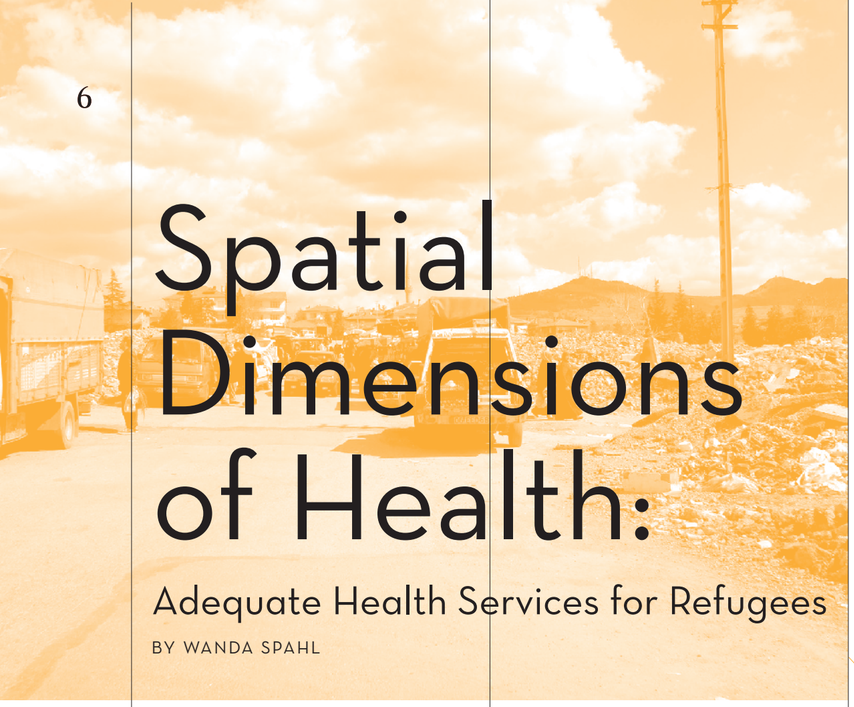

Spatial Dimensions of Health:

Adequate Health Services for Refugees

BY WANDA SPAHL

▲
The market street of the Önder neighbourhood, between buildings demolished because of public urban development projects

Health needs are dynamic and play out in a politically loaded field. Like many countries, Austria is currently undergoing controversial reforms. Questions about who gets funded and is prescribed benefits within the public healthcare system remain disputed: who is entitled to health services? Who is excluded from the system? How can we guarantee access? On what basis do doctors make a diagnosis? What is illness? What is health? And what is a health need? In answering these questions, spatial dimensions play a crucial role. Health and healthcare provision are closely entwined with their organisation and affiliated practices in urban space. Adequate policies and their analysis should acknowledge these spatial dimensions in order to meet one of the most important basic needs. In pointing out ways to do so, I will introduce information about the pursuit of healthcare of refugees in Ankara, Turkey, and engage in reflections about possible ways to incorporate spatial dimensions when looking at health needs of refugees in Vienna.

WHERE DO YOU LIVE AND HOW DO YOU LIVE?

Often, health policies focus on financial aspects and distributional issues and on medical treatment within already established institutions. Increasingly, lifestyle is taken into consideration. This can be seen in prevention measures. One can think of anti-alcohol and anti-cigarette campaigns in this regard or the promotion of physical activities. But it is well known that health outcomes are to a large degree more a consequence of current and previous experiences than health entitlements and treatment. Socio-economic inequalities beyond legal provisions matter. Therefore, disadvantaged groups such as refugees who suffer from socio economic inequalities should be covered by a health policy to achieve successful and all-encompassing ends .

To master this task, spatial aspects have to be taken into account: one dimension in this regard is the location within the city. Where do you live? To what extent is the health infrastructure accessible? A second dimension is the quality of life. How do you live? What kind of accommodation do you have? How do you perceive your immediate environment? Both dimensions have tremendous consequences for a person's health.

HEALTH: BASIC HUMAN NEED

Health is a fundamental human right. Different countries engage in varying tactics to meet the health needs of their citizens. In Turkey, a comprehensive system of universal health coverage (see Note A) was established quite recently. In 2003, the country started reforms to ensure access to healthcare for all citizens. Now the system is financed via taxes, fosters family physicians for delivering adequate and patient-centred primary care and aims at an improvement of hospital management through public-private partnerships.

