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Aysegul Toksoz

Regulation through Legal Ambiguity: Politics of Reproduction in Contemporary Turkey

Aysegul Toksoz

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Reading Committee:

Katherine Beckett, Chair

Resat Kasaba

Judith A. Howard

Michael W. McCann

Program Authorized to Offer Degree:

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Abstract

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Aysegul Toksoz

Chair of the Supervisory Committee:
Katherine Beckett, Professor
Department of Sociology

What do rights to reproductive health practises, such as abortion and contraception, stand for in a context that is ripe with obstacles for women as they seek access to safe reproductive healthcare? What is the work that rights accomplish in such a context? The Turkish case offers insights into such questions, as a number of reproductive health practises, including abortion, caesarean sections, and contraception became politicised and shrouded in legal language almost overnight in 2012 when the former Prime Minister initiated a fiery controversy around these issues. While the politicisation of reproductive health has not been accompanied by a parallel legal change banning these practises, it has had its own effects; including, most importantly, the onset of an unprecedented abortion rights movement and intensification of problems that women faced as they sought access to certain reproductive health services.

Focussing on this case, *Regulation through Legal Ambiguity: Politics of Reproduction in Contemporary Turkey* explores the ways that law in general and rights in particular generate indirect yet transformative effects. It inquires into the apparent puzzle that the very absence of formal legal change can have transformative power of its own on the everyday practices of relevant actors. At the same time, it asks what the impact was of this strong rights mobilisation, palpably successful at the level of preventing restrictive legislation from being passed but nonetheless short of generating significant impact on everyday practices in healthcare institutions.

The dissertation argues that the rift between the hostile government discourse and the absence of restrictive legal change generated legal ambiguity and rendered the legal status of abortion and caesareans ambiguous. Healthcare workers, in turn, despite their expressed support for women's rights, were propelled to improvise their own restrictive limits when offering their services in order to safeguard themselves in a professional environment that was already filled with tensions. Despite this bleak state of affairs, however, women's rights activists consider their campaign successful for the broad and long-term alliances that it initiated.

TABLE OF CONTENTS

Chapter 1 . Introduction.....	1
1.1 Studying Reproduction: Theoretical Underpinnings	5
1.2 Legal Regulation of Reproduction in Turkey	10
1.3 Theoretical Framework and Contributions of Present Study	14
1.4 Overview of the Chapters	19
Chapter 2 . Data and Methods	25
2.1 Research Tools	27
2.2 Site Selection	28
2.3 Participant Selection.....	34
2.4 Data Collection	37
2.5 Analysis	41
2.6 A Note on Reliability	42
Chapter 3 . Ironies of Legal Talk: Reproduction Goes Controversial.....	44
3.1 From Banality to Inaccessibility.....	45
3.2 Politics of Gender under the AKP’s “Unholy Alliance”	51
3.3 The Hot 2012 Summer.....	62
3.4 Conclusion.....	71
Chapter 4. Talking Rights.....	73
4.1 Choosing the Right(s) Frame	75
4.1.1 A Language That Unites.....	77
4.1.2 An Empowering Language	81
4.1.3 Knowing One’s Rights	85
4.2 Substantiating Rights	88
4.2.1 Quality, Free, Accessible	88
4.2.2 Abortion Rights as a Collective Right	91
4.2.3 The Decision Belongs to Women.....	95
4.2.4 “Abortion Is a Right, Uludere Is Massacre”	97
4.3 Whither Litigation	99
4.4 Conclusion.....	105
Chapter 5. Understanding Healthcare in Turkey circa 2000s: An Interlude	108
5.1 Difficult Times for Conducting Research	110
5.1.1 Healthcare System before the 2000s	111
5.1.2 Transformation in Health, 2004–Present.....	115
5.2 Difficult Times for Accessing Reproductive Healthcare	121
5.2.1 Imperfectly Functioning Central Planning.....	125
5.2.2 The Broken Referral Chain.....	130
5.2.3 Perverse Incentives	136
5.3 Conclusion.....	141

Chapter 6. Negotiating Limits, Negotiating Legality: Everyday Practises in Healthcare	
Institutions.....	143
6.1 Negotiating Limits.....	145
6.1.1 Pregnancy Monitoring Schemes.....	148
6.1.2 Contraception	153
6.1.3 Abortion.....	157
6.1.2 Caesarean	164
6.2 Negotiating Legality.....	169
6.3 Rights in Conflict	175
6.4 Conclusion.....	187
Chapter 7 . Of Compensation and Compassion	189
7.1 When Two Rights Collide: Calculating Risks in Reproductive Health.....	192
7.2 Who Is the Subject of (Reproductive) Rights?	199
7.3 Conclusion.....	209
Chapter 8 . Rights on the Streets, Rights in the Exam Room: Of the “Effectiveness” of	
Rights Claiming.....	211
8.1 How to Assess the Effectiveness of Rights Claiming?.....	213
8.2 Looking Back: Critiquing Rights Claiming after Claiming Rights	218
8.3 Recovering Rights	225
8.4 Rehearsing (Gender) Revolution	229
8.5 Conclusion.....	233
Chapter 9 . Conclusion	235
Bibliography	245
Appendix I.....	266
Appendix II.....	272

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Nevin'e...

