quickly—the school is now officially accredited. On the manager's Facebook page is a photo of him, a Syrian colleague, and the Deputy Minister of National Education of Turkey smiling for the camera at an Education Ministry office. Clearly, the manager has maintained friendly relations with Turkey's government bureaucrats. It is clear that he is now focused on the school's success, and lets others focus on the dental clinic's management.

The Khayr Clinic is an organizationally interesting case, in that it follows, to some extent, both the larger scale organizational privatization pathway while also clearly segmenting

organizational functions into dental care and education. Yet regardless of how one should categorize it in the framework, the insight remains: funds accrued during a hybrid humanitarian period leveraged the creation of a new private venture. And, when that venture faltered, a residual private venture nevertheless provided a minimal stream of funds in the dental care niche.

The Bilad Clinic is a cleaner case of hybrid segmentation and downsizing. The managers had also chosen to downsize what was once a bustling secondary care outpatient clinic to a private dental clinic. When I visited in 2021, I was shocked by the renovations that had taken place in the original space, which I had last visited in 2019. What used to be a fairly dingy waiting room with rows of black chairs had been replaced with a gleaming waiting room—it was kindly requested that I put on plastic shoe cover "galoshes" so as not to drag in dirt from the outside. The floors were gleaming black and white marble, grey leather chairs lined the space, and the room was dotted with bouquets of flowers. The ceiling was carved with scalloped flourishes, the air conditioning was running in October, and there was a small aquarium in the corner with some goldfish blithely swimming around. A blurred glass door led into the dental examination room, which staffed one dentist at a time. When I was guided through to see the dentist on shift, the first thing I noticed in the examination room was a large tv screen hooked up to security camera footage of the entrance where I had dutifully donned my blue galoshes.

In our interview, I asked the manager of the Bilad organization how they had decided to downsize from a secondary care clinic to a dental clinic. The last time I had spoken with a different Bilad manager in 2019, he had insisted that the clinic would continue operating so long as there were refugees that couldn't access healthcare in Istanbul, whether or not the clinic was legal. Then, even after they had been closed multiple times by the authorities and then reopened, he had said: "We have nothing to lose—it is helpful for the doctors who need to work and the

patients who cannot get their care anywhere else."[100] What, I wondered, had changed by 2021 in the management's decision-making about operating a clinic?

It turned out that the managers had been quite practical in their transformation efforts. They refocused efforts on their humanitarian services within Syria's borders. This particular organization is well-funded by Islamic aid networks based in Kuwait and has contributed significantly to infrastructure development in Northern Syria. They decided only to maintain a dental clinic in the space of the original clinic.

> Our goal is to support Syrians for free, not to make profit. We want to keep things low cost. If we decided to privatize our services it would have to cost more, and we'd need more doctors, and the whole process would get complicated…They opened Migrant Health Centers already. Why would we do the job that is supposed to be the job of the Health Ministry? That isn't out purpose.

Like other organizations, the manager of Bilad emphasized that their organizational mandate was humanitarian. Yet he reinforced the other manager's statement in 2019 that Bilad's purpose was to fill gaps in provision, not to carve a path forward as yet another private provider in Turkey's healthcare landscape. In this manager's estimation, there was no longer a need for Syrian-run healthcare to fill a provision or access gap among Syrian refugees. There was, however, one remaining gap that the manager noted when I pointed out that they still had a dental clinic operating. He said that the dentists had insisted they continue. There is, after all, no program for dentists to get incorporated into government-run Migrant Health Centers. While a handful of dentists have been appointed to the few "expanded" Migrant Health Centers, the number of Syrian dentists vastly outnumber the available jobs in orders of magnitude larger than the oversupply of Syrian doctors to MHC slots. The manager said: "They [the dentists] kept saying,

[100] Interview with Bilad Clinic manager, November 5, 2019.

'why did you close the clinic, we need jobs'…so they pressured us. Eventually we decided we would do that. After all, the Migrant Health Centers don't cover dental health."

He took care to note that this dental clinic is primarily just a residual operation that is not a particularly important part of the organization's larger purpose. But when I asked if it had separated from the organization as a stand-alone private entity, he resisted that characterization. "Yes, we are still connected, because in the end we are the ones who established the place, bought the building, and if a person needs help, we still transfer them to the clinic. The space is owned by the organization, so it couldn't really become something separate. We built it."[101] Even with the complete organizational transformation into a private dental clinic, the manager emphasized its humanitarian added value.

Khayr and Bilad ultimately both took steps to maintain a form of private health provision for Arabic-speaking beneficiaries. But in both cases, the discursive justifications for this form hinged not on continued demand among Syrian patients, but on a persistent provision gap in a specific niche: dental care, and in Khayr's case, also Arabic language education. Despite the state's notable changes in the structure of Arabic language healthcare for Syrian patients, dental care was a domain left largely untouched, save for the establishment of a handful of "Expanded Migrant Health Centers" with one dentist employed in each. In their new forms, Khayr and Bilad maintained residual and markedly downsized private care provision. In the case of Bilad, the rest of the organization's efforts continued to focus on cross-border humanitarian aid. Khayr, perhaps more akin to Shifa, Rafah, and Hayat, also ventured down a more markedly privatized pathway, just in the diverging service provision domain of education. Both, in the end, chose to leave secondary outpatient care to Turkish providers.

[101] Interview with Bilad Clinic manager, October 12, 2021.

Just one of the remaining organizations had abandoned a private clinic altogether. The Shams Clinic had no operations left in Istanbul as a health clinic. It had refocused completely on humanitarian projects in Northern Syria and Lebanon. Shams had begun phasing out the clinic long before government enforcement cracked down. As early as 2018, they had ceded the terrain to larger, better resourced clinics in their neighborhood that were already attracting the lions' share of patients. Doctors still gathered in the subterranean clinic, where I met and chatted with a group of them as few patients trickled in and out. For Shams, however, healthcare provision was always a key part of their organizational identity. When their market dried up in Istanbul due to neighborhood crowding and a lack of managerial will to compete, they shifted focus fully to humanitarian efforts across borders. While they are based in Istanbul, they carry out all of their aid projects in Lebanon, where they provide healthcare to Syrian refugees, and Northern Syria, where they provide aid and housing support to internally displaced populations.

Ultimately, the clinics diverge down three organizational pathways once the humanitarian niche begins to contract in refugee healthcare provision. The most well-resourced clinics--and paradoxically the most "humanitarian"—pursued pathways of formalization through more complete organizational privatization. Their humanitarian sector narrowed in service of focusing resources on the main private venture. While clinics still drew on their humanitarianism discursively, it was more as a way to justify their survival over time than their resultant organizational form. The second pathway entailed the maintenance of downsized, privatized residual healthcare work in dental care. The justification for this venture was markedly different. It was both a supply side and demand side project that filled a remaining provision gap for Syrian refugee dentists and patients. In this way, managers pivoted their organizations toward a discrete opportunity structure that remained unfilled in the Turkish healthcare landscape. Profit

continued to be a motivation, but it occurred in a narrower market. Finally, one organization I followed closed the for-profit elements of the venture and refocused on humanitarianism. This organization had never taken off as a private provider and had always had funds buttressed through humanitarian sources abroad. In the end, the hybrid humanitarian terrain fragmented into "purer" organizational constituent parts.

Residues of Temporariness in an Institutionalizing Field

All of the clinics discussed in this chapter built on key features of the hybrid humanitarian activities that had taken root in the years preceding the restrictive turn in late 2018 and 2019. They capitalized on the resources and legitimacy accrued while they were operating in the humanitarian niche to stretch their operations into new forms. Even as humanitarian clinics moved along the hybrid spectrum and became increasingly profit-oriented over time, they appealed to humanitarian networks. The resources they were able to garner as donations proved critical even as they were using these resources for services one would be hard-pressed to categorize as charity.

Yet, even as these organizations all transformed their operations into more formal forms, informality remained a central residue of organizing in the humanitarian niche. Even through formalization processes, informality did not disappear, it just became a less visible and more durable feature of organizing. When I speak of formalization, I refer to organizational and entrepreneurial efforts to abide by regulatory pressures in the shifting institutional context to maintain their operations. I do not mean to imply that the forms that emerge are fully formal. Rather, they are a move on a spectrum of informality and temporariness *toward* formality and longer-term institutionalization. Indeed, institutional formalization and durable informalities were inextricably linked. Formalization for immigrant-run healthcare organizations was only

possible if they were able to employ a steady stream of doctors, many of whom could not attain their full equivalencies due to geopolitical dynamics that made diploma certifications all but impossible, as discussed in the preceding chapter.

Even as individuals and organizations make efforts to legalize their operations in a host community, there are a number of onerous structural barriers as well as entrepreneurial justifications to stop short or diverge from fully legal operations. What results is a large, eclectic, and overwhelmingly semi-formal collection of healthcare arrangements in the private provider terrain. Migrant Health Centers are the one formal, legal organization that was formed to provide healthcare for Syrian refugees during this period. State hospitals remain the main formal conduit for care for Syrians so long as they maintain their temporary protection statuses. But for those who cannot or choose not to access state services, what remains in the interstices is a healthcare terrain characterized by various shades of legality.

These different shades of informality are visible not far under the surface of many Syrian-run health clinics' formal forms. First, there are the privatized clinics like MediPark and Oasis. These are officially registered as polyclinics. Yet they employ a number of doctors who are still en route to attaining their equivalencies. While most are Syrian, they have also started employing other Arabic-speaking doctors, including doctors from Iraq and Egypt. These clinics allow these doctors to work as they work out the legalization of their work. Other clinics that downsized and created residual dental clinics are semi-formal in a different way—they are registered under the names of Turkish dentists. This is a common practice among Syrian dentists who want to work in private practice. They register under a (typically) retired Turkish dentist's name, who then takes a cut of the profits for bearing the administrative burden of registration. In dental clinics I visited, Turkish dentists' names were prominently displayed on signs, on doors, and even on

framed certifications on walls. There were, however, no Turkish dentists in sight. Informality, despite all these efforts to formalize, was durable.

Conclusion

Theoretically, this chapter has examined how emerging organizations adapt to a turbulent policy context. It shows that early legitimacy and resource accrual facilitate a paradoxical outcome: a more pronounced abandonment of the organizational mission that buttressed its early survival. That is, the more humanitarian presenting an organization was early on, the less humanitarian it was in its ultimate formalized form. This is because, while formalization requires great resources, it also means *less* operational change. That is, the "more" humanitarian clinics were able to consolidate the type of work they were doing in the humanitarian niche even after it fades. They were able to maintain a steady beneficiary base, if not grow it. In contrast, the organizations that did not establish as deep of a humanitarian reputation end up with fewer resources and could not or chose not to formalize their secondary clinics in the same way. They still privatize, but through significant downsizing and/or transformation of their operations into narrower market niches.

What are the implications of these transformations for provider terrain? First, it means that Arabic-language secondary services are largely concentrated in a smaller number of growing clinics. With competition minimized, these clinics can more freely raise their prices, thereby serving an increasingly well-off beneficiary base. Second, it means these clinics can expand their patient base with their dense established networks and name recognition. Third, the durability of informal practices throughout these transformations means that Syrian healthcare professionals continue to work in precarious arrangements. This is a feature of a healthcare field already marked by increasing privatization and entrenched informality, rather than a bug. The next

chapter examines this process of service privatization through the lens of the doctors. It trains analytical attention on how these doctors situate themselves in the Turkish healthcare terrain, with particular attention to the patients they are serving.

Chapter 7: Toward Cosmopolitan Embeddedness

I had already met Dr. Hisham once, when I had gone along with a friend to her orthodontist's appointment. I had chatted with him informally as he carefully fixed metal brackets onto my friend's teeth. My friend, a budding influencer in the Syrian refugee community who posts instructional Turkish-language videos, was getting the braces at a discount. The understanding was that she would post on her Instagram account about Dr. Hisham's excellent handiwork. As she filmed the selfie video beaming with her metallic smile, Dr. Hisham and I arranged our next meeting for a formal interview. When I came back the second time and rang the doorbell of the apartment building where his office was located, I noticed a camera pointing squarely at my forehead. I had an appointment to meet him and knew I was welcome, but I also was reminded that not every visitor was. Like many of the clinics run by Syrian doctors, there was always an eye on the door, so staff could glimpse unannounced visitors.