But how are non-citizens such as refugees covered by the health system? Not everyone automatically profits from the healthcare system. Access often depends on the legal status and the consequent rights. In Turkey, if registered, refugees have access to most services of the public health system. However, accessing these services is often difficult. Increased marketisation of the health system with top-up payments is a burden for vulnerable populations. Generally, refugees face increased health risks owing to hazardous experiences in the country they fled, often strenuous paths of migration, and stress factors in the host society such as insecurity in future prospects and restricted access to social services. The high number of refugees – with around four million people making up around 5% of the overall population of Turkey - risks overstraining the established structures of the health system.

NOTE A: UNIVERSAL HEALTH COVERAGE

A universal health coverage system can function as powerful social equalizer. "Universal health coverage means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship." The main dimensions of universal health coverage comprise equity in access in the sense that that the whole population is covered by the system, quality of healthcare and financial risk protection. Still, each country needs to decide whom to extend access to, which services to cover, and how to pay for them.

URBAN REFUGEES IN TURKEY

What healthcare access do refugees in the cities of Turkey get in reality? This is a question that is very much connected with both spatial dimensions in focus here, the location, and the quality of life. Those factors – alongside issues such as an increased workload for health professionals and difficulties in the treatment situation based on language and culture – are crucial for successful fulfilment of refugees' health needs. In previous years, Turkey has been hosting more refugees than any other country in the world. With the outbreak of the Civil War in Syria in 2011 the number of people seeking refuge in the country has increased steadily (see Note B). In July 2018, more than 3.5 million Syrians were registered in Turkey, alongside people from other countries such as Afghanistan, Iraq and Somalia. Estimations indicate that 10% of the refugees live inside camps, mainly in the southeast; all others live in cities across the country. The high numbers of incoming people have posed considerable challenges. One crucial challenge is meeting their health needs.

NOTE B: LEGAL STATUS OF REFUGEES IN TURKEY

In 2013, with the adoption of the Law on Foreigners and International Protection, it was the first time that Turkey created a political framework for migration. Yet, article 61 maintains the geographical limitation from the 1951 Geneva Convention, by which the status 'refugee' is restricted to persons fleeing Europe. This limitation derives historically from the emigration experiences made in World War II. People currently residing in Turkey are not able to get the legal status 'refugee', which is possible in nearly all other countries that adopted the Geneva Convention, such as Austria. In Turkey, all Syrians are granted temporary protection, while non-Syrians can qualify for subsidiary or conditional protection, and apply for the resettlement program by the United Nations High Commissioner for Refugees.

For further reading: Soykan, C., 2017. Access to International Protection – Border Issues in Turkey, in: States, The Law and Access to Refugee Protection: Fortresses and Fairness. Hart Publishing, Oxford ; Portland, Oregon.

ANKARA 2016: HOUSING AS SPATIAL ASPECT OF HEALTH

At the beginning of 2016, I spoke to non-state refugee supporters such as NGO representatives and private helpers, health personnel, academics, key figures of the refugee communities and civil servants in Ankara. My objective was to have a better understanding of the living situation of refugees residing in urban areas of Turkey. It was clear for the people I spoke to that geographical and local conditions are crucial barriers or facilitators of healthcare access for refugees.

"62.000 Syrian people are documented in Ankara. But there are lots of people trying to live on the streets, in the parks. So we do not know the exact number unfortunately. Two thirds of this population in Ankara live in a province called Altindag. There poverty is so high." (Turkish Medical Association doctor)

Ankara is the Turkish capital, and with approximately five million inhabitants, the second largest city. It hosts more than 60.000 refugees, who live citywide. Housing for the refugees is not provided by the state. About two thirds of them live in the Önder neighborhood, a hilly Gecekondu Bölgesi (see Note C) in north-east Ankara in the city district Altındağ. In recent years, Turkish people have increasingly left Önder. Walking through the streets, Arabic is the main spoken language; most shops are owned by Syrians. According to a Syrian woman, places to live depend on the economic status: Refugees with the least means live in the camps close to the Syrian border. Richer ones come to Ankara, where the ones better off reside in richer districts, and the lower income refugees in Önder.