CHAPTER 1

INTRODUCTION

I explained to Rayiha, that three years after the military coup in 1980, Kenan Evren Pasha had done a charitable deed by bequeathing unmarried women less than ten weeks pregnant the right to get an abortion in hospitals. This right has benefited most those brave city women who could make love without getting married. In order to benefit from this right, married women had to persuade their husbands to give a signature confirming that they consented for aborting the child. Many husbands in Duttepe had refused to give that signature, saying abortion was not necessary, that it would be sinful to get one, that a child would look after them in the future; so many women had to give birth to their fourth, fifth child after long quarrels with their husbands. Some other women had aborted themselves through primitive means that they learned from each other. I told my sister, "If Mevlüt does not sign, don't be tempted by those witches and do something like that, or you'll regret it." Then there were men like Korkut, who don't care about giving those signatures, I told Rayiha about them too. Many husbands, because signing is easier than wearing condoms, get their wives pregnant saying they can get abortions anyways. After the new law, Korkut got me pregnant three times. I had three abortions in the Etfal Hospital, and of course I regretted once we started to make money. This is how I learned what to tell the doctor at the hospital and from whom to get which form. "Rayiha, we'll first go to the councilman to get the papers proving that you're married to Mevlüt; then we'll go to the hospital and get the paper showing that you're pregnant, signed by two doctors, as well as an empty form so that you can take it home to get Mevlüt sign it. Deal?"

Thus explains Vediha, the wife of an upwardly mobile contractor with modest roots, to her sister Rayiha how abortion on request was legalised in Turkey and how this new right affected the lives of urban women like themselves in Nobel laureate Orhan Pamuk's best-selling novel *A Strangeness in My Mind* (2014, my translation, emphases added). While the unmistakable cynicism in these lines needs to be taken with a grain of salt,¹ Pamuk lucidly illustrates, in a few brief pages, commonplace tensions around reproductive practises and their ghastly consequences. Later on in the novel, Mevlüt does not display so much qualms about giving the necessary signature, but, dragging his feet in

¹ Surveys conducted in Turkey after 1983 show that abortion has been most prominent among married women who already had more than one child, and single women seem to have resorted to abortion less frequently than their married counterparts.

procrastination, he ends up never getting the paperwork done. In despair, Rayiha tries to get an abortion on her own in the bathroom of their tiny house in the Duttepe shantytown of Istanbul, which results in her death.

This dissertation is as much about the persistent juxtaposition of the notion of rights to the practise of abortion that strikes one in the above passage, as it is about the severe challenges that women face as they seek access to reproductive healthcare in contemporary Turkey. In the case of abortion in particular, spousal consent is only one step that needs to be taken in a rather long journey, which begins with the search for a healthcare institution where abortion is provided, and a doctor who is willing to offer one, and ends only when one successfully meets a series of bureaucratic requirements within a rather short span of time. Indeed, Vediha herself had to undergo three abortions in the Etfal Hospital until she learned “what to tell the doctor at the hospital and from whom to get which form” in order to obtain one. Without her guidance, Rayiha perhaps would not have been able to accomplish all these tasks on time even if Mevlüt had given his signature right away.

Over the past decade—that is, about fifty years after the legalisation of contraception, thirty years after the legalisation of abortion, and fifteen years after the fictional death of Rayiha in her bathroom—the difficulties that women experience as they steer the labyrinths of healthcare institutions have only intensified, as I will show in the following pages. More strikingly, alongside the increasing severity of practical difficulties in accessing reproductive health services—which are harder to detect and thus tend to remain invisible—reproduction also became a matter of public discussion in 2012, when then Prime Minister Erdoğan, in one of his oft-repeated outbursts, voiced

his hostility toward certain reproductive healthcare practises, including abortion and caesarean sections, and later, contraception.² His outburst also coincided with the onset of a new pregnancy monitoring scheme that aimed to ensure that every pregnant woman is immediately registered with a health professional upon the detection of pregnancy, which increased the fears that the government was on a “hunt” for pregnant women. The “private” tensions between husbands and wives that Vedita described in the above quote thus came to assume a central place in “public” debates³ in Turkey, which had never happened previously even during the periods of liberalisation of laws governing reproductive practises.

Medical professional associations as well as women’s and feminist organisations report that access to reproductive healthcare in general and abortion in particular has been seriously undermined over the last few years. While in the next chapters I dispute the assumption that access was unproblematic prior to 2012, I concede that the politicisation of reproduction has had its own effects, including, most importantly, the onset of an unprecedented abortion rights movement. Indeed, Erdoğan’s vociferous attack on abortion, contraception, and caesarean sections triggered the mobilisation of a

² It is a challenge for observers to pinpoint what exactly made Erdoğan to include caesarean sections into his list of unacceptable practises. The most reasonable explanation is that as health risks increase with each subsequent caesarean, most obstetricians are reluctant to offer more than two caesareans to a woman, or to assist the virginal birth of a woman who has a caesarean history. Caesareans may thus limit a woman’s fertility in a rather roundabout way. While this explanation sounds far-fetched, it is the most viable one that I have heard so far.

³ The assumed division between the “private” and the “public” realms has been criticised by feminists for decades (di Leonardo 1991; Fraser 1989), which is perhaps best summarised by the maxim “the personal is political.” I do not mean here to reproduce the notion that there is a natural division between the two spheres; but I nonetheless want to underline the idea that while such tensions are not less political when they are experienced within the confines of individual families, the ways in which they are thought of and talked about undergo considerable transformation as they are translated into the language of the public space.

vocal opposition movement, which came to express itself through the language of women's rights to these healthcare services.

It is against this backdrop that I seek to understand what reproductive “rights” stand for and how they come to be practised at the everyday level in healthcare institutions. To this aim, I conducted research among healthcare providers—practitioners, expert doctors, nurses, and other employees of public and private healthcare institutions—who are in charge of delivering those rights. Yet, as the following chapters show, providers do not just mechanically extend whatever benefits that stem from the rights that exist on paper to all women who come at their doors. Rather, they exercise significant discretion when deciding which practises to offer, which ones to avoid, and to whom to offer their services. They thus serve as gatekeepers in the area of reproductive health. As such, healthcare workers are key actors who *make* policy through their case-by-case decisions at the everyday level (Corrigan 2013, Lipsky 2010). These routine decision-making processes are therefore a crucial area of study for understanding how law, and more specifically women's reproductive rights, come to produce concrete effects in real life.