Once inside, Dr. Hisham's warmth emanated through the clinic. He offered me some maté, which he proudly explained was an import to Syria from the earlier generations of Levantine Arabs who had migrated to Latin America. He insisted I keep my maté straw, metal with an orb filter on the end to keep the tea leaves and twigs at bay. He told me which Syrian shops in Istanbul sold the best maté so I could stock up. It seemed Dr. Hisham's entire life was propelled by an urge to reach across borders. He had begun his medical studies in Yemen, then had moved to Saudi Arabia afterwards where he worked for a while. When speaking of Yemen, his eyes lit up as he described Yemenis openness to foreigners like himself. In Sana'a, he had studied French and Dutch, and dreamed of moving to France or Quebec or Germany. He did later almost end up moving to Canada, after completing the Canadian equivalency process in 2009.

But he had settled back in Damascus, and life was pretty good at the time. He thought, why not stick around close to family after many years away.

Even in Damascus, he lived his life like a diplomat. He would seek out students who came from abroad to study Arabic at Damascus University—students from Switzerland, Germany, America, the Netherlands, and more. He would help plan excursions for them to see parts of Syria beyond Damascus. He noted that all these foreigners were always in awe of the generosity of the Syrians. He spoke proudly of the fact the Europeans he would meet would regularly proclaim that they were jealous of the Syrian way of life—always eating together, always drinking tea together, playing music together, and hosting guests at all times.

The notion of any sort of envy of Syrian life, however, quickly dissipated when the war broke out in 2011. When Dr. Hisham realized it was time to escape Damascus, he turned to Turkey—he had met many Turks in Yemen and adored them. He began to study Turkish before traveling, and continued when he arrived. Since arriving in Turkey, Dr. Hisham has done everything he can to practice dentistry legally. He speaks Turkish nearly fluently. He is one of the few doctors who successfully got his diploma certified by the Syrian embassy in Turkey, because he arrived in early 2012 and managed to initiate the process before diplomatic relations fully froze between the two countries. Very few people had come that early, prepared with their documents. Dr. Hisham had been ready. When the time came and he was allowed to take the dentistry equivalency exam in 2018, he took it and passed. But, for some reason, his Turkish citizenship still has not come through, which meant he still could not legally open his own dental clinic.

For ten years now, Dr. Hisham has cobbled together different types of informal work across Turkey. His reputation as an esteemed and skilled dentist is strong and widespread. He

estimates that eighty percent of his patients come from abroad, many for dental implants. But Dr. Hisham is at his wit's end. "I could go bigger and make a polyclinic or a dentistry center, but I'm scared. I can't actually do that because I'm illegal." Recently, some people had come to his clinic posing as Ministry of Health officials and attempted to extort money from him under threat of closing his informal clinic. He continues to work, hoping that his citizenship issue will be resolved. But for now, he remains in an uneasy suspension between legal and illegal work. He projects the energy and ambition of a global citizen, but, in the place where he lives, stable legal belonging has eluded him.

This chapter is motivated by a striking incongruity that has come to characterize healthcare provision by refugees. While some Syrian doctors have developed prodigiously expansive patient bases, both among local immigrants and tourists coming from abroad—they remain in frustratingly precarious working arrangements. How have doctors carved out this work in Turkey despite legal barriers? More broadly, how do immigrant entrepreneurs overcome institutional barriers to inclusion? And finally, how do their work configurations shape refugees' access to services? The chapter builds on insights from the preceding chapters, examining dynamics of patient demand, the effects of an increasingly privatizing healthcare terrain, and sustained institutional barriers for doctors' professional integration.

At this juncture it is worth summarizing what previous chapters have shown. First, there remained persistent patient demand among Syrian refugees for Arabic-language healthcare, even after the Ministry of Health established Migrant Health Centers employing Syrian doctors to help meet this demand. Syrian doctors working outside these MHCs remained key brokers in Syrian healthcare. They served as translators of medical advice, sources for second opinions, linkages to private hospitals, and providers of secondary care for individuals who did not have temporary

legal status in the province where they lived. Yet given onerous barriers to equivalency and legal work, doctors continued to provide these services to Syrians in informal or semi-formal arrangements. Some worked informally in Turkish providers, some worked in the hybrid humanitarian clinics, and some tried to open their own small clinics, or some combination thereof.

As chapter 5 detailed, Syrian doctors continued working outside of MHCs in these informal arrangements by justifying their critical role in Turkey as healthcare providers, despite legal and bureaucratic limitations on their work. They did this by discursively discrediting existing rules and regulations circumscribing their work, then resituating themselves as critical providers in the Turkish healthcare terrain. No longer just doctors filling an Arabic language care niche for vulnerable refugees, they became something more. They reframed their work as underutilized yet essential in Turkey's ailing healthcare system, which is losing doctors by the day. They affirmed their position as sought-after professionals in the global healthcare market, both for their skills and their multilingualism. Other countries have recognized these skills, but Turkey, they argued, has not. Moreover, Turkey was already a hub for multilingual care in a globalizing healthcare marketplace. The only thing preventing Syrian doctors from legally pursuing their work in these existing niches, they pointed out, was obstinate Turkish policy born out of an orientation towards Syrians that sought to prevent their full integration.

This chapter picks up from these discursive practices and considers their brick-and-mortar manifestations. It explores how Syrian doctors work anyway, despite the frustrating institutional reverberations of Turkey's temporary protection policy. Rather than focusing on the legal statuses or certification configurations of individual doctors, which are variable, I look at how different types of semi-legal work manifest at the organizational level, where individuals

with a range of legal work arrangements nevertheless coalesce around the same types of providers. Moreover, it examines how immigrant entrepreneurs situate themselves in an institutional terrain that does not make adequate legal space for their work. I argue that when highly-skilled immigrant entrepreneurs face legal barriers to establishing organizations in a host community, they make claims to their economic importance in the host country. They do this emphasizing how they both meet local demand for goods as well as shepherd international dollars into host country coffers.

Establishing Organizational Belonging in a Temporary Policy Context

Examining immigrant claims to alternative forms of belonging in the absence of legal belonging is not new in the migration literature. This phenomenon is typically analyzed in the citizenship literature and focuses on individual immigrants. For example, middle class and elite Indians in Dubai do not have access to legal citizenship, yet they still tend to make claims of belonging to the state. They make these claims in economic rather than legal terms. That is, they claim that their work in Dubai as entrepreneurs in a heavily market-oriented society makes them an integral part of the social fabric. This is despite their legal exclusion from full membership in the polity (Vora 2013). In this case, supranational logics of the market matter for claims to belonging even as individuals disavow political belonging in the same state context. This tension between long-term residence and institutional non-belonging is a fact of life for generations of populations in the Gulf countries, including not only immigrants but also undocumented domestic populations. Protracted experiences of liminal legality occur in spite of these population's essential—and demographically overwhelming—contributions to the social and economic fabrics of the countries in which they reside (Lori 2019).

Indeed, economic belonging can be an important facet of an immigrant's sense of belonging in a host polity. Studies have shown that highly-skilled professional refugees feel more of a sense of economic belonging in a host country than do their working-class counterparts (Yuval-Davis and Kaptani 2009). The feeling that immigrants have an economic stake in their host community is an important aspect of fostering belonging (Antonsich 2010). Analyses of economic belonging—even in the absence of other forms of political belonging—suggest that the way immigrants organize their work-lives can be a central aspect of cultivating belonging in a community.

I extend Vora's analysis of claims to economic belonging in a global market among immigrant entrepreneurs to the organizational level. Rather than focusing on "belonging," already an amorphous concept at the individual level and an unwieldy idea to apply to organizations, I consider more concrete notions of organizational importance within a field. Just as individual immigrants may claim membership through the centrality of their work to the functioning of a host country, absent citizenship, so too do immigrant organizations situate themselves as essential providers of goods and services in a host terrain. Like individuals who may lack political or legal belonging, some organizations may lack legal recognition. Claims of essential service provision thus provide some cover for these administrative shortcomings while nevertheless making a case for their societal indispensability.

Given that this chapter speaks to immigrant service providers rather than immigrants' personal experiences, it is useful to also conceptually pivot to the level of the provider. Kloosterman's mixed embeddedness perspective provides us with a useful framework for considering immigrant entrepreneurs' work practices. Not only does it orient us toward the entrepreneurs and the opportunity structures they identify for business, but it also alerts us to the

broader host state institutional context that shapes this opportunity structure. In Kloosterman's successive works refining the mixed embeddedness perspective, one assumption is that the "macro-institutional framework" is relatively stable within any given state. Kloosterman emphasizes that most of his analytical attention is oriented toward the interaction between the individual entrepreneurs and the local opportunity structure. He admits that the macro-level--conceptualized in the framework as the structure of the host state economy--is connected in a "more loose way" (Kloosterman 2010: 28).

Refinements of Kloosterman's multi-level analytical framework have ventured into transnational terrain (Wahlbeck 2018). Accounting for immigrants' contexts beyond the host state, they analyze the cross-border resources that immigrants draw on to establish their enterprises (Solano, Schutjens, and Rath 2022). They also bring into consideration the opening of markets that span multiple states (Miera 2008). Transnational resources, networks, and markets contribute to immigrant entrepreneur's transnational mixed embeddedness, from the micro-level of individual entrepreneurs' resources to the macro-level of global markets (Bagwell 2017). While refinements of the framework have usefully accounted for greater scalar and spatial considerations, I turn my attention to the ways that entrepreneurs' themselves selectively invoke, leverage, discredit, or circumvent institutional forces as they situate their work within these globally expansive networks. Building on their discursive justifications for work elaborated in chapter 5, I examine how refugee entrepreneurs actively shape opportunity structures and establish brick-and-mortar practices in the host community terrain.

Diversifying Local Providers

The early hybrid humanitarian clinics created by Syrian doctors relied heavily on networks with Turkish humanitarian aid organizations and other politically connected government personnel.

This allowed them to accrue the legitimacy and resources needed for their survival. As the humanitarian niche narrowed over time, so too did the efficacy of these networks for perpetuating organizational survival. Clinics gradually began implementing higher cost services in order to meet their bottom-line. Some doctors became restless in these clinics, while others were downright unhappy with the ways they were managed. Many decided that it was time to venture off and find alternative forms of work. This meant either applying to work in MHCs, initiating equivalency processes as of 2018, and/or venturing off on their own or with a small number of colleagues to find other forms of work.

When Dr. Louay first felt the stirrings of revolution in Syria in 2011, he knew he had to get out. Not one to get involved in politics, he quickly found a broker in Syria who connected him to a dental practice in Saudi Arabia. Once there, he went through the relatively simple re-certification process so he could practice as a licensed dentist. He then moved from Saudi to Dubai—certifications carry over within Gulf countries—and continued to practice for a few years. But as the war dragged on, the Gulf countries became increasingly inhospitable to Syrians. He kept getting dropped from clinics, which was stressful, given that his ability to reside in these countries depended on a stable work contract. And, of course, stable work depended on his ability to reside there. After ten months of monthly visa renewal applications, he had had enough. He decided to travel to Turkey, where he heard there were decent work opportunities. He spent two years working jobs unrelated to healthcare. For a while he worked at a small hotel, preparing food, tidying beds, delivering room service, and working in the hotel shop. He then heard about Syrian health clinics that were starting to open.

He went to Hayat, Rafah, and Shifa Clinics looking for work in 2015. The clinics were not to his liking. He had thought they would be more tidy, more organized. He was not inspired.

But then, serendipitously, he got to talking with his Turkish landlord one day. The landlord mentioned that his friend, a Turk, was a dentist, and connected Dr. Louay to the practice. There, he met his colleagues—mostly Iraqi and Syrian dentists. The Turkish dentist himself was just managing the clinic. Within this Turkish dentist's clinic, Dr. Louay tried to cobble together a patient base after three years not working. He would get forty percent of the patient fees, and the clinic would get the remaining sixty. This international space became his work home, while he tried to reintegrate into his profession and stabilize his status in Turkey by applying for citizenship. He had not yet had the time to study for equivalency test, but had managed to get back on his feet professionally in the informal arrangement.