Another district which is known for its refugee population is Keciören. Its Gecekondu areas in the outskirts of the city, with little infrastructure, are home to most Afghans in the city. Their houses are placed in the hilly sideways of aan out-of-town arterial road. The closest public transport is reached in a walk along the paths between exceedingly simple Gecekondu houses. Then you arrive at a bus station next to a very busy road, where not much can be found. An empty snack bar is surrounded by an abandoned parking lot with dusty grounds.

Inferior housing conditions in remote areas often cause health problems. They are fertile ground for the spread of parasites. The lack of adequate heating and hygienic infrastructure, mouldy walls and dusty floors cause illnesses. In such an environment these can easily turn into chronic diseases.

GEOGRAPHICAL LOCATION OF HEALTHCARE SERVICES IN ANKARA – ONE LARGE HOSPITAL

The healthcare structure in Ankara mainly relies on Ankara Eğitim Ve Araştırma Hastanesi ("Ankara Teaching & Research Hospital"). The hospital is the fourth largest in Turkey and the largest one in the capital. The main visitors are economically disadvantaged Turkish people. Additionally, Ankara Hospital treats approximately 6,500 foreign patients per month. Most of them are Syrians, followed by Iraqi Turkmen, Afghans, and others. Yet the conditions in Ankara Hospital are not beneficial for migrants. Firstly, resources are overstretched. Even before the migration influx there were too many patients in the hospital. Now, with the additional migrants, supplying adequate care is difficult against the background of this over-capacity. Secondly, language is a problem. The number of translators provided by the Ministry of Health is far too low. Thirdly, the insufficient staff-patient ratio and the lack of translators create unhealthy staff-patient relationships. Regarding these and other cultural challenges, some of the healthcare staff refuse to treat refugee patients. Then a portion of the medical staff takes over. They are engaged to serve refugees' health needs, even though they are working in inferior conditions.

"We do it. You saw the man working there (she refers to an Arabic speaking employee of the Foreign Patient Admission office). I think they are paid very little, but they talk to them like friends." (Doctor in Ankara Hospital)

Further, although Ankara Hospital is relatively close to the districts with most refugees, sometimes transportation costs by bus or taxi to the hospitals are a financial burden. In case of acute and serious illness many refugees are in despair. Often, and especially if their children are sick, they call ambulances to get treatment. They are unfamiliar with the health system in Turkey and thus create extra costs.

NOTE C: GECEKONDU BÖLGESI

Gecekondu Bölgesi is the Turkish term for a squatted neighbourhood – 'gece' means 'night', 'kondu' means placed' and 'bölge' indicates a geographical district or region. Such neighbourhoods consist of hastily built houses constructed without building permission. They originally developed when large parts of the rural Turkish population moved to the major cities such as Istanbul, Izmir and Ankara. Now, Gecekondu Bölgesi also shelter most of the urban refugees in those cities. The houses vary drastically in quality and size, manifesting different living standards - some are tidy, others have sandy floors, some are neat apartments, others one room barracks with cloth as walls. In recent years, the government- backed housing agency TOKİ (Turkish: Toplu Konut Idaresi Başkanlığı) has demolished many Gecekondu Bölgesi and replaced them with mass-housing compounds.

ALTERNATIVE SOLUTIONS AND DISPERSED HEALTH INFRASTRUCTURES

Because of these difficulties, refugee patients find alternative solutions. All over urban areas in Turkey refugees have practised as physicians illegally. Alongside the factor of cultural proximity, geographical proximity is key. Refugee doctors practise in the neighbourhood. People decide to consult a doctor, who might not even have a real licence, with inferior medical equipment. They speak the same language and know the preferences of their patients. They are easy to reach. Healthcare infrastructure only works if it suits the needs of patients and picks them up in their life situation.

"The Syrian doctors can't get a work permit. They are not allowed by law, but they can give really confusing instructions to the patients sometimes. Sometimes it's good, it's positive. They are very helpful and they can refer the

Syrians to hospitals. But in some cases they give some misconceptions to them. (...) It can have very negative results. For example we had a case in which a 15 year old child actually had a problem with his brain. He had a nail in his head and he had to be operated on but the doctor tried to perform a surgery by himself with some of the tools that he was carrying around with him. And if we hadn't interfered, perhaps that life would be lost. It's a very dangerous issue actually. And sometimes they can also demand money from the refugees for performing these surgeries." (Turkish NGO worker)

Also smaller health centres are low-threshold alternatives to hospitals. The Turkish Ministry of Health together with Hacettepe University and the United Nations Population Fund collectively run small health centres. In Ankara, there are four Women Health Centres. They are mostly frequented because of their geographical proximity to the refugees' houses. Yet the largest and better equipped centre is placed in an area without refugees, while e.g. no centre is placed in Keciören. This planning error results in ineffective health infrastructures.