The chapters below seek, on the one hand, to explain how and in which ways women's well-entrenched rights to reproductive healthcare services have eroded in a relatively short span of time. On the other, they endeavour to understand the recourse to the very same rights, which seem to have failed their beneficiaries, by the groups who resist government hostility. Part of the research upon which this dissertation is based was thus conducted among activists who organised a large-scale abortion rights campaign over the Summer 2012 in response to Erdoğan's attacks. These two components of my study are meant to complement one another, as they correspond to the two levels at

which rights operate: at one level, as concrete remedies conferred to certain groups and persons; at another level, as discursive tools for reclaiming or objecting to such entitlements. These two levels are not independent from one another. Rights claimants need to have a sense of how things work in the real life of healthcare delivery, whereas healthcare workers, as my dissertation reveals, are susceptible to the discourses that circulate about reproductive rights while using their discretion.

Considering these two levels simultaneously, the following chapters seek to answer a series of questions that pertain specifically to the Turkish case on the one hand, and more broadly, to our theoretical understanding of law and rights on the other: First, what does it mean to have the right to contraception, abortion, and caesarean delivery in a context that is already ripe with obstacles that women face as they seek access to safe reproductive healthcare? Second, how do rights come to materialise, sometimes in unexpected ways, at the level of everyday practises in healthcare institutions? Finally, why are rights perceived, against all odds, as indispensable political tools by those who seek to expand women's freedoms?

Studying Reproduction: Theoretical Underpinnings

My contention is that the answers we give to such questions have significant implications for expanding our understanding of politics at large in so far as reproduction, with all its connotations pertaining to both Marxist concept of sustenance of a labour force (through household labour as well as procreation) and continuity across generations within social systems, is an inherently political concept. Indeed, while biologically speaking, only some bodies are able to conceive, the ways that gender is socially

constructed around conception and birth do not seamlessly flow from this fact, as the historical and temporal variability in social arrangements around reproduction attest. In other words, gender can neither be reduced to a mere by-product of biology, nor are gender relations accidental within modern polities, but they constitute the very core of the institutional arrangements regarding the relationship between states, markets, and (gendered) individuals. As Susan Gal and Gail Kligman (2000: 5) eloquently put it, “[n]ot only do the ideologies and policies that states produce circumscribe the range of possible relations between men and women, but ideas about the differences between men and women shape the ways in which states and economies are imagined, constituted, and legitimated.” In this vein, studying reproduction offers key insights not only into women’s experiences, but also into the very character of the polity.

Furthermore, in the contemporary world, reproduction is undeniably a key area through which modern states intervene into individuals’—and particularly into women’s—lives and bodies. Hence, as Gail Kligman (1998: 3) suggests, “reproduction serves as an ideal locus through which to illuminate the complexity of formal and informal relations between states and their citizens.” Effectively, the politics of reproduction ties in with state concerns about demography on the one hand; and on the other hand, it is a fulcrum of ideological contestations about “proper” womanhood, motherhood, morality, nationalism, beliefs, and personal aspirations. As such, even though women are the primary targets of reproductive policies (Maternowska 2006), politics of reproduction can serve not only as an index of gender relations and women’s citizenship status (Pateman 1988, Walby 1994), but can also shed light onto the character of the polity at large and the transformations that it undergoes (Yuval-Davis and Anthias

1989).

The transformations that Turkey has undergone since 2002, when the Justice and Development Party (*Adalet ve Kalkınma Partisi* – AKP) and its leader Erdoğan ascended to power, have been hot topics within and outside of academia over the last decade. These discussions, especially with respect to women’s status, have been animated first and foremost by the party’s religious credentials. In a way, this dissertation can be considered as part of this on-going conversation. But in line with critical feminist readings of women’s status in the Middle East (Abu-Lughod 1998; Kandiyoti 1990), I also seek to bring a fresh perspective to the discussion by avoiding the tendency to subsume all political antagonisms currently taking place in Turkey under the rubric of Islam. I thus do not take the abortion/caesarean debate and the problems of access endemic in reproductive healthcare simply as a derivative of the assumed Islamisation of society in Turkey. Instead, I seek to explore the many complex dynamics at play in this area. Indeed, during my fieldwork, none of my healthcare employee respondents used religious references when talking about their professional duties; religion was mentioned during my interviews, if it was mentioned at all, only when my participants shared their own readings of contemporary Turkish politics with me. While to many it may be surprising how little mention Islam receives in this dissertation, it does so because my data guided me away from it.

Thus, this dissertation endeavours to understand the current transformations that Turkey is undergoing through the lens of reproduction. But its more specific focus is on the role of law within these processes of political and social change. Indeed, law is a key mechanism through which states seek to control and regulate reproductive practises—a

point that has been taken for granted in the literature on reproduction. Laws pertaining to abortion in particular, and to reproduction in general, have been subject to extensive feminist theorising (Petchesky 1990; Cornell 1995; Poovey 1992). Informed by these theories, scholars in various fields have conducted empirical research in different contexts about the historical evolution of abortion laws in particular contexts (Miller 2007; Stormer 2002; Solinger 2005), the human costs of anti-abortionism (Whittaker 2010; Joffe 2009), the political ramifications of struggles over abortion (Luker 1984; Marx Ferree 2002) and the implications of the coalescence between legal and medical expertise (Sheldon 1997; Kellough 1996). Yet, in line with the major threads of feminist legal theory—be it in its radical (MacKinnon 1989) or post-structuralist (Smart 1989) variants—most of these studies take law itself for granted even when they problematise it. That is, even though these works by and large challenge the legitimacy of particular laws and foreground activist attempts to change these laws, they consider law simply either as an instrument of control by the patriarchal state over female bodies, or as a mechanism of governmentality designed to conduct individuals' actions in certain ways.⁴ In either case, the specific significance of law—that is, the ramifications of the fact that those struggles are being fought on a legal plane, *through the forms of law* (Thompson 1974: 262)—drops out of the picture.