Branching from Syrian healthcare providers to Turkish or non-Syrian immigrant providers that were already established in Istanbul was a common practice among Syrian health professionals. One orthopedic surgeon I spoke with, Dr. Jameel, had immediately started networking with Turkish doctors as soon as he arrived in in the country. He had, like Dr. Louay, had an unsuccessful stint in Saudi Arabia where even though he had his certifications recognized, he kept being pushed out of work for being Syrian. Once in Turkey, he sought stability first and foremost. He began working alongside a Turkish orthopedic surgeon as an assistant or intern, as he called it himself. He credited his strong English skills for his ability to branch out into new doctors' networks. He eventually applied for his equivalency and, after an initial failure, succeeded on the second exam.

When we spoke, he had his primary care equivalency and was working at a Turkish hospital. He had arranged a 50-50 deal with the hospital, where half of the treatment fees went to the hospital and the other half went to him. He was happy with this arrangement. "I don't like a salary…I like an open market, so I chose the 50-50 arrangement. If I work more, I get more. If I

work less, I get less…I work at hospitals, but I work my own way. I am the director of myself. I have my own team…I'm very comfortable. I don't like to be managed by others. For now, this is good. Because it's very, very hard to have my own hospital: the golden job."[102] Dr. Jameel had embraced an entrepreneurial arrangement in the Turkish hospital where he could be in charge of his own work. He was effectively running his own orthopedic surgery clinic with the support of the hospital. But legally, he knew that he could not establish his own practice under his own name. So he was, for now, satisfied with the work he had arranged for himself.

While often Turkish doctors proved to be useful network connections, Syrian doctors also relied on other immigrant doctors for assistance. Dr. Ziad had also started working alongside certified Turkish doctors as a "doctor's assistant" after moving on from the humanitarian clinics. He had gone through the training to work in a Migrant Health Center but had ultimately opted not to pursue that route. He had also tried taking the equivalency test once without studying and failed. He decided that he could not forfeit six months of income to study for the exam, and then deal with government-mandated service assignment in an arbitrary region of Turkey. Instead, he focused on forging ties in the private clinic terrain in Istanbul. He had met an Uzbek gastroenterologist who then connected him to a Turkish endocrinologist. Dr. Ziad fostered the relationship by finding Syrian patients to send to her for treatment. Later, they started working together. Dr. Ziad would bring patients to her practice and would help treat them there.

Dr. Ziad has gradually expanded his patient base beyond Syrians. He now has patients coming from abroad, from Saudi Arabia, Europe, and Canada. But, he notes, they are "our kind"—Syrians. He explains: "They come here because they want care for cheaper, and the quality in Turkey is good. I bring these patients to the private hospitals. We then…find them a

[102] Interview with Dr. Jameel, November 26, 2021.

provider. Here in Turkey, I'm the connection point, people trust my work, and they don't know much about Turkey. A lot of work comes to Turkey through Syrian doctors. There's a lot of medical tourism coming through us." Dr. Ziad positioned himself as a key broker in the Turkish healthcare landscape, eventually bringing in patients from abroad.

Transnational Economic Justifications for Work

Dr. Ziad's journey from a broker for Syrian refugee patients' secondary care to a transnational medical tourism broker is not unique. Syrian refugees' arrival in Istanbul was, in many ways, a shock to the existing terrain of providers. All of a sudden, pronounced demand for Arabic-language healthcare overwhelmed existing Turkish providers. Yet, on the other hand, Arabic-language care had already been a developing niche, particularly in Istanbul. While Syrian refugees may predominate as Turkey's Arabic-speaking immigrants, Turkey also hosts a wide range of Muslim and Arabic-speaking immigrants. When the *dernek* clinics opened, their clientele had gradually expanded from Syrians to Egyptians, Yemenis, Moroccans, Tunisians, Iraqis, Palestinians, and more. The demand for immigrant-friendly care had already been there, before the arrival of Syrians, but the shock of Syrians led to the emergence of new organizations to meet this demand. With an increasing Arab immigrant population, more immigrants began coming to Turkey. Turkey has also increasingly become a hub for Arab exiles, including journalists, politicians, and activists (Keddie 2020). Where there is a sharp increase in Arabic speaking immigrants, demand for Arabic language services follows.

This surge coincided with a broadening transnational orientation in Turkey's healthcare field, which has come to host a thriving medical tourism industry. Aside from being the "hair transplant capital of the world", Turkey has become a global hotspot for a broader array of services for tourists (Callaghan 2024). These include ophthalmology, orthopedics and

traumatology, internal medicine, gynecology and obstetrics, general surgery, and dental services (Kaya, Karsavuran, and Yildiz 2015). By 2018, Turkey was receiving the fourth highest number of foreign patient arrivals in the world (Yilmaz 2021). Indeed, the Turkish state firmly supports Turkey's health tourism sector by incentivizing medical tourism accreditation through the Joint Commission International, and Turkish Airlines provides up to 50 percent discounts on ticket prices for international patients (Yilmaz 2021).

A particularly incongruous phenomenon gained momentum during my fieldwork in between November 2020 and June 2021. During this period, Turkish residents were subjected to strict pandemic curfews. Monday through Friday, individuals were only allowed out of the house during work hours. Those over the age of 65 only had permission to be out between 11:00am and 2:00pm. All restaurants and cafes were limited to delivery operations. The entire weekend—Friday night to Monday morning—was a total lockdown, in which no one was allowed to leave their homes except for essential tasks. The entire month of Ramadan in April/May was a full lockdown with no reprieve. Police issued steep fines to individuals who broke these curfews.

Yet, throughout this period, tourists were not beholden to these rules. Tourism—including medical tourism—continued at a steady clip. In fact, Turkish Airlines increased its discounts for medical tourists to stimulate more travel. Journalist Ceylan Yeginsu covered this phenomenon in a *New York Times* article published in January 2021. She notes that, despite Turkey's weekend lockdowns, "visitors are allowed to roam free without any restrictions. On Istanbul's main Istiklal Avenue, men recovering from hair transplant procedures can easily be spotted with bandages around their heads" (Yeginsu 2021). Despite the seeming hypervigilance of the Turkish state in containing the spread of Covid-19, international travel, particularly that which stimulated the economy with medical procedures, was actively encouraged.

It is also important to note that many Turkish health clinics that draw tourists operate without formal registrations or by employing semi-formal practices. According to reports on Turkey's hair transplant industry, six out of ten hair transplant clinics were operating illegally in 2016 (Hava 2016). In these clinics, technicians and nurses rather than physicians perform the transplants, reducing what are already relatively low hair transplant costs. Given a lack of monitoring by the Ministry of Health, such unregistered clinics operate relatively easily. Informal healthcare, and informal medical tourism, are a feature of Turkey's healthcare terrain. Syrians' insertion into the semi-formal medical tourism market, then, is no aberration.

I met Dr. Ghassan one morning after perusing his Instagram account, which had a combination of hardcore weightlifting videos, photos of his patients' gleaming teeth, and rave Google reviews of his dentistry services. I expected an intimidating, muscular hulk to meet me at the café. Instead, I came across a soft-spoken, affable young man with pristine Turkish and an easy temperament. Dr. Ghassan had faced a slew of challenges as he tried to establish his professional place in Turkey's dentistry landscape. He had spent four years in Syria working with the Syrian Red Crescent and providing emergency aid to victims of bombings, and then finally left Syria in 2015. After briefly spending time in Istanbul working as a carpenter and failing to find work as a dentist, he moved to Bursa, a nearby province. There, he worked in a series of informal arrangements, eventually getting cited for operating an illegal clinic. When he was applying for citizenship, this court order came up. He was tried and let off relatively easily, in his words. He was told that he must pay $500, and if he ever works illegally again, he will be punished with jail time.

Dr. Ghassan ended up passing his general dentistry equivalency exam and got his citizenship. He opened a clinic in Istanbul where he now works legally, but for the fact that he

does not technically have the secondary care certification to provide the orthodontic work that he does. He described his clientele:

> I get people from abroad. But right now, there is no tourism. The tourists I typically get are from America, from Canada, from Europe. But they're our kind. They find my office through Google Reviews, you can find the location online. I also use Instagram and Facebook, and then other people we get through connections. For example, I had a friend I used to work with in Bursa, he ended up going to Germany, but he refers people that he knows to me if they are looking for care abroad.

I asked how many of his patients were tourists.

> Thirty percent are probably tourists, but right now there aren't that many people coming. Part of the problem is that because I work with a license, I have to pay more fees and my prices end up more expensive, and the locals, the economic situation here is truly terrible, a lot of locals can't afford it. For example, a root canal can cost 800-900TL. Well, if a guy's monthly income is 5000TL, they can't do it, even though it's an emergency treatment that he needs, he has pain…
>
> I'm really not happy living in Turkey from a personal standpoint. These big clinics and centers, they do all these ads, I can't compete with their prices. These are Syrian or Arab clinics but also some Turkish. The bigger clinics can offer cheaper prices…
>
> I don't get any Turks, we could say zero. Mostly its Arabs. Egyptians, Palestinians, Libyans. There are prices that technically we're supposed to stick to that are released by the Dentists' Association but no one actually follows that, Turks included.[103]

Dr. Ghassan's comments are notable for a number of reasons. First, he refers to a common practice in Turkey--that price floors set by the medical and dental associations are often not heeded in practice. This leads to stiff competition in service provision for small clinics like his. He has situated himself in a demand niche serving the Arabic-speaking population in Istanbul, yet he still struggles to compete. The second striking feature of Dr. Ghassan's analysis is his direct reference to how refugee networks perpetuate his business through medical tourism. It is not merely word of mouth, or advertising, that reaches populations abroad. In fact, direct links

[103] Interview with Dr. Ghassan, February 25, 2022.

between Syrian refugees who used to live in Turkey but have since moved help perpetuate trust networks and sustain Syrian doctors' increasingly transnationally oriented businesses. This trend of resettlement and immigration to third countries leading to expanded patient networks was a common trend, particularly among dentists I spoke with.

Dr. Hisham, the dentist who had trained in Yemen, also described the power of refugee networks in perpetuating his business. He reflected on how striking it was that he came to Turkey with $1400, barely enough to get a start in the new country, and now was running a dental clinic with international reach. He talked about his patients, and how news about his excellent services spreads. Dr. Hisham explained:

> They all refer each other from friend to friend. You know, one comes to me, and then they call their relatives, and then they refer each other. In fact, one of them, I have this patient, he's Syrian, I saw him six and a half years ago. I fixed his teeth here. He afterwards applied to migrate to Canada, and then he became a citizen there. And there, he got citizenship, he built his own work, he owns a company, he even has people who work for him, and he came back to me to renew his smile. I was so surprised when he came back. He came from Canada just for this. And you know, here is a case where a Syrian doctor is bringing dollars from outside.[104]

Some of Dr. Hisham's patients were themselves resettled Syrian refugees for whom traveling back to Turkey for dental care made financial sense. By sharing this anecdote about his Canadian-Syrian patient, Dr. Hisham pointed to his broadening patient base.

Additionally, Dr. Hisham explicitly stated how his work contributes to Turkey's economy. Dr. Hisham emphasized this point for another reason—he is still working informally. When we spoke, he had been trying for years to formalize his work status in Turkey, to no avail. He had taken the equivalency test, failed, then taken it again, and passed the second time. But, unlike many other doctors, he has been unable to get his citizenship, and he does not know why.

[104] Interview with Dr. Hisham, January 7, 2022.

He started a company because he heard that investing in a business in Turkey was a way to signal commitment to becoming a member of Turkish society and fast-tracking citizenship. But in the amount of time it was taking to communicate with the Directorate of Migration about his citizenship during Covid-19, the company's registration lapsed. The record of his citizenship application had since disappeared from the government's E-Devlet online portal. He even recounted an anecdote in which he had met Süleyman Soylu, the Minister of the Interior, in person, and complained that he still didn't get his citizenship after nine years. He had no idea why his citizenship application had produced such difficulty while everyone around him was getting it relatively easily. Dr. Hisham persisted with his practice, working under the name of a Turkish dentist. "We have a pretty big business here, but I can't make it bigger because if I get more famous they will notice me…But of course without the citizenship, this is about as high as I can go."