VIENNA TODAY: SPATIAL DIMENSIONS IN INTERPRETIVE HEALTH RESEARCH

Currently I am researching health needs of refugees in Vienna. I will map the city based on patient experiences, provider perspectives such as physicians' point of views, and health policies. With this we can see the infrastructures and services in situ, actual usage and perceptions of them, and of course what is missing to cover health needs adequately. I expect spatial circumstances to play an equally important role here as I have observed in Ankara. For example, in the Austrian capital, housing might be inadequate. Private apartments for refugees are often overcrowded. Persons with respiratory problems reside in basements with dangerous levels of mould. Or the infrastructure provided might be used ineffectively. People with a common cold consult the emergency department of a hospital.

Like health policies itself, the analysis of health policies should acknowledge spatial dimensions so that better health outcomes can be achieved. They can receive attention in various ways when analysing health needs and service delivery– in the themes of the research findings, in data collection, and in the analysis of data. Data in qualitative social science research can take various forms– interviews, photos, documents etc.

I will now propose several ways to incorporate spatial dimensions methodologically. In my research I follow an interpretivist approach (see Box 4). In the realm of healthcare, such an approach "focuses on the social construction of health policies through the ability of individuals for meaningful action, and highlights the meanings that inform the actions of the individuals involved in all kind of healthcare practices." Accordingly the aim is to attain socially contextualised knowledge of health needs. Health in this respect is dynamic. It cannot be measured with pre-defined and standardised indicators. Our blood count does not mirror our health. Health is more. It changes from place to place and over time. It is both subjective and socially negotiated.

ANALYSING POLICIES WITH SPATIAL DIMENSIONS

Firstly, themes of research findings can be spatial. I have already described important spatial dimensions in Ankara. Other themes can include the current housing situation. Especially a lower socio-economic status can lead to inferior circumstances. For instance, someone with a respiratory disease might afford only low-ranked flats. If these have mouldy walls for instance, the housing situation becomes a crucial part of the person's health needs. For refugees, another important theme is the space that has been traversed during flight and the space that has been left behind. The home, the place of origin is crucial to understand health needs. An example of this is the medication prescription and use. In some countries such as Austria the prescription of medicaments is done hesitantly, whereas in others such as the US or Syria it is more common to give prescriptions. A patient from one of the latter countries then sees the usage of drugs as urgently necessary to become healthy. The patient might be dissatisfied with the doctor then, and in the worst case the healing process might be delayed because in the new place there is perhaps no infrastructure that covers previously covered needs! (might result in unsatisfactory doctor-patient relationships.)

Secondly, the data collection itself can make use of space on the research site to achieve a better understanding of the health needs of refugees. Methods in this regard are for example thematic maps of the city, mental maps, and go-alongs. In case studies of cities, the spatial distribution of health facilities is crucial. One method we may highlight is the creation of a thematic map of the city with health venues which turn out to be important for refugees. This might include major public hospitals and hospitals specialised in migrant and refugee care, but also health insurance service desks, social services and mental health institutions. Next to mapping the city as a whole, so-called mental maps are a way to account for subjective perspectives. Each person will have an individual way of navigating the health system, including diversified and smaller-scale units of health venues such as family physicians, pharmacies, social service providers and community-based and peer-to-peer help. Another approach is walking as method.

NOTE D: INTERPRETIVIST APPROACH

Crudely put, social science is divided into interpretive and positivistic approaches. The latter often engages in quantitative methods. The researcher presumes he/she can capture the world by thoroughly collecting facts, as for instance done in major surveys about human behaviour. Instead, in interpretive approaches the researcher presumes that she already interprets the world the whole time. She does this for example with her social and historical background, her language and the concepts she applies. This means that all knowledge is produced by particular groups of people, at a certain time and a certain place. Things we "know" depend on who we are, when we live, and where we live. We cannot analyse reality, but rather get partial insights from the perspective of an insider. We can never detach from our social and geographical surroundings.
Interpretivist approaches to analysing health policies aim at uncovering meanings of policies. Policies are broadly understood as comprising a variety of elements: Next to the legal framework, experiences by people who are targeted with certain laws, practices by people who fulfil certain rights such as administrators and physicians, and actual outcomes related to health are at the centre of attention.