To avoid this trap, my dissertation brings together the feminist literature theorising the relation between reproduction and women's citizenship with law and society studies. My purpose is to examine how law as a medium of contestation produces effects of its

⁴ However, Carol Smart cautions against taking law as identical to patriarchy, and conceptualises law as a set of practises and discourses. Yet, this theoretical note of caution seems to be lost from view in empirical studies on abortion and other reproductive health practises.

own. To be more precise, I seek to understand how law simultaneously assumes both regulatory and contentious roles “as an always potentially present dimension of social relations” (Hunt 1993: 3). I contend that grasping how health professionals envision legality, how their decisions about what actions fall within and which ones fall outside the law are made, and how individuals carry out their everyday actions within these parameters is indispensable for achieving a full understanding of how law “in a complex and contradictory fashion reproduce[s] the material and ideological conditions under which [patriarchal] relations may survive” (Smart 1995: 144).

Simultaneously, thinking of law not simply as a mechanism of coercion, but also as a dynamic and constitutive area of contestation is crucial for grasping the peculiarities of the Turkish case. Indeed, the government’s attack on women’s reproductive liberties did not take the form of a legal action in the strict sense of the term. Although legal discourse and even the threat of legal sanctions were repeatedly used, no legislative changes to extant laws were ever made. Similarly, neither professional associations nor women’s rights groups have resorted to formal legal channels, despite the fact that their discourse was deeply infused with legal language. Still, I argue that the persistent use of legal idioms by all parties involved was neither coincidental nor immaterial. Accordingly, attending to the role played by law is vital in order to make sense of the struggles fought over reproductive practises.

Such an endeavour calls for a broad notion of “law”, which would go beyond formal legal settings and enable an understanding of the complex mechanisms by which legal tactics and symbols shape ways of claiming, exercising, and contesting power. In the next section, after briefly reviewing the literature on laws regulating reproduction in Turkey, I

offer the outline of a theoretical framework underpinning such a conceptualisation, which guides my approach through the dissertation.

Legal Regulation of Reproduction in Turkey

The scholarship on reproductive practises in Turkey is not exempt from the rather simplistic view of law discussed in the previous section. My theoretical differences from these approaches notwithstanding, these works offer a rich history on reproductive policies in Turkey, which is indispensable for offering context for the research on which my dissertation is based. Thus, I begin this section by offering a summary of the key points in this literature. Then, delineating the contrasts between these works and my theoretical orientation in conceptualising law, I lay out the conceptual framework underlying my dissertation.

The most important legislative changes pertaining to reproductive health practises in Turkey came about in 1965 and 1983. Prior to these two dates, the Republic of Turkey followed the pro-natalist political and legal leanings of its imperial predecessor from its inception in 1923 onwards. In 1965, contraceptives and therapeutic abortion were legalised. Almost two decades later, in 1983, abortion on request until the 10th week of pregnancy was legalised with certain caveats regarding consent.⁵ These legal changes, in a sense, mirrored the accelerated pace of political and societal transformations that the country underwent during these periods, as both came in the years following military

⁵ The law specifies the requirement of spousal consent in case the pregnant woman is married and parental consent in case a minor is pregnant. Apart from these two stipulations, pregnant woman's consent is deemed sufficient on its own for obtaining abortion on request.

coups.⁶ Remarkably, both pieces of legislation passed without pressure from below; a strong feminist or women's movement in Turkey to mobilise for such demands was by and large absent in Turkey over those years.⁷ On the other hand, the liberalisation of laws did not trigger any “backlash” among the populace at the time.

Taking note of this absence of popular demand, the extant social science literature on reproduction-related laws and policies in Turkey relies mostly on an instrumentalist

⁶ There are competing scholarly accounts of the military coups in Turkish history. The conventional interpretation relies on the “strong state thesis”, which has dominated social science literature on Turkey for decades. In broad terms, this perspective analyses the late Ottoman and Republican periods on the basis of a comparison to Western European capitalist development, identifies an alleged “lack” of capitalism/bourgeoisie/civil society, which it in turn explains on the basis of a presumed absence of intermediary elements in those societies (Heper 1985; Mardin 1969). The modernising Ottoman elite and the secularist Republican cadres, cut off from the rest of the society, are considered as the backbone of this strong state; while “the state” is differentially employed to refer to official institutions, the officials and civil servants running those institutions, or to a transcendental entity that encompasses both the institutions and their functionaries but goes beyond them. In this equation, the main tension between the state and society is religion, so far as the state is depicted as uniformly secular while society is represented as deeply religious. Yet, societal resistance against the strong state remains relatively weak, and whenever it emerges, it is suppressed violently by the heavy hand of the military (İnsel 2001). For instance, the 1960 military coup is explained as the state's response to growing influence of populist and religious Democratic Party, whereas the 1980 military coup is read as its reaction to the radicalisation of Islamist and socialist movements. In contrast, critics of the strong state thesis seek to reinstate the class dimension into the discussion, and to delineate material conflicts underlying the military coups (Akça 2009, 2014; Dinler 2011).