While it may have prevented his clinic from continuing to grow due to the perils of excessive visibility, the informal status of his clinic did not prevent Dr. Hisham from reaching an international clientele. He noted that the vast majority of his patients were coming from abroad, and mostly for implants or the coveted "Hollywood Smile", where patients get a full set of gleaming dental implants. As proud as Dr. Hisham was of his growing business, he bemoaned the fact that he gets hassled by Turks who try to extort him by threatening to report the clinic to the authorities. "I studied five years and then another five years' specialty, and I feel worthless that someone can just come and blackmail me like that," he lamented.

When I was interviewing Dr. Hisham, his Syrian colleague Dr. Mohsin was working in the room as well, and gradually joined our conversation.[105] He gave a remarkably well-structured

[105] I later did a separate interview with Dr. Mohsin as well. This quote is from the interview with Dr. Hisham.

summary of Syrian doctors' added value to Turkish society that was being curbed by the difficulties in formalizing their work:

> [S]o if the government made a system, it would be so good for many different reasons. First it would get rid of the scammers and the doctors who don't work well because you would have to approve their licenses. Second, they'd be under the control of the Ministry of Health so they wouldn't be underground. Third we would pay taxes. And fourth there would be more activity in the market, it would be economically good for the country. We encourage health tourism. We bring in people, my family is all over the world. We have like, if we look at my extended family there's like 200 people from Beijing to Washington, they will come here for treatment. They'll come and do some tourism, they'll see relatives and they'll get their teeth done. It's great marketing. More than 80 percent of our patients come from outside. I'm probably bringing in $100,000 and I'm bringing it as an illegal guy. If I could be legal, I would bring so much more money because that $100,000 could become $1 million because in the end people know we're informal and illegal and so there are still some hesitations. And so, if we were formal we could even have that much more business.

By recasting Syrian doctors' potential market in global terms, Dr. Hisham and his colleague make a case for their role as integral players in Turkey's national economy. They emphasize their direct contributions to their host country in spite of its seeming callousness as a place of refuge and professional re-integration for highly skilled medical professionals. Moreover, they justify their informal work as aligned with Turkey's broader interests.

Dr. Daoud, the gastroenterologist, resisted the term medical tourism when it came up in our conversation. "Medical tourism is about hair implants, what we call elective--you can pick the treatments, like gastrectomy to lose weight. Or dentists are cheaper, or plastic surgeries…I'm not seeing those people. The people who come to me, they have a problem and they are seeking a solution. That other stuff is commercial." Yet, despite the fact that he personally drew a line between elective and nonelective care in defining the bounds of medical tourism, he also described examples from his own experience which could be categorized as medical tourism if we were to use a broad (and indeed relatively standard) definition that includes all travel across

borders for medical care. He continued: "On Friday I had two patients. One came from Iraq--he came for the assessment all the way from Iraq. Our reputation as Syrian doctors is very high in Arab countries…On Friday I also had a Syrian patient from the US. She's like you. She found us through Facebook, or maybe Telegram." He then launched into a striking case of medical tourism, though he did not define it as such:

> Some [Syrians] come to get their medical assessment here because they cannot understand if what the report says at the Turkish hospital is serious or not. And this language barrier is not just a problem in Turkey, where people can't understand their own situations. Two years ago, I had an Iraqi patient, a tourist from Sweden where he was a citizen. He was on vacation and ate some bad things and so he came to Khayr Clinic and by chance I happened to be there. I gave him some medicine and then he went back to his country. Two to three months later he had serious abdominal complaints, and he went one, two, three times to a Swedish doctor but they told him you don't have anything. So, he booked a trip to Turkey. We did an endoscopy and found many ulcers, we gave him medications and he got well. When he returned to Sweden he issued a legal complaint against the hospital—his daughter was a journalist so she wrote a story on it, and described how after three weeks of suffering he took a trip to Turkey to see Syrian doctors. After this story they paid for the cost of the trip. I was surprised by this.[106]

Sometimes their patients are medical tourists proper--those coming to Turkey for the purpose of seeking medical care—while others are just tourists who happen to need care while in Turkey. No matter the type of tourist, Syrian doctors have filled a niche in the healthcare market, particularly for, but not limited to, Arabic speakers.

The degree to which this market is in competition with or complementary to Turkish doctors' practices remains a contested question. In many cases, the doctors I spoke to were able to work informally because they had established personal relations with a Turkish doctor who wanted their practice to have an Arabic speaker. One Syrian doctor who had worked with a Turkish doctor before establishing his own legal clinic reflected on his previous work in Istanbul: "Before I worked here I worked in Turkish [private] hospitals, with Turkish surgeons and

[106] Interview with Dr. Daoud, November 28, 2021.

doctors. The Turkish hospitals liked having Arabic speaking doctors because, unlike Turks, Syrians do not have [private] health insurance that covers costs at the hospital, so they pay full price. We had a lot of Arab patients for this reason, because they would pay more money."[107] The clinic he opened with Syrian colleagues, in contrast, kept prices relatively low at 70TL for a checkup, and served a 99 percent Syrian population.

Yet in other cases, doctors surmised that their protracted professional difficulties were tied to the fact that Turkey did not want to integrate Syrian doctors for fear of competition. One dentist explained to me that sometimes, if Turkish clinics hear that a Syrian clinic is giving services for cheap prices, below set price floors, they will report the clinic to the Provincial Health Directorate.[108] Another dentist tied this sense of competition directly to medical tourism:

> The Dentists' Association, they don't want foreign doctors to work in Turkey because if they work that opens the door for business for foreign doctors. They depend on foreign customers, the health field brings in a lot of money from abroad and Turkish doctors want that money for them…If Arabic speakers start opening clinics and doing advertisements, I am sure Turkish doctors will have weaker work.[109]

Whether or not Syrian doctors were potential collaborators or competition when it came to bringing in greater profits from international patient flows, one thing was clear: Syrian doctors had become a new and thriving niche in the international medical tourism industry. This was the case despite the fact that most employed semi-legal practices. Most were either missing equivalencies, registered under doctors who did not work in the clinic, undercharging for services, and/or engaging in other routinized informalities of everyday business in a domestic terrain already marked by informality. Through this work, Syrian doctors became further embedded in dynamic transnational healthcare networks.

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[107] Interview with Dr. Abdullah, October 11, 2021.
[108] Interview with Dr. Ibrahim, November 23, 2021.
[109] Interview with Dr. Samer, March 3, 2022.

Serving the Global and the Local

Though Syrian doctors' activities were heavily circumscribed by legal, bureaucratic, and practical barriers, they found alternate pathways to put their skills to work in Istanbul. The humanitarian niche, which had granted Syrian doctors a temporary foothold in the healthcare landscape, gradually contracted. This left clinics and doctors recalibrating their place in an environment that was simultaneously more open to Syrian doctors' work and more restrictive of the legal conditions under which they could pursue that work. Syrian doctors harbored frustrations wrought by the prohibitive secondary equivalency process as well as retroactive resentments of opportunities not afforded to doctors. This did not stop them, however, from claiming what they saw as their essential place in the social and institutional fabric of healthcare in Turkey. The previous section discusses the ways Syrian doctors cast their work in global terms. Syrian doctors' claims to economic importance in the community derived from their expanding global reputations and networks and ability to pull in tourists. This section shifts focus back to the local communities in which Syrian doctors were embedded. At the local scale, Syrian doctors continued to stress their critical role as providers of care for immigrants from a variety of backgrounds, filling a market unmet by the existing healthcare terrain. No longer framing this role as purely humanitarian, as they did in their early days of work, they nevertheless stressed that their skills were uniquely suited for persistent local immigrant demand for services.

I spoke with one health professional who was a physical therapist. Dr. Ghada had managed to informally find work in a Turkish clinic when she arrived. With her Syrian PT degree, she was not allowed to work independently or manage her own clinic. In fact, she was not even sure about the legal status of her work at the Turkish clinic, and mentioned that she was pretty sure all the PTs were working under the name of one licensed Turkish PT. "I still don't know why they

didn't ask me for equivalency," she reflected. Nevertheless, she decided to leave that clinic when she realized that she would have to treat both men and women. Coming from a conservative religious background, she was uncomfortable with the idea of working with male patients. Instead, she decided to work at Rafah and Khayr clinics for four years, until both closed in 2019. She then worked at a different Syrian clinic that was shut down after two to three months because of a licensing issue.

At this juncture, Dr. Ghada decided that she would work independently, doing PT sessions at the houses of the individuals she treats. Because of her previous work, she had many connections to doctors working across Istanbul who would refer patients to her. Even during Covid-19, she cautiously did house visits. I asked her what types of patients she sees. "I see Syrians, Iraqis, Egyptians, Palestinians, Somalis, Sudanese, everyone. Anyone who speaks Arabic. One time I had a Turkish patient. I don't usually like to because of the language, but this patient insisted. The patient's cardiologist was Syrian." Curious about the freelance set-up she had devised, I asked her about how she prices her services.

> It depends on how far the location is, what the health issue is, how many sessions. So for example some kids, they have brain damage or neurological issues, these kinds of people need sessions for the rest of their life, so you can't really charge them a lot because they will need a lot of sessions, it's not just five or six sessions, so I adjust it. I've also seen a lot of Syrians who are survivors of the war and their conditions are really bad, both economically and as a patient, so I don't take money in these cases. Sometimes I only take money because the patients insist, they say that they don't accept for me to come and not pay, so I'll take a little but it'll just be a nominal amount, sometimes it's not even enough to pay for the bus, it's just a little so they don't feel ashamed, it really depends.[110]

What Dr. Ghada describes here echoes a shift that was happening among Syrian doctors more broadly. With formal forms of humanitarianism phasing out, decisions about care and charity were left to individual doctors. At the same time, doctors' patient bases had expanded into a

[110] Interview with Dr. Ghada, January 10, 2022.

diverse group of immigrants, as Dr. Ghada described. While she was still most comfortable in Arabic, she treated patients from all over the Arab world and Africa, even those whose main languages are not Arabic. Over time, Syrian providers became enmeshed in local immigrant healthcare beyond Syrian patients.

Dr. Ahmed, the Syrian pediatrician who had completed his training in Turkey, also described a gradual widening of his patient base in Istanbul. For Dr. Ahmed, it is not only different immigrant groups who come—he also draws patients from across other provinces in Turkey.

> They come from all over…Edirne, Bursa, Bolu, Sakarya, Izmir, Yalova…they hear about me through references and they come. About 50 percent are Syrians, and then 30 percent are other migrant groups, and then the other 20 percent are Turks. They hear about me through social media, I have Facebook and Instagram, but also mainly it's through references. About 50 percent of my patients are Syrian, it could be a little more, but in general they can't pay the fees. When I was at [a private] hospital in Bağcılar more like 75 to 80 percent of my patients were Syrian but it's dropped here because of the price.[111]

Dr. Ahmed, unlike Dr. Ghada the physical therapist, is more clinical in setting prices, leaving little room for charitable service. Dr. Ahmed follows the price floors set by the Turkish Medical Association, and these prices are too high for many Syrians struggling to get by in Turkey. Yet Dr. Ahmed has no shortage of patients, given that other immigrant populations file in through his doors regularly. When I entered his office, there were two families on their way out. He mentioned to me that one of the families was Libyan, and had been coming to him for the last year. It took them six months to get their ID cards, so Dr. Ahmed had registered their child as stateless in order to provide care. The other family was from Tajikistan. They were also unregistered, and had faced difficulty accessing care elsewhere. A friend had referred them to

[111] Interview with Dr. Ahmed, January 27, 2022.

Dr. Ahmed. They were able to communicate in broken Turkish and received the care they needed for their child.