For further reading: Geertz, C., 1973. Thick description: Toward an interpretive theory of culture. New York: Basic Books. 3-30 Wagenaar, H., 2011. Meaning in action: interpretation and dialogue in policy analysis. London ; New York: Routledge Yanow, D., 1996. How does a policy mean? interpreting policy and organizational actions. Washington D.C.: Georgetown University Press.

It aims at understanding complex life situations also through familiarising oneself with the landscapes people pass and paths they walk. As such, "go-alongs" (term coined by Margarethe Kusenbach) complement research endeavours which aim at a contextualised understanding of experiences. Such spatial approaches for capturing the delivery of social services put the perspectives of migrants in the foreground, instead of analysing pre-given localities as they have been planned by the administration.

Thirdly, space can also play a role in the process of data analysis. Situational

▲
Gecekondu Bölgesi in Ankara with mass-housing compounds in the background developed by the government-backed housing agency TOKİ

Analysis is an analysis method which developed out of the famous "grounded theory" and is rooted in interpretive perspectives (see Note D). A situation comprises a broad variety of elements beyond the human factor. It understands that all these different elements co-constitute each other in a specific situation. Next to the more classical social science data such as observed behaviour or interviews, there is a focus on the relationalities among individuals, organizations, institutions, technologies, cultural symbols, histories and so forth. Human actions are set in relation with nonhuman objects. Accordingly, spatial dimensions can be included as important element of the analysis. In situational maps multiple kinds of data can be included from multiple sites. This means that it is a tool that offers the possibility to relate what is said to what is around us.

In applying spatial methods for interpretive policy analysis, the focus is on the refugees' agency. Their actions actively shape the space around them. Mapping health facilities of a city is more than visualising hospital locations. The described spatial methods help to generate a contextualised picture. This takes the individual history and socio-cultural background into account. The emphasis is on the individual person who navigates the health system. A contextualised approach enables us first to understand the relation between formal provisions and actual practices, second to find barriers – in the sense of provisions – that should be there in theory but are not in practice, and third to identify missing infrastructures, which are not present in theory, and not anticipated by the already existing policy tools.

DESIGNING GOOD HEALTH POLICIES

For the World Health Organization "improving the health of migrants and refugees goes beyond providing access to health services. It includes ensuring that the basic needs of migrants and refugees are addressed including adequate nutrition, water, sanitation, hygiene, housing, education and employment. It involves addressing the complex upstream political and socio-economic factors that affect a person's health."

Spatial dimensions are crucial for successful health policies. Both the described life situation of refugees in Ankara and the proposed theoretical reflections about mapping health needs are examples in that regard. Space is an aspect that has to be taken into consideration like time in the form of the personal history, or like the social situation affected by gender, educational background and family status. This will surely require a definition of space. It might also lead to new perspectives on space. I am sure that social researchers can learn a lot in this regard from city planners, architects and vice versa.

The final aim of social policies should be that of meeting human needs, with health being among the most crucial. Ensuring adequate services relies on political decisions. Paths taken and decisions made considerably shape how we live. High-income countries in particular have a duty to provide policies which guarantee that these needs are met for people living in the territory. The fulfilment of health needs is part of a life lived with dignity. This goes beyond the mere provision of access and takes the socio-economic situation into account, since it is obviously rooted in the spatial environment.

1 I understand the term refugee for people who fled violence or persecution in their home countries. I refer to them as disadvantaged owing to:
(i) increased mental and physical health risks on the basis of a history of flight and a well-established body of literature on worse health outcomes for immigrants, (ii) discrimination, and (iii) precarious legal status with the consequences of psychological distress, inferior housing conditions, worse job prospects and so on.

2 I was conducting research for my Master's thesis "Stratified Membership. Healthcare Access for Urban Refugees in Turkey.".

3 Bevir, M., & Waring, J. (Eds.) 2018. Decentring health policy: learning from British experiences in healthcare governance. Abingdon ; New York: Routledge

4 Clarke, A.E., Friese, C., Washburn, R., 2018. Situational analysis: grounded theory after the interpretive turn. Los Angeles: SAGE

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