⁷ While women's movements were not absent from neither the late imperial era nor the early Republican period, the official ideology of the new Republic successfully subsumed these movements under its “state feminism” (Tekeli 1998), purporting that its modernisation project adequately championed women's rights and satisfied all of their possible demands. Indeed, a series of initiatives, from legal reform to education programmes were launched during the early republican period, which left women “emancipated but unliberated” (Kandiyoti 1987). Amidst the politicisation of the general climate in the country during the 1970s, many women disillusioned with the Kemalist project joined the ranks of radical left-wing or Islamist movements (Zihnioğlu 2003). Feminism as a social movement independent of state and other (“*malestream*”) political movements flourished only during the latter part of the 1980s—ironically, precisely because women's issues were perceived as non-political in nature and thus non-threatening to the status quo, which offered women an opportunity to organise in feminist groups during the post-coup period when all other political movements were violently suppressed (Sirman 1989; Tekeli 1986).

approach to law.⁸ Law is considered an important area of investigation in this body of scholarship in that it is seen as a key disciplinary tool, yet the contestations that take place within the legal field remain by and large understudied. Accordingly, in this scholarship, the state appears as *the* agent enacting legal changes, with the aim of manipulating population growth on the basis of the political and economic exigencies of the day. Consequently, law is reduced to a tool that the state uses in order to achieve its extensive goals pertaining to population control.

The predominant narrative in this literature traces state intervention into reproduction back to the Ottoman Empire's "state modernization" of the 19th century. Prior to that period, the Ottoman state used to treat conjugal matters as belonging to an inviolable private realm following sharia law,⁹ whereas the reform period was marked by intrusive demographic policies that were introduced as a means toward military and economic prosperity: Population growth was presumed to be the key to achieve these goals. Accordingly, abortion and birth control were strictly prohibited with imperial edicts from 1838 onwards (Balsoy 2009). A series of legal, medical, administrative and

⁸ The works in this area do not necessarily share the same theoretical orientation or epistemological paradigm, even though one can discern the influence of Foucault's frame of biopolitics in the field.

⁹ The Koran encourages contraception, but does not address the issue of abortion directly and there does not exist a single and unified "Islamic" attitude towards abortion, but a multiplicity of doctrinal interpretations. Among those, the *Hanafi* School, which was predominant in the Empire, tolerates abortion during the first 120 days of pregnancy as far as the pregnant woman's husband is informed of the situation (Asman 2004). Historical accounts suggest that the time limit of four months into the pregnancy was commonly accepted, and husband's intervention could be eschewed (Hatem 1997). This allowed Ottoman women to have greater freedom over their own bodies *vis-à-vis* the state, and sometimes even *vis-à-vis* their male relatives. According to the accounts of foreign visitors, abortion used to be a rather frequent, even banal practise before the Ottoman reform period (Davis 1986). The religious discourse that the 19th century reformers resorted to for criminalising abortion is thus considered by commentators as an *ad hoc* legitimation of the new policy (Miller 2007).

educational policies were implemented from then on, along with the mobilization of a religious discourse against abortion in the advice press (Demirci and Somel 2008). Upon the dissolution of the Empire and its foundation in 1923, the Republic of Turkey followed the same policy line as it confronted the problem of underpopulation due to casualties of war, mass deportations, and genocidal violence (Akçam 2004; Kolluoğlu 2013). In an attempt to boost the population growth in a country whose economy relied heavily on agricultural production, state incentives for birth promotion as well as a strict ban on birth control and abortion were pursued. While the policies adopted were similar to those of the previous period, the basis of the discursive underpinnings of pro-natalist policies shifted from religion to nationalism (Akşit 2010).

In a similar vein, the radical shift in population policy is attributed to the changing economic constraints of the post-war era: As the large-scale mechanisation of agriculture during the 1950s rendered a considerable part of the rural population economically superfluous, it triggered an extensive wave of migration from rural areas to urban centres in the second half of the decade. At the same time, newly industrialising cities presented an important pull factor for those leaving rural areas. Urban population of the country rose by 75 per cent, indicating that one out of every ten persons living in rural areas migrated to urban centres in this period (Keyder 1987). However, neither the level of industrialization, nor the infrastructural capacities of the cities, was ready to absorb large numbers of people. Consequently, a discourse of “too-rapid” population growth became prevalent in the 1960s. Population growth was no longer regarded as a source of national strength but as the fundamental cause of a variety of economic and social ills, above all an impediment to the desired economic development (Gürsoy 1996). In what follows, a

“population control” policy was adopted and replaced pro-natalist approaches. As a first step, legal prohibitions over the sale and use of contraceptives have been removed in 1965 with the Law no. 557, the Population Planning Law. Abortion on request remained illegal, but termination of life-threatening pregnancies was legalised.

Public health advocates continued their lobbying efforts to legalise abortion on request throughout the 1970s in order to prevent self-induced and clandestine abortions, which posed a significant threat to women’s lives and health (Figà-Talamanca et al 1986). They eventually found an opportunity to reach their goal in the aftermath of the 1980 military coup, as the Military Advisory Council that ruled the country from 1980 to 1983 displayed little concern for accountability and was thus capable of passing potentially controversial laws precipitously that elected governments shied away from. The draft legislation prepared by medical experts, proposing changes to the Law no. 557, was brought to the Council’s meetings on April 13 and 14, 1983. The two-day discussion resulted in the passing of the Law no. 2827 Concerning Population Planning, which is still in action today (Miller 2007).