Throughout my interviews during my dissertation fieldwork, the number of different immigrant beneficiaries that doctors treated became a veritable world tour. Every doctor would mention a new and even more surprising country of origin in their recent patient visits. In many ways, the Syrian doctors are more aware of immigration flows to Istanbul than their Turkish counterparts, because unlike Turks who often do not differentiate between Arab populations, the Syrian doctors are attuned to the linguistic and national differences. Dr. Louay essentially gave a summary of immigration and refugee flows to Istanbul based on his clientele:

> We have Arabs in general…recently also there are a lot of Palestinians and Iraqis. You know…also now there are a lot of people from Morocco, Algeria, Tunisia. They start to come more than before…there are a lot of Egyptians and recently also Lebanese. I mean it's not only Syrians. Most of our clients are Syrians but not only, because a lot of Arabic nationalities now come and stay in Istanbul.[112]

It is worth dwelling on the fact that there are two important axes of variation that are being underscored with these growing lists of immigrant beneficiaries. The first is more obvious. As Syrian doctors gain a foothold in Istanbul, word spreads among immigrant groups about clinics that are relatively welcoming to foreigners. But another centrally important axis of variation is that of legal status. The healthcare services that are provided by Syrian doctors are lax when it comes to legal status checks. This is in part because they are private. Private care, even in Turkish private clinics and hospitals, is often rendered regardless of legal status—if you can pay, and present some sort of ID, you can receive services. But Turkish providers are more likely to go through the bureaucratic procedures of inputting beneficiaries as "stateless" in their online systems before rendering services. Unregistered immigrants may shy away from any sort of

[112] Interview with Dr. Louay, February 11, 2022.

legibility to bureaucratic processes for fear of legal reprisal. Refugee-run providers, as a result, are both more open to diverse immigrant groups both as a matter of principle and as a matter of legal bureaucracy.

As Dr. Bilal noted about the Oasis Clinic, "We get Iraqis, Libyans, Yemenis—no Turks though, because they can get care for free from the government. We get Syrians of all legal statuses…we get those who are registered and those who aren't. IDs don't make a difference for whether you can explain your condition or not."[113] Syrian healthcare providers had always been attuned to the issues of healthcare access without legal status. As chapter 4 details, many Syrian co-nationals either did not have temporary protection IDs, or had IDs registered in different provinces that made them ineligible for care in Istanbul. Moreover, slow processing times on immigration status had left many Syrians seeking out care from their co-national doctors, often from the hybrid humanitarian clinics. This meant that Syrian doctors were at least aware of the challenges that a variety of immigrants faced in the Turkish healthcare terrain. Many faced language barriers and identification issues, just like Syrians. The manager of MediPark gave a similar roundup of beneficiaries. "We get the whole Iraqi community, we get Yemenis, Egyptians, Somalis, we've even been getting tourists recently, because they hear there's a place that has Arabic language care. We get Moroccans, Tunisians, anyone who knows Arabic. Also, you know Zeytinburnu has a lot of Turkic people, they can't access state services, so they come too. They don't know Arabic but they come with translators."[114] Once a primarily linguistic niche, these providers gradually serve a broader immigrant population of varying ethnicities and legal statuses.

[113] Interview with Dr. Bilal, September 6, 2021.
[114] Interview with Dr. Aziz, September 2, 2021.

But, as discussed in the previous chapter, as hybrid humanitarian providers gradually privatized, their humanitarian services also became more ad hoc. Dr. Ahmed's work follows this pattern. He does not take charity patients given that he has a bustling business to run in an ever-weakening economy. He has no problem taking patients who do not have registration, so long as they have some form of identification document, but he does not give care for free. As the humanitarian niche has narrowed, doctors are increasingly making their own judgment calls about whether to treat patients who may not be able to pay. Dr. Jameel, for example, is also pragmatic about the fact that his patients should at least have *some* form of ID. He explains that it is not his idea, but how the Turkish hospital he works at must legally function:

> Dr. Jameel: The system at the hospital refuses to accept patients without ID unfortunately. In the past, yes. We could take that kind of patient at the charity offices…[But now, they] should have some kind of *kimlik*. It can be a passport too, it doesn't have to be a Turkish ID.
>
> NK: So they need some sort of ID.
>
> Dr. Jameel: It's law yeah. We cannot accept unknown people at the hospital…nowadays, I apologize to such people. In the past, I used to accept them. But now I cannot... I cannot...[115]

As Dr. Jameel has attempted to formalize his work, he also recognizes that unregistered patients are left with narrowing options for care. Given the new rules surrounding his work—which remains semi-formal but exists within a formal institutional context—Dr. Jameel must be practical. Unregistered patients must go elsewhere for their service. If they can pay, they likely have a reasonable number of options. If they cannot pay, they must increasingly rely on the good will of individual doctors who will accept a case without payment. The days of charity clinics, as the previous chapter showed, have gradually narrowed. The Migrant Health Centers are one of the last bastions of care where unregistered refugees and migrants may go. But even in the case

[115] Interview with Dr. Jameel, November 26, 2021.

of MHCs, not all accept unregistered individuals. It depends on the local Municipal Health Directorate's policy. But as we know from chapter 4, unregistered individuals often avoid state providers. At MHCs, unregistered individuals are still registered into the system, but they are registered as "stateless". For many refugees, that bureaucratic process could be enough of a deterrent, for fear of making their unregistered status legible to the state. They are left weighing the pros and cons of such a decision—is it worth registering with the state as "stateless" for free primary care services?

Conclusion

The preceding sections have sought to show how, despite being blocked from fully legally incorporating into Turkey's healthcare terrain, Syrian doctors nevertheless find ways to work as health professionals. Many do so either in immigrant-run clinics or in Turkish providers. Some also create their own ventures, gaining primary care equivalency and setting up clinics in their own names. Others also continue to work stints in the privatizing clinics discussed in the previous chapter. One of the main features that unifies these ventures is that they are increasingly serving a more diverse immigrant population within Istanbul. This includes other Arab nationalities, but it *also* includes immigrants who do not share the same language. It is more than an ethnolinguistic niche. It is an immigrant healthcare niche defined by some degree of legal status flexibility and openness to immigrants in a country becoming more anti-immigrant by the day.

The second feature that unifies many—though not all—of these private healthcare providers is that they are becoming more transnational. They are reaching an increasingly globally dispersed but heavily networked population of resettled refugees, their friends, and the broader population of medical tourists who already have their eyes trained on Turkey for low-

cost, high-quality medical care. Accounting for the institutional forces that block Syrian doctors from fully regularizing their work, I describe this simultaneous embedding in local and global networks *cosmopolitan embeddedness.* Cosmopolitan embeddedness as I conceptualize it can be considered the organizational counterpart to claims to social and economic belonging absent legal belonging. Moreover, the Syrian doctors "break out" into the host community economy in a surprising way. Counter to the general expectations of the mixed embeddedness perspective, where immigrant entrepreneurship often emerges and remain in low-skilled markets, Syrian doctors break into a lucrative and expanding high-skilled market (Kloosterman 2010: 30-31).

Until now I have discussed the local immigrant population and the global medical tourist population as distinct scales. Yet it is also the case that the principles of medical tourism are increasingly being applied to immigrants, and often the most vulnerable ones. A field report conducted by a group of social scientists based in Istanbul looked at immigrants' access to healthcare, beyond the Syrian population. As expected, the report found that unregistered immigrants often shy away from approaching state healthcare providers for fear of being detained and deported. Yet it found another prevalent practice. When unregistered immigrants *did* approach state hospitals for care, despite their lack of status, they were often charged for their services using the state's established medical tourism prices for care.

For immigrants lacking status, the "Regulation Concerning International Health Tourism and Tourist Health" is increasingly being used as the default price list for care in state hospitals. Legally, immigrants of any legal status are still supposed to be entitled to free emergency care, free treatment for communicable diseases, and, during Covid-19, free care for the coronavirus. The report found through qualitative interviews that some hospitals were still charging undocumented immigrants for those services, and then reporting those who could not pay to

authorities (Sevinin 2020: 13). Interestingly—and unsurprisingly given the discussions in previous chapters—NGO interviewees in the report point to private clinics run by Syrians as a relatively reliable place to send immigrants lacking status when they find themselves unable to access state care (Ibid.: 25). In Turkey, it seems, medical tourism and immigrant healthcare are increasingly converging, both in Syrian-run health clinics and in state providers.

The story I tell throughout this chapter, and the dissertation more broadly, should not be interpreted crudely as yet another example of the all-encompassing march of neoliberalism run amok. As this march continues, the argument might go, public healthcare is gutted and public goods are increasingly privatized, and immigrant healthcare is no exception to the rule. One should not jump too quickly to this conclusion. For one, it bears repeating that Syrians under temporary protection *do* have free access to state healthcare. Turkey's healthcare system has expanded care to both citizens and immigrants in the past fifteen years by universalizing care and providing generous rights to healthcare for registered refugees. The story is not so simple. There has, as scholars Volkan Yılmaz and Tuba Ağartan remind us throughout their scholarship, also been an increasing trend in privatization of healthcare services, with an increasing number of Turkish citizens opting for private care and superior services, when they can afford it. These two processes of universalization and marketization have coexisted (Agartan 2012; Yilmaz 2013, 2017, 2021).

It is also important to recognize—without necessarily endorsing—the fact that the private sector has essentially absorbed the humanitarian functions of immigrant healthcare that were once the purview of the hybrid humanitarian clinics in the early days of humanitarianism. The Migrant Health Centers have also played a role. But as primary care providers, that role has been functionally small. A recent paper on migrants' access to healthcare underscores the centrality of

the private sector to immigrant healthcare in Turkey. In its abstract, it matter-of-factly states that, "the existence of many private healthcare institutions offering various services to patients with different incomes and operating in informal ways has improved accessibility, availability, affordability, and accommodation and thus affects the fit [of immigrants with providers] positively" (Genç and Elitsoy 2023: 1). The paper goes on to discuss how immigrants with a variety of legal statuses and income levels continually choose private care, and often care that is informally rendered, despite the associated costs.

To read this as either an indictment or endorsement of "neoliberalizing" welfare systems would be to miss the point. Agnostic of what is *good* or *bad* in this complex situation, what I am more interested in is *how* the host country's institutional environment structures immigrant service provision and access. And, just as importantly, I am interested in how immigrant activities interact with existing providers to further shape the healthcare terrain over time. What we see here is that, as humanitarianism loses its luster, healthcare providers that once served the vulnerable refugee population must find other ways to continue working. Drawing on opportunities in the field they had not been oriented toward in the early days of humanitarianism, these entrepreneurs renegotiate their work as socially and economically essential providers in Turkey's healthcare terrain at both local and global registers.

Chapter 8: Conclusion

As wars break out, or political instability produces dire humanitarian circumstances, large numbers of people will attempt to flee. When refugees decide to cross borders, they are confronted with the nationally specific rules that will govern their lives on the other side. If crossing borders illegally, a forced migrant may seek out a host state that grants asylum. With asylum begins a more permanent pathway to residency. They may also remain undocumented, with no legal status setting them apart, bureaucratically, from the so-called economic undocumented migrant who has not fled violence. They may settle in a refugee camp, where humanitarian organizations purvey basic services. Individuals may either hope to return home, to resettle as refugees in a third country, or eventually head into an urban center, if they can leave the camp. Like the asylee, the resettled refugee will be placed on a pathway to permanent residency in the host state.

Yet there are also many cases in which temporariness and uncertainty reign for longer periods of time. For example, if a prospective asylee is *not* granted asylum, they may nevertheless be granted an ambiguously temporary reprieve from deportation if their home country remains unstable. They remain in the country of failed asylum in a state of legal in-betweenness (Lori 2017: 761). Refugees who stay in refugee camps also remain in increasingly protracted but institutionally temporary situations. Or, as we have observed in the last few years, temporary protection statuses—previously a relatively fringe legal status—have become increasingly common. These statuses are generous in both the quantity of statuses conferred to groups fleeing humanitarian crises, and the quality of rights bundled in the status. Syrians in Turkey, Colombians in Venezuela, Ukrainians in the European Union, and Afghans in Iran have all recently been granted these humanitarian statuses. Often, those who hold a temporary legal

status in these countries coexist with refugees from the same country of origin whose statuses are irregular, as well as those who have managed to attain more permanent residency statuses. Among co-nationals, this leads to a complex spectrum of lives lived somewhere between inclusion and exclusion in the host policy. Holding temporary status, we know from canonical sociological research, produces "liminal legality" for status-holders. This research captures the temporal uncertainties of statuses that may be renewed—or not. The cadences of status renewal, and looming lapses into illegality, are the focus of this important body of work.