Theoretical Framework and Contributions of the Present Study

My goal is not to question the validity or usefulness of the works I summarised above, but for the purposes of this dissertation, I will depart from the instrumentalist view of law on which they are based. Adopting similar views, commentators within and outside the academia (Acar and Altunok 2013; Kalıntaş 2012) suggest that Erdoğan’s anti-abortion and anti-caesarean comments represented a new shift in population policies. Such analyses point at the changing world order under the sway of neoliberalism, one

characteristic of which is the movement of manufacturing industries from developed countries into the developing world. Within these confines, the “comparative advantage” of peripheral countries like Turkey in their integration into the world economy relies mostly in their supply of cheap labour (Ceny 1997). This may be an accurate interpretation; it is difficult to contradict the idea that political economic calculations figure into policy decisions. Yet, these perspectives are limited in that they fail to appreciate the complex ways in which such policies are translated into practise at the everyday level, how different groups wage struggles around them, and particularly, the role of law itself as a medium of contestation within those processes.

One problematic assumption that underlies the instrumentalist view of law is the notion that policy decisions—determined either on the basis of the state elite’s objectives, or the unintentional but coordinated workings of biopolitical rationality—are seamlessly implemented at the level of everyday practise. That is, they presume that once there is a shift from pro-natalist to anti-natalist population policies reproductive health practises serving those extensive goals will become immediately available to women and successfully implemented in a widespread manner (or vice versa). Judging from the first decade of the 2000s, however, this seems not to have been the case in Turkey. Data on the availability of contraceptive methods prior to the onset of the debate is limited, but the small-scale studies conducted around the 2000s point toward a rather large unmet demand.¹⁰ While the rapidly increasing prevalence of caesarean sections as a delivery

¹⁰ There is a dearth of social science research on access to contraception over that period. TNSA, on the other hand, is conspicuously silent about the unmet demand for contraceptives. Research conducted at local level at health sciences departments single out that unmet demand for contraceptives is rather significant. For instance, Kavak (2006) conducting a study with women giving birth in a Black Sea town hospital, found out that

method is well documented, it was neither considered within the framework of population policy, nor were the numbers problematised except in a narrow medical circle.¹¹ On the other hand, there is evidence that abortion on request was by and large unavailable in public institutions prior to the onset of the debate in 2012, at a time where there neither was any indication of a change related to population policy, nor the legal status of abortion was altered.

These apparent paradoxes (which appear to be paradoxes only from an instrumentalist perspective) should help us to see that the role that law plays in regulating reproduction goes beyond a mere policy tool. My dissertation thus draws on socio-legal scholarship that has debunked the formalist view on law as a clear, coherent entity, which directs individual behaviour in a predetermined way, as a “myth” (Fitzpatrick 1992). Rather, law should be understood as “a complex repertoire of discursive strategies and symbolic frameworks that structure on going social intercourse and meaning-making activity among citizens” (McCann 1994: 282). This broad and dynamic conceptualisation of law suggests that the power of law is never absolute and the consequences of any kind of legal intervention are typically multidirectional, multifaceted, and often paradoxical. Hence, law is not an autonomous sphere above society, from where rules are imposed onto it. Instead, law is embedded within other arenas of social life and institutions, constitutive of discourses, identities, relations, and interactions that emerge from and

95% of women expressed a desire to use contraception during the postpartum period, whereas only 10% were able to do so. Kavak suggests that this is due to the hospital personnel’s lack of education about postpartum contraception and their ensuing inability to provide counselling. Similarly, Pınar (2010) identifies low levels of access to contraceptives among Ankara women in peri-menopausal period.

¹¹ Over the first decade of the 2000s, Turkish Gynaecology and Obstetrics Association’s publications regularly discussed the high prevalence of caesarean deliveries. For instance, Dölen and Özdeğirmenci 2004.

circulate within them (Bourdieu 1987; Santos 1987). Understanding law in this way allows a profound grasp of how certain discourses become hegemonic in and through law (Ewick and Silbey 1998; Merry 1990), how they can in turn be challenged by competing discourses through the same (legal) means (Merry 2000; Lazarus-Black and Hirsch 1994), and subsequently, how law plays a constitutive role in society (Hunt 1991; Silbey and Sarat 1987).

I contend that understanding the abortion/caesareans controversy of Summer 2012 and its consequences requires a constitutive approach to law, so far as both mobilisation of law in this instance and the consequences it set in motion defy the linear causality that instrumentalist approaches purport. During and after the controversy, complete formal inaction on the side of both government actors and women's groups was offset by the extensive use of legal idioms, above all rights talk, and threats to resort to formal legal channels by all parties involved. In acknowledging that the "efforts to create and give meaning to norms, through a language of rights, often and importantly occur outside formal legal institutions such as courts," (Minow 1987: 1862), socio-legal scholarship offers the necessary theoretical tools to unpack the complexity of the processes through which actors (be it politicians, healthcare workers, or activists) mobilise law, and in doing so enable law to produce unpredictable effects.

Through this theoretical lens, I contend that one of the most significant consequences of the controversy was that it generated ambiguity with regards to the legal status of reproductive healthcare practises. This ambiguity was accentuated by the ferocity of the abortion debate, widely covered by the press. It is on this legal ambiguity, and the way that it affected how healthcare employees understood and acted on the legal

limits to their profession, that my dissertation focuses in order to make sense of the transformations of the reproductive healthcare delivery patterns.

Overall, this dissertation is an inquiry into the meaning-making processes of non-legal actors about law both as a constraint over their actions and as a potential resource that they can strategically mobilise. Through this inquiry, I hope not only to add one more empirical study to law and society studies literature, but also to bring a theoretical contribution: On the one hand, socio-legal scholarship has traditionally focused on disputing and dispute resolution processes, giving the area a court-centred orientation. More recently, scholarly attention has shifted towards the notion of “legal consciousness” (Ewick and Silbey 1998; Kirkland 2008; Nielsen 2000), which offered a richer understanding of how law functions as a force in the construction of social reality, much of which takes place far away from the courts (Falk More 1978). Indeed, through this body of work, the ways in which law becomes a hegemonic force and gain the power to (de)legitimise certain social practises has been more thoroughly theorised and empirically explored. Yet, the tendency in the literature “to deemphasize statutory provisions, the various forms of delegated legislation, and, above all, administrative regulations, directives, guidelines, and codes of practice” (Vincent 1994: 118) lingered, even though many acknowledged that these more mundane aspects of law affect people’s, and especially women’s, daily lives much more considerably (Smart 1989). Consequently, administrative law, and the ways that it impinges on social and cultural meaning-making processes, and the modes of resistance that local actors develop against its provisions, have been left largely unexplored. On the other hand, even though practically every socio-legal scholar has to deal with the question of law’s ambiguity at

some point, the concept has not been explored extensively; the scholarship on organisations (Edelman 1992, Kelman 1981) and the recent literature on immigration (Menjivar 2006; Kubal 2013) being exceptions. I hope my dissertation will make a timely contribution to the literature, arriving at a historical moment when national and supra-national legal institutions proliferate and various legal constructs come to suffuse into ever more aspects of our lives.

Overview of the Chapters

The next chapter lays out the methodology that I used in conducting the fieldwork upon which this dissertation is based. Apart from presenting the methodological premises that I built on while conducting research and analysing data, the chapter also describes how I designed the research and gives a detailed account of fieldwork and analysis processes.

Chapter 3 depicts the irony underlying the dynamics that the abortion debate unleashed, namely, the fact that an abortion rights movement has become possible in Turkey only when the right to abortion became under attack. To this aim, it first sketches out the state of affairs in the area of reproductive health and activists' vain endeavours to organise for reproductive rights prior to the debate. It then presents a rather lengthy discussion of the general political climate that loomed over Turkey throughout the past decade, with an emphasis on gender. Indeed, as reproductive health employees work almost exclusively with women, the broader outlook of gender politics affects their professional field disproportionately. On the other hand, the abortion campaign activists had been organising under these conditions since before the controversy began. This discussion thus seeks to give the reader a general sense of the environment from which

the actors in this study drew their general frame of reference while thinking and talking about gender, reproduction, and law. As law does not mechanically determine individual action, and "... needs to be resituated among a number of other, non-judicial mechanisms," (Foucault 1980: 141) contextualising the 2012 debate within the broader political trends in the country is indispensable. Finally, the chapter offers a detailed account of the twists and turns that the controversy took over the Summer 2012, showing how the area of reproductive healthcare, previously consigned to expert knowledge and only occasionally implicated in law and politics, became shrouded in legal language through public statements and actions.

Chapter 4 focuses on the portion of the fieldwork conducted among abortion rights activists. As women from a variety of political organisations in Istanbul saw in Erdoğan's outburst an opportunity to finally organise advocacy for reproductive rights, they came together and quickly mobilised during the Summer 2012. The focus of the chapter is on this initial stage of mobilisation, and more specifically it asks what prompted activists to adopt a rights frame as the basis of their campaign. The chapter describes activists' ideas about the favourability of the rights language for their purposes and documents their endeavour to give new, empowering meanings to their use of rights idioms. Acutely aware that rights on paper do not guarantee concrete remedies, activists sought to articulate a comprehensive politics centring around, but going beyond formal rights. In addition, the chapter explains why activists refrained from resorting to formal legal channels for securing abortion rights, despite their espousal of legal language. By and large, this chapter stands as a reminder that people are not simply "duped" by the

promise of rights, but that they make strategic choices under the conditions that they have not chosen themselves.

I call Chapter 5 “an interlude”, because this is where I take a step back from my main narrative in order to convey the reader some idea about the overarching organisation of the Turkish healthcare regime, and the place of reproductive healthcare practises within it. As a series of structural transformations, commonly described as neoliberal in nature, have been implemented in the area of healthcare over the last decade, this endeavour is at times challenging but also indispensable. My initial goal in writing this chapter was, by tracing these transformations, simply to provide context for the following chapters which delve into healthcare employee’s worlds. Yet, as it proceeds from second-hand accounts of the healthcare system to what my respondents had to say about their own work environment, the chapter moves beyond merely descriptive and presents part of my analysis. In other words, the context in this case turns out to be not merely the background against which the drama is played out, but very much a part of the drama itself. The chapter thus presents some explanation regarding the inaccessibility of reproductive healthcare in the public sector.

The more explicitly analytical points about how law and legal ambiguity operate in health workers’ real-life practise are presented in Chapters 6 and 7. I begin Chapter 6 with an account of the limits that my respondents reported observing while practising their profession, such as the time limit for abortion. The idea that I build on here is that written laws and rules are not put in practise without mediation, but have to go through the filter of health workers’ interpretation—that is, they need to go through a process of translation—in order to turn into real-life practise. Such a process of translation, of

course, does not occur in vacuum. Rather, it is inherently dependent on the broader legal and political environment within which it is undertaken. The chapter thus embarks on delineating those influences on the ways that health workers draw the limits to the legality of their actions. How do health workers understand the limits that law places upon their profession? How are their interpretations of the scope of those limits transformed by the Summer 2012 debate? How do these understandings guide their everyday practises? In other words, how do laws, and the controversies that revolved around legal language come to produce material effects at the level of concrete service provision?