This dissertation has sought to build on this sociological research in migration studies by scaling up the analysis of refugee reception to the level of the organization. This scalar move is analytically important because it redirects attention from status-holders to status regimes. That is, how do temporary migration policies shape the collection of state institutions and—in their relief—nonstate organizations, with which individuals interface? By focusing on healthcare organizations run *by* refugees *for* refugees, the dissertation gains analytical leverage on a variety of key questions in migration studies. How refugees navigate healthcare services in a host state is the most obvious, but others include questions pertaining to refugee-run organizations, high-skilled refugee employment, and refugee entrepreneurship. As such, the dissertation explores not just how policy affects refugees, but also how refugees mobilize, organize, and co-constitute the institutional terrain in which they access services. At this point, no sociologist would be surprised by the trite proclamation that refugees are not merely victims, but in fact have agency in shaping the places in which they settle. My hope is that the dissertation is able to trace concrete pathways through which refugees become active architects of and key fixtures in the host community organizational social fabric, even as their long-term inclusion in the polity as a national group remains an open question.

The Broad Takeaway

The main argument advanced by the dissertation encompasses the arc of the five empirical chapters. That is, when national policies are ambivalent about integrating forced migrants, they organize by drawing on local and transnational networks for legitimacy and resources. Moreover, as entrepreneurs and organizations cope with increasingly long periods of "liminal legality", humanitarian refugee policy that once buttressed their work transforms from benefit to burden. They refocus their efforts on garnering resources and legitimacy through social and economic rather than political means as they embed into the host community organizational landscape.

Early on, an immigrant organization's ability to appeal to the host state's geopolitical interests is critical for its survival. In this empirical case, the organizations that align with Turkey's (geo)politically empowered religious humanitarian networks are better able to weather the unpredictable regulatory context in which they emerged than other organizations. The fact that clinics are operating illegally, without appropriate registrations, is destabilizing but does not spell closure. That they are serving local refugees in need, while supporting Syrian opposition efforts across the border, are both of central importance. Domestic rules and regulations are secondary.

Humanitarianism loses salience over time as an organizing principle of refugee governance. Acute needs are more effectively met by state services, and most refugees increasingly gain their bearings in the host community. The humanitarian niche narrows. At this juncture, if immigrant organizations intend to keep operating, they must find alternatives to humanitarianism as a legitimizing principle. Over time, immigrant service providers reorient their work both discursively and institutionally. Discrediting the temporary humanitarian policy that once buttressed their informal work, forced migrants reorganize their work around social and

economic imperatives. They situate themselves as critical actors in both local and transnational economic activity that contributes to the host state economy. Again, domestic rules and regulations are secondary. Instead, organizations embed in increasingly multicultural networks of local immigrants and international tourists.

Ultimately, both Syrian-run health clinics and Syrian doctors working in Istanbul are able to partially incorporate into the healthcare terrain, insofar as they are able to establish steady work relative to more precarious forms of informality they inhabited earlier on. Yet this process never fully penetrates the domestic state strictures that govern the activities they participate in, despite efforts to conform to host community rules. This is due to the residues of temporary policy that placed organizations and individuals on trajectories of informal work that are difficult, if not impossible, to regularize. Entrepreneurs and organizations nevertheless institutionalize as they move from humanitarian embeddedness to an increasingly cosmopolitan embeddedness. Below is a figure that summarizes the overarching argument of organizational survival.

Table 8.1: Process of Organizational Survival in a Narrowing Humanitarian Niche

	Humanitarian Embeddedness	**Cosmopolitan Embeddedness**
LOCAL	Urgent demand for services among local refugee population	Routinized demand for services among local (immigrant) population
NATIONAL	semi-formal/informal operations temporarily tolerated by state	Organizational formalization conforming to minimum satisfactory rules
INTER-NATIONAL	(geo)politically advantageous work that aligns with host country political objectives	Expansion into transnational market, social and economic benefit to host country
	Narrowing of the humanitarian niche ---------->	

Beyond the Healthcare Context

What, then, can this particular case tell us about immigrant organizations more broadly? We need not leave Istanbul to consider how this framework might tell us something about immigrant

organizations beyond the realm of healthcare. Take Syrian-run schools in Turkey. From 2011 to 2016, a wide array of schools, called Temporary Education Centers, were established for Syrian students. Some of these were schools created by Syrian refugees and received temporary permissions from the Ministry of Education to function in Turkey, as families contemplated whether they would stay in Turkey longer or return swiftly to Syria. In fact, as mentioned before, the Khayr Clinic was originally the Khayr Arabic School. Khayr was a large Syrian educational organization established by Syrian educators that used the Syrian curriculum. It was one of many schools operating as hybrid humanitarian school throughout Istanbul until 2016. These schools were, in large part, registered as charities and operated under the purview of humanitarian organizations. In 2016, however, the Ministry of Education came out with a strictly enforced rule that all Syrian schools should shut down, and Syrian students enrolled in Turkish schools. This transition was a massive bureaucratic and logistical undertaking, but it was one the Turkish state invested in carefully, with the aim of eliminating all TECs by 2020 (Karaagac, Bilecen, and Veenstra 2022).

Education is, of course, substantively different from healthcare when it comes to refugee incorporation. Healthcare is primarily a service rendered without particular nationalist or ideological underpinnings (though by no means devoid of these forces, particularly in maternal care as it brushes up against pro- or anti-natalist nationalist agendas). Education, on the other hand, is fundamental to language acquisition as well as both overt and covert ideological and national indoctrination through daily rituals and course curricula. For this reason, Turkey's unabashedly nationalist educational institutions were swifter and more thorough in their dispersal of Arabic-language schools and more concerted in their effort to get Syrian kids into Turkish

schools. Immigrant healthcare organizations, particularly as guardians of community public health more broadly, are more of a benefit than a potential threat to the native populace.

But the elimination of Syrian-run schools, as we know from the example of the Khayr organization, is also not a complete story. Eventually, some of these organizations resurfaced as private Arabic language schools. No longer using Syrian curricula, these schools use different Arab country curricula and cater to a student body beyond just Syrians—they count many Arab nationalities among their student bodies. No longer humanitarian organizations, these schools are now registered private schools. Some have Ministry of Education certification, though Khayr shows us that even as schools formalized they did so through shades of formality—for a while, Khayr's new school was *not* fully certified and was operating semi-legally. Khayr does not have Turkish students. It caters to an increasingly middle class, multinational student body while at times openly defying some basic state education strictures, including the ban against gender segregation in elementary school. With the process of formalization, the organization has re-embedded in a more cosmopolitan idiom, much like the healthcare organizations examined in this dissertation.

Beyond the Turkish Context

This dissertation has sought to show how temporary or ambivalent refugee reception contexts shape immigrant organizations' emergence and institutionalization. Yet it is also cognizant of the fact that individual countries enact temporary policy in distinct ways. In Turkey, for example, Syrian doctors were given no legal professional pathway to work until the SIHHAT Project was established in 2016 and gradually implemented through 2020. The equivalency route also only became available in 2018. Given that Syrians started arriving in Turkey in 2011, this left ample time for informal healthcare practices to emerge and become routinized. This cadence is

markedly different from the experience of Ukrainian doctors in Poland, for example. Poland hosts 1.5 million Ukrainians registered under temporary protection, and among them are a large number of health professionals. Poland offers temporary medical licenses to health professionals hailing from abroad. It has also passed legislation that expedites the recognition of Ukrainian citizens' medical licenses so that they can practice in Poland for 25 months.[116] Moreover, many Ukrainians still choose to travel back to Ukraine for their medical care, despite possible risks (Méheut 2023). Ukrainian-run healthcare organizations have not been a topic of discussion, given swift state-level policy interventions.

Yet if we move away from healthcare and retrain our attention on schools once more, familiar trends start to emerge. Given that temporary protection starts out exactly as what it says it is—a temporary status, with hopes of a swift return home for refugees under protection—the initial organizations refugees establish in the host community are designed with a temporary humanitarian purpose. Like the Syrian-run schools in Turkey, some Ukrainians in Poland established their own schools (Tomkiw and Johnson 2022). A leading example of these schools is Unbreakable Ukraine—a Ukraine-accredited school that began with campuses in Warsaw, Krakow, and Wroclaw and has expanded in 2023 to 12 cities (Unbreakable Ukraine). Unbreakable Ukraine is registered as a nonprofit rather than as a school in Poland. The project receives support from Save the Children, Care International, and UNICEF.

Yet, according to the organization's posts on Facebook, it has faced challenges with legal registrations. In one organizational press release, the president of the charity is quoted as follows: "The Minister of Education said that there can be no other education system in Poland other than

[116] See details of the policy published at the Legal Portal for People Fleeing Ukraine post, titled "How can a Ukrainian doctor start working in Poland (as a doctor)?" August 24, 2023. Retrieved at https://ukraina.interwencjaprawna.pl/how-can-a-ukrainian-doctor-start-working-in-poland-as-a-doctor/#:~:text=Citizens%20of%20Ukraine%20who%20have,practice%20a%20profession%20in%20Poland.

the Polish one, and all children under the age of 18 are subject to compulsory education…But there are not enough places in Polish schools, and we are filling this gap, so the ministry closes its eyes and everyone pretends there is no problem. Ukrainian and Polish ministries ignore each other."[117] They lack the requisite charity funds to maintain its operations, so they have started collecting "parental contributions" for their children's attendance. In September 2023, they began collecting tuition, but maintained discounts for vulnerable students, including orphans, children of injured soldiers, disabled students, and children with two or more siblings. While they continue to expand, they do so as what we might also call hybrid humanitarian organizations, as initial humanitarian support has dried up.

What happens to this school, or others like it, in the coming years is an open question. It may close, if funding coffers dry up, and the Polish Ministry of Education decides to phase it out. If I were to venture a cautious guess from the findings of my dissertation, it is very possible that schools like this might register as private schools in Poland, and may even adopt the relevant international school standards, as they fill a niche in the Polish educational landscape. There was already a small niche of Ukrainian schools in Poland before the war in Ukraine broke out, and these have similarly functioned as semi-legal hybrid charity schools throughout the conflict, collecting monthly fees from students. Given Ukrainians pride in the Ukrainian school system—many proclaim its superiority relative to the Polish system—the humanitarian niche may give way to new forms of organizing absent humanitarian motivations (Maza 2023). It is possible, for example, that these schools would open up to other immigrants, like Belarusians, whose language is closer to Ukrainian than Polish. Or, like the segmenting hybrids, they might pivot

[117] See post, translated from Polish and published at Unbreakable Ukraine's website, here: https://nezlamna.org/organization/ukrainian-schools-in-poland-or-orphans-of-education-ministries-in-poland-and-ukraine-are-washing-their-hands/.

towards more specific niches that remain, like supplemental Ukrainian language classes for families that want their children to maintain home language facility even as they study in Polish schools.

What the dissertation suggests is that the emerging humanitarian hybrid form, and the resources garnered in these early stages of the humanitarian niche, provide organizations that can make a (geo)politically advantageous case a means to survive initial uncertainty. This buys organizations time and resources to transform into new niches down the line, if they so choose. These organizations become enmeshed in the organizational fabric of the communities in which they are located, even as they contend with the regulatory burdens of formalizing their work. While we cannot know what will happen with Ukrainian schools in Poland, it is safe to surmise that their organizational trajectories will be renegotiated as humanitarian, economic, and regulatory forces bear on their day-to-day functions. This detour to Poland is just one context in which insights from this dissertation might inform our understanding of immigrant organizations in temporary protection contexts. Organizations that that provide humanitarian services in the short-term but intend to function in the long-term may follow similar paths.

Beyond the Temporary Protection Context

The previous section has ventured into an empirical case of immigrant organizational emergence in a context of temporary protection outside of Turkey. Moving beyond temporary protection policies proper, this section considers other refugee or immigrant reception arrangements that are meant to be temporary but nevertheless become long-term. While this phenomenon may be a feature of temporary protection policy in particular, it is also a major fact of life in other "temporary" contexts. Indeed, the notion of permanent temporariness is oft-invoked in relation to refugee experiences in the global South. It is also used in reference to immigrants' experiences in

countries with strict citizenship rules, as in the Gulf states. In the latter cases, states circumscribe citizenship for the few "natives" while leaving the rest of the majority immigrant population, as well as undocumented local populations, outside of full, stable citizenship.

I contend that insights from this dissertation can also help us think about immigrant organizing in these protracted yet nominally temporary contexts. I turn away from education and healthcare now to another type of temporary organization that can become permanent: the refugee camp. Refugee camps as institutions are meant to be temporary. They often start as tent camps, and are intended to protect displaced persons until they can return to their homes. Yet as displacement becomes protracted, these refugee camps may ossify—literally—as more durable buildings replace canvas tents.

For Palestinians whose lives have been shaped by the United Nations Relief and Works Agency (UNRWA), temporary policy has stretched not just years, but generations. This protracted "humanitarian situation" shapes the types of services and rights individuals have access to within a humanitarian apparatus never meant to institutionalize. UNRWA's policies also shape the ways that Palestinians organize and advocate for rights and services within camp contexts (Feldman 2018). Even the peculiar physical spaces of Palestinian refugee camps--"camps" that are not tents but rather tightly packed labyrinths of concrete apartments--are a product of temporary policy's long-term effects. The ways that these camps institutionalize are loosely reflective of some of the forces discussed in the dissertation.

Initially, refugee camps begin as shelters made of temporary equipment. Following Israel's expulsion of Palestinians from their lands into neighboring countries in 1949, Palestinians took temporary shelter in camps comprised of the ephemeral canvas tent. This temporariness lent credence to the fact that Palestinians could eventually return to their lands,

and that Lebanon could therefore keep the integration of these refugees at bay. Yet the following years and decades disproved this basic notion. Tents were replaced with buildings, even as Lebanon tried to forestall the physical ossification of these spaces by intentionally preventing the flow of cement and other building materials into the camps. The physical construction of cement camps spelled a form of permanence that Lebanon was not interested in.

Yet even as these camps became more permanent physical fixtures, they remained outside of direct governance structures. In Lebanon, the governance of some of the camps transferred from the International Committee of the Red Cross and then shortly thereafter UNRWA to Palestinian Authority affiliates. They were not under the control of the Lebanese. These spaces slowly became more than just Palestinian refugee camps. Labor migrants as well as other refugee groups began to settle alongside the Palestinian refugees in what became intensely globalized urban shantytowns. These spaces filled with Bangledeshi, Ethiopian, Eritrean, and Egyptian labor migrants, Doms (an originally nomadic ethnic group in the region), Iraqi refugees, and then after 2011, Syrian refugees fleeing the war (Abdul-Ahad 2024; Zaki n.d.). Even as these camps have becoming firmly embedded in Lebanon's urban fabric, they remain spaces marked by exclusion and informality. Stateless refugees are blocked from the majority of jobs in the Lebanese labor market, leaving them working primarily in highly exploitable labor arrangements or in camp businesses.

Despite their exclusion from national governance, these camps become increasingly embedded in global economic exchange. For one, the vast majority of Palestinians living in Lebanese refugee camps depend on remittances from family abroad (Kortam 2010) and actively work to build ties with the Palestinian diaspora abroad for supplementary aid and support (Hajj

2021).[118] Transnational economic networks are the lifeblood of Palestinian survival in a Lebanon that does not facilitate Palestinian access to dignified work. These connections are also, in one way, an insidious force, as certain goods like drugs make it in to the camps relatively easily in spaces otherwise intentionally cut off from market exchange with its surroundings. Drugs often come from neighboring countries like Syria and cast a social pall on already difficult urban spaces (Abdul-Ahad 2024; Nashed 2014). Administratively excluded from the state in which they reside, refugee camps' residents nevertheless engage in densely networked local and global modes of exchange. The camp becomes embedded in the social fabric of Lebanon through the multitudes of immigrant and refugee denizens who engage in informal work and exchange while remaining legally outside of it.

I present this extended example of the permanently temporary refugee camps in Lebanon to think through applications of the dissertation's overarching insights. Often, organizations that are established under a rubric of temporariness end up perpetuating themselves long-term. Institutional survival (and therefore, in the case of camps, individuals' survival) depends on resources that are both provided and foreclosed by host communities. This leads to institutional dynamism at both the hyperlocal and transnational levels, bypassing an unsupportive host state. Camps become hubs of urban poor populations, including a wide array of immigrants. They also become hubs of cross-border economic exchange, for better or for worse.

Long-term Implications

[118] It should also be noted that most Lebanese also depend on remittances from abroad, especially in recent years in the wake of severe economic crisis. See this UNDP report entitled "The Increasing Role and Importance of Remittances in Lebanon": https://www.undp.org/lebanon/publications/increasing-role-and-importance-remittances-lebanon.

One question that may linger in the reader's mind, crassly put, is: who cares? Why does it matter how these temporary service providing institutions may or may not survive in the longer-term? In order to address these questions, I venture back to the dissertation's case of Syrian-run health clinics in Turkey. Theoretically, one question looms large: won't the second generation just integrate into Turkey's existing healthcare institutions, and render questions of this dissertation irrelevant? The answer is, as it often is, yes and—more emphatically—no. In some ways, the processes I examine throughout the dissertation are indeed very specific to the time of research: I did many of my interviews with Syrian doctors who will likely not ever gain their full Turkish equivalencies, whether because they attempted and could not advance, or because they chose not to bother. The next generation of prospective Syrian medical students in Turkey—the ones in school now—will have Turkish medical degrees. Professionally, they will be integrated. And they will almost certainly have Turkish citizenship, given the state's propensity to grant citizenship to the Syrian high-skilled professional class.[119]

Yet I argue that the pathways etched by the organizations that emerged in the critical ten years following Syrians arrival in Turkey will continue to reverberate in the healthcare field. These organizational forms will remain as residues of temporary protection. While "path dependency" may be too strong a description of the probable trajectories of Syrian doctors, certain professional pathways are now well-trod for them in Turkey, and professional networks are dense. It is likely that many Syrian doctors will follow their predecessors' tracks into private practices with an eye toward medical tourism markets. This is, for the record, also what many newly minted Turkish doctors are pursuing, leaving important specialties like general surgery

[119] This is, of course, not at all assured. Given that Turkey has become increasingly anti-refugee, it is also wholly possible that the state could stop granting those with temporary protection status citizenship, regardless of their education levels or prospective contributions to the Turkish economy. Syrian refugees' integration as citizens remains and open and politically contested questions, no matter their social class.

unmanned while fields like plastic surgery and dermatology soar in popularity (Karakas 2022). But given the niche carved by their predecessors, Syrian doctors have a ready-made opportunity for practice occupied by less competition than their Turkish counterparts.

An additional theoretical question lingers: is this not, then, just a protracted story of immigrant entrepreneurs exploiting an ethnic niche? The protracted period of uncertainty wrought by temporary policy could be interpreted as just a bureaucratic delay of the inevitable. One could argue that Syrian doctors, after all, eventually entered the market for Arabic language care that they would have come around to earlier, had they had access to the healthcare labor market. While this is, to a degree, likely true, I contend that the initial forms of refugee organizing critically shaped the opportunity structures that emerged for Syrian doctors from the bottom-up. First, the clustering of Syrian healthcare workers in hybrid humanitarian organizations concentrated doctors in a relatively small number of large clinics. (As the third chapter notes, many doctors *did* try to create their own small private practices, but these either were shut down or could not survive financially). This consolidation of providers had important effects on subsequent healthcare providers.

First, these clinics gradually became hubs for all stripes of immigrants in Turkey who either could not access state healthcare due to their legal status or did not want to deal with the bureaucratic processes entailed. While the clinics catered to a largely Arab ethnic market, they also became well-known access points for immigrants from Central Asia and from non-Arabic speaking African countries. These densely networked doctors were able to bring in a range of specialists to a relatively small number of clinics in Istanbul. They were able to accrue resources and buy expensive equipment to support their expanding services. This concentration of resources and, as a result, name recognition likely facilitated their expanded client base. The

specific pathways of survival therefore created particular configurations of providers that attracted broad immigrant and tourist patient bases.

It is possible to imagine how the "ethnic niche" of Arabic-language healthcare might have been filled in a different institutional setting, where logics of temporariness did not foreclose Syrian doctors' integration into the labor market. Take the example of Ukrainian doctors in Poland, mentioned before. By integrating them swiftly into Polish providers, Ukrainian-language care has become concentrated primarily in the state providers refugees have legal access to in the country. Moreover, the Syrian doctors themselves told me what work would have look like for them—they continually pointed to the German model, similar to that in Poland, where Syrian doctors were put on a track of expedited equivalency and integration into German healthcare providers. The Arabic-language healthcare niche, there too, was largely contained within formal structures and in state providers. We can also imagine an alternative where doctors went out on their own and successfully established their own private practices, with little state oversight. This would have likely led to a more fragmented terrain of Arabic-language private care, rather than creating select large clinics with comprehensive secondary care services. While we see this to some extent, many of the doctors who are able to branch off and create their own clinics nevertheless depended on the larger clinics for income during the period of hybrid humanitarianism. This stream of income likely facilitated their ability to open their own clinics later on.

This is all to say that, indeed, this is a story of ethnic entrepreneurship. Newly arrived refugees introduce demand for a specific linguistically-appropriate and bureaucratically accessible service. Entrepreneurial refugees organize to meet this demand by drawing on available resources and networks. What the dissertation adds to this discussion is how the legal

institutional environment structures particular types of organizations over time, both by hardening early patterns of work—such as entrenching informality—while also transforming what is considered legitimate within a diminishing humanitarian niche. I further argue that these outcomes matter for the types of services that become available in the Arabic language in the private market. The outcomes also matter for what remains out of reach for vulnerable refugees who lack the means to pay for fee-for-service secondary care.

Policy Implications

While this dissertation is not meant to be read as a policy report, it nevertheless exposes some of the problems that may emerge in contexts of long-term temporary reception of forced migrants. It is worth venturing into some of the possible policy solutions for these problems. Indeed, some of the most concrete policy recommendations came directly from my interlocutors, whose lives have been shaped by the temporary policy context. The most central and general policy recommendation is one that other countries like Poland figured out swiftly: countries should expedite the integration of highly skilled migrants into formal work in areas of need like healthcare. Ukrainian doctors who attain the temporary medical license can work alongside their Polish counterparts (World Health Organization 2023). As of February 2024, almost 4000 Ukrainian doctors had been granted permission to work in Poland (TVP World 2024). More specifically, when countries receive a large number of refugee doctors coming from a country still mired in violence, the Ministry of Health should devise a program whereby their certifications can be checked without home country validation. These doctors should then be placed into internship or practicum positions as soon as administratively possible. Language courses should be coupled with this program, so doctors can both practice and gain facility with the local language.

This is the demand that most Syrian doctors I spoke with had, and they pointed to Germany as an example of what could have been done. It is particularly disappointing that no such program was undertaken in Turkey given the sustained and growing shortages of specialists in Turkey's healthcare system. Moreover, there was a clear language barrier between refugee patients and Turkish doctors that Syrian doctors could have helped alleviate more swiftly. Instead, Turkey bided its time with the integration of Syrian doctors. And when they did establish a system to employ Syrian doctors in state facilities, they established separate primary care Migrant Health Centers but did not create any pathway for secondary care provision in the Arabic language.

From my conversations with Syrian patients and doctors, as well as officials overseeing the project, I contend that the Migrant Health Centers were, on balance, a beneficial addition to the healthcare landscape. The SIHHAT Project's effort to place translators in state hospitals was similarly beneficial. Yet, as I heard time and again from my interlocutors, the Migrant Health Centers were not enough. For refugee patients more used to accessing secondary care directly, primary care centers felt peripheral, or, as many interviewees noted, were best for small issues. I am agnostic about whether it is good or bad to provide separate clinics for immigrants and citizens, given the very real complications of a language barrier. I can imagine an intervention in which some of the existing Family Health Centers were assigned one Arabic-speaking doctor, rather than creating separate Migrant Health Centers from scratch. But this intervention would also complicate existing employment arrangements of Turkish doctors in a way that separate Migrant Health Centers do not.

The broader policy implication of this work, however, goes beyond healthcare. If countries are going to accept large numbers of forced migrants under temporary protection, they

should make institutional adjustments to integrate refugee professionals into service provider configurations. This means that doctors should have expedited pathways to practicing alongside host country doctors, and teachers should be incorporated into after school programs or language programs or other public school adjacent services. Even if salaries are paid by NGOs, INGOs, donations, or other funding agencies rather than state coffers, such services will not only lead to more stable employment for professionals, but also more expedited and comprehensive access to services for refugees. This is not a blanket policy plea to eliminate informal employment, which no scholar or practitioner could make in good faith given the impracticability of such a sweeping aim. Indeed, Turkey's ability to take in over 3.6 million refugees and offer protection rests squarely on its ability to absorb informal labor into its economy. But etching pathways to formalization early can help eliminate the proliferation of unregulated services.

Many of the doctors themselves complained about how they ended up in legally unprotected work. As some doctors I spoke with confided frankly, healthcare is a risky business. Sometimes doctors make mistakes. Sometimes patients emerge worse off after medical care. Sometimes doctors do not make mistakes, but are blamed nonetheless when a patient's health takes a negative turn after treatment. When doctors are working in informal settings, they have no legal protection if something goes wrong. While I was in Turkey in 2021, two informal clinics were shut down by the authorities after they were reported for medical care gone wrong. One was closed due to a patient's complication with anesthesia during a dental procedure, and the other was closed because a gynecologist was reported for what seemed to be a patient-doctor miscommunication. Neither case was investigated. The clinics were promptly closed. In many cases, doctors *also* want rules and regulations that protect their work—when they are pushed into the shadows, both doctors and patients suffer.

Finally, we must grapple with the increasing prevalence of temporary protection regimes. These are unprecedentedly generous policy arrangements in refugee reception. Rather than confining refugees to camps, or only resettling a miniscule fraction of individuals in a safe third country, temporary protection regimes are facilitating swift protection for large numbers of forced migrants. But, as this dissertation has shown, temporariness, and the institutional architecture that maintains individuals suspended between inclusion and exclusion, can produce challenges for refugees. The uncertainty of possible status cessation and deportation back to a still unstable home country looms in the Turkish case. Yet on balance, I am a firm proponent of temporary protection arrangements that provide large numbers of refugees generous social rights in a host polity. The main challenge for these arrangements is that host countries take on an overwhelming financial burden. Policy should focus on facilitating significant and sustained funds to the countries that host these refugees, and more countries should open their borders with temporary protection arrangements to help share the burden. Then, countries can establish viable pathways to permanent residency for these populations.

Despite warranted criticism of Turkey's temporary protection regime, it still stands as a leading example of refugee protection. The goal of this dissertation is not to criticize Turkey's temporary protection regime, but to highlight the ways in which its institutional makeup structures service provision for refugees. It also allows us to think critically about policy adaptations that could improve this globally ascendant legal apparatus. Imagining ways that temporary protection regimes can further facilitate refugee well-being is critical to the project of refugee protection globally. To be sure, each country faces its own political and social particularities. Colombians and Venezuelans, for example, speak the same language, as do some (though not all) Afghans and Iranians. Moreover, immigration politics play differently in these

countries. Turks—never particularly inclined toward multiculturalism--are becoming increasingly anti-immigrant with the extended stay of Syrians and arrival of Afghans. In Poland, the politics of Ukrainian reception are reasonably copacetic. Nevertheless, the broader institutional reality of extended temporariness is something that all of these host countries must contend with: how will they provide services, how will they contend with informality, and how will they find "durable solutions" to protracted refugee crises, whether through eventual integration, or otherwise.

Appendix A – Patient Interview Lists

Interviews 2020-2021

Pseudonym Age, Gender	**From**	**Living in**	**Relevant Legal Status***
Alaa 65, F	Latakia	Fatih	TP, Istanbul
Rima 25, F	Latakia	Fatih	TP, Istanbul
Hana 30, F	Damascus	Beylikdüzü	Turkish Citizen
Hiba 58, F	Latakia	Beylikdüzü	TP, Istanbul
Farha 43, F	Daraa	Fatih	TP, Istanbul
Lila 28, F	Latakia	Fatih	TP, Istanbul
Rabia 50, F	Aleppo	Fatih	TP, Gaziantep
Jiyan 35, F	Qamishli	Fatih	TP, Istanbul
Maisam 20, F	Latakia	Fatih	TP, Antakya
Nisa 26, F	Aleppo	Fatih	TP, Istanbul
Fatima 42, F	Damascus	Esenyurt	TP, Istanbul
Zubaida 38,F	Damascus	Fatih	TP, Istanbul
Sahar 48, F	Damascus	Fatih	TP, Istanbul
Hala 32, F	Damascus	Fatih	TP, Istanbul
Yara 24, F	Homs	Fatih	TP, Istanbul
Salma 31, F	Latakia	Fatih	Residence Permit
Majed 34, M	Damascus	Beylikdüzü	Turkish Citizen
Janah 23, F	Idlib	Fatih	TP, Istanbul
Lina 31, F	Damascus	Fatih	TP, Bursa
Farid 30, M	Damascus	Fatih	Residence Permit

Aya 50, F	Idlib	Güngören	TP, Kayseri
Omar 29, M	Deir Ezzor	Sultangazi	TP, Siirt
Mohamed 35, M	Aleppo	Arnavutköy	TP, Istanbul
Sana 30, F	Aleppo	Sultanbeyli	TP, Istanbul
Reem 24, F	Aleppo	Sultanbeyli	TP, Istanbul
Maryam 30, F	Aleppo	Bahçelievler	TP, Istanbul
Khaled 30, M	Aleppo	Bağcılar	TP, Istanbul
Fadi 39, M	Afrin	Güngören	TP, Istanbul
Maher 22, M	Aleppo	Bağcılar	TP, Istanbul
Firas 23, M	Damascus	Fatih	TP, Istanbul
Nadia 22, F	Aleppo	Küçükçekmece	TP, Istanbul
Dina 43, F	Aleppo	Sultangazi	TP, Istanbul
Rayyan 18, F	Aleppo	Zeytinburnu	TP, Istanbul
Basma 20, F	Daraa	Esenyurt	TP, Istanbul
Sara 39, F	Aleppo	Bağcılar	TP, Istanbul
Dana 19, F	Damascus	Esenyurt	TP, Istanbul
Amir 24, M	Damascus	Bahçelievler	Residence Permit
Amal 60, F	Idlib	Bağcılar	Residence Permit
Hind 44, F	Damascus	Esenyurt	TP, Istanbul
Shirine 40, F	Damascus	Bayrampasa	TP, Kayseri
Rania 50, F	Damascus	Fatih	TP, Istanbul
Yasmin 44, F	Damascus	Güngören	TP, Istanbul
Mira 29, F	Deir Ezzor	Fatih	TP, Istanbul

Nasir 27, M	Homs	Bağcılar	Residence Permit

*In one case the person had since successfully changed their status to Istanbul, but the interview was largely about their healthcare experiences with non-Istanbul registration in the city

Appendix B – Syrian Healthcare Professional Interview Lists

2021-2022 – Health Professional Interviews (including clinic administrators and healthcare workers)

Gender	Pseudonym	Specialty	Type of Work	Legal Status
M	Dr. Wissam	Pediatrician	MHC, private	Turkish Citizen
M	Dr. Ramy	Internist	MHC	Turkish Citizen
M	Dr. Aziz	Pediatrician*	Manager, Shifa Clinic	Turkish Citizen
M	Dr. Bilal	Hematologist*	Manager, Rafah Clinic	Turkish Citizen
M	Dr. Mahmoud	ophthalmologist	Hybrid Clinic	Residence Permit
M	Dr. Asad	Internist	Hybrid Clinic	Tourist visa
F	Dr. Asma	Dentist	Hybrid Clinic	Residence Permit
M	Dr. Adnan	Generalist	Hybrid Clinic	Residence Permit
F	Dr. Lama	Technician	Hybrid Clinic	Residence Permit
M	Dr. Abdullah	Surgeon	Private Clinic	Turkish Citizen
M	Dr. Amir	N/A	Manager, Bilad Clinic	Turkish Citizen
M	Dr. Rashid	N/A	Admin, Khayr Clinic	Turkish Citizen
M	Dr. Abdel	Pharmacologist	Hybrid Clinic (retired)	Turkish Citizen
M	Dr. Ali	Hematologist	Hybrid Clinic (formerly)	Turkish Citizen
M	Dr. Hassan	General surgeon	Hybrid Clinic	Turkish Citizen
M	Dr. Hamid	Generalist	MHC	Turkish Citizen
M	Dr. Ibrahim	Dentist	Private Clinic	Residence Permit
M	Dr. Omar	Orthopedic surgeon	Private Clinics	Turkish Citizen
M	Dr. Jameel	Orthopedic surgeon	Private Turkish Hospital	Turkish Citizen
M	Dr. Kamel	Cardiologist	Hybrid Clinics	Residence Permit

M	Dr. Daoud	Gastroenterologist	Private Turkish Hospital	Turkish Citizen
M	Dr. Hikmet	Orthodontist	Private Clinics	Turkish Citizen
M	Dr. Khalil	Dentist	Hybrid Clinics	Turkish Citizen
M	Dr. Hisham	Dentist	Private Clinic	Residence Permit
F	Dr. Ghada	Physical therapist	House visits	Turkish Citizen
M	Dr. Hamza	Internist	MHC	Turkish Citizen
M	Dr. Farid	Dentist	Private Clinics	Turkish Citizen
M	Dr. Mohsin	Dental surgeon	Private Clinic	Turkish Citizen
M	Dr. Ahmed	Pediatrician	Private Clinic	Turkish Citizen
M	Dr. Mousa	Ophthalmologist	Hybrid Clinic	Turkish Citizen
M	Dr. Louay	Dentist	Private Clinics	Residence Permit
M	Dr. Waleed	Rheumatologist	Private Clinic	Turkish Citizen
M	Dr. Ziad	Endocrinologist*	Private Clinic	Turkish Citizen
M	Dr. Sharif	N/A	Admin at Rafah Clinic	Turkish Citizen
M	Dr. Ghassan	Dentist	Private Clinic	Turkish Citizen
M	Dr. Ramzy	Dentist	Private Clinic	Residence Permit
M	Dr. Samer	Dentist	Private Clinic	Temporary Protection
M	Dr. Bassel	Dentist	Private Clinic	Turkish Citizen
F	Dr. Maysa	Dentist	Studying	Turkish Citizen
M	Dr. Mansur	Dermatologist	Hybrid Clinic	Turkish Citizen
M	Dr. Nader	Pediatrician	MHC	Turkish Citizen
M	Dr. Bassam	Pulmonologist	Turkish NGO	Turkish Citizen
M	Dr. Ammar	General Medicine	Turkish NGO	Turkish Citizen

M	Dr. Anwar	Internist	MHC	Turkish Citizen

2017-2019 Clinic Administrator Interviews

Gender	Specialty	Type of Work
M	N/A	Administrator, Shifa Clinic
M	N/A	Small private clinic manager
M	Dentist	Small private clinic manager
M	N/A	Manager, Khayr Clinic
F	N/A	Administrator, Shifa Clinic
M	N/A	Manager, Shams Clinic
M	Ophthalmologist	Manager, Safa Clinic
M	N/A	Administrator, Rafah Clinic
M	Hematologist	Manager, Rafah Clinic
M	Hematologist	Manager, Bilad Clinic
M	Dentist	Small private clinic manager
F	N/A	Administrator, Shifa Clinic
M	N/A	Manager, Bilad Clinic
M	Ophthalmologist	Manager, Safa Clinic
M	N/A	Administrator, Rafah Clinic
M	N/A	Administrator, Shams Clinic
M	General Surgeon	Administrator, Hayat Clinic
M	N/A	Administrator, Bilad Clinic

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