The transformations described in the Chapter 5 help explain the dynamics of this translation. But in order to move beyond this partial explanation, I focus in Chapter 6 more closely on the idea of legal ambiguity, and show how it lead health workers to adopt narrow and strict limits to certain practises but not to others. I contend that understanding the problem of access plaguing reproductive health delivery cannot be simplistically explained on the basis of the fear that a powerful statesman created among state employees, much less by his capacity to render his point of view hegemonic. Instead, through a grounded analysis of health workers' accounts, I argue that the very notion of rights creates certain unforeseeable effects over providers' decisions. More specifically, providers counterpoise the notion of patients' rights against women's rights, and single out their fear of being sued to explain why they draw restrictive and rigid limits to their practise. Chapter 7 furthers this analysis by exploring how health workers reconcile their expressed support for women's right to access to reproductive health services with their unwillingness to offer certain services or selectiveness in deciding

when and to whom to offer those. Here, the analysis circles back to the political climate in Turkey, and links the health workers' accounts to the broader trends of neoliberalisation and neoconservatisation.

All of these analyses present a rather bleak picture for women who seek access to reproductive healthcare in Turkey. Not only are there systemic barriers to affordable and available reproductive healthcare, but the dynamics that are at play at the level of routine service delivery in healthcare institutions raise the question of whether the notion of rights is a useful tool for those who want to expand women's freedoms. I follow this thread in Chapter 8, and return to activists' accounts to explore more explicitly the "effectiveness" of rights claiming in this context. While acutely aware of the persisting (even worsening) shortcomings at the level of service delivery, and at times critical of their own campaign language and strategies, activists did not see their campaign of Summer 2012 as ineffective. Instead, they drew my attention to some other ways that the campaign had, in their view, generated very important and positive effects. In other words, this chapter makes the case that just as rights produced certain unforeseeable consequences for reproductive health delivery, they did the same in terms of serving movement goals.

Ultimately, the dissertation underlines the contextual nature of rights. Indeed, there is no way of positively determining whether rights do or can "work" in the desired way—the only thing social science tools can achieve to do is to observe and analyse what work, intended or unintended, they accomplish under particular influences in specific contexts. The case at hand, if anything, suggests both caution and some hope as to the potential of rights. On the one hand, not just academia, but also social movements in general and the

feminist movement in particular, could benefit from a keener appreciation of this contextual nature of rights. On the other hand, the abortion rights campaign in Turkey brings back the idea that “[r]ights claims assert women’s selfhood collectively, thereby giving women a sense of group identity and pride; they make manifest the fact that women can act and claim their place in history” (Schneider 2008: 14). I hope that my dissertation will (and who knows, perhaps in an unintended and roundabout way!) contribute to a more productive engagement of law and rights with women’s struggles.

CHAPTER 2

DATA AND METHODS

Methodological Premises

The research puzzle and questions that I presented in the previous chapter drove me to adopt a qualitative rather than quantitative methodology. As I sought to explore how reproductive health workers envisioned the limits of the legal in the legally ambiguous terrain, and how activists strategically mobilised rights language, my research was an inquiry into the ways in which people, more specifically in this case health professionals and activists, made sense of law, adopted or resisted particular claims about law, and acted upon these understandings. In other words, I studied the meaning-making processes regarding law, and how those meanings gained transformative power over everyday actions when they become prevalent. A close scrutiny of the meaning-making processes and their reflections on everyday activities, as well as attention to historical and contextual specificity, rendered qualitative methods and an interpretive analytical approach the best fit for this endeavour.

Institutional ethnography, an approach developed by the feminist sociologist Dorothy Smith, inspired my methodological design. As a mode of inquiry, institutional ethnography is built upon the premise that in contemporary world, everyday life is organised to a large extent by trans-local social relations such as bureaucracy, administration, management, as well as the complex of scientific, technical, and cultural discourses (Smith 2005). Smith calls these social relations “relations of ruling”, since they penetrate, coordinate, and preside over local settings. The goal of the institutional

ethnographer is to make these relations visible, so as to understand how trans-local coordination becomes possible across settings that can be vastly different from one another. To this aim, particular settings penetrated by a given relation of ruling are studied. The linkages between the local setting and broader political, social, economic, and cultural power relations are made. Accordingly, this approach promotes the use of ethnography for gathering data and linking ethnographic data to supra-local social structures and processes.¹²

In this vein, the analysis that I present in the following chapters is based on an interpretation of what people do (the “work” that they achieve) and the ways that they talk about it (institutional discourses). The concepts of work and discourse orient the analytical focus toward the interface between institutional¹³ relations and individual embodiment of these relations. My focus, henceforth, is on this interface rather than on individuals themselves.

At one level, this framework is helpful in revealing how legal ambiguity gives rise to shared patterns in routine activities across physically remote healthcare institutions as

¹² George Smith (1990) enumerates the distinctive features of studies adopting institutional ethnography method as follows:

(1) start from the actual lives of people and undertake an analysis of a world known reflexively; (2) stake out an ontological commitment to a social order constituted in the practises and activities of people; (3) take, as their analytic, the notion of “social relations”; (4) are based on the use of meetings with government officials and professional cadres as ethnographic data; (5) analyze texts such as media reports, legislation, internal agency memoranda, annual reports of government departments, in developing a description of how a ruling regime works; and (6) illustrate the necessity of bracketing ordinary political explanations in order to provide a scientific account of the social organization of a ruling regime.

¹³ In Dorothy Smith’s framework, “institution” does not merely denote a particular type of organisation, but it refers to nexus of coordinated discourses, courses of action, and processes that take place at various sites (Smith 2005). My references to hospitals and clinics henceforth should not be conflated with this methodological conceptualisation of institutions.

health workers try to make sense of the laws and manage their actions accordingly. At another level, institutional ethnography offers an insightful perspective on activist engagement with institutional discourses, and on interactions between social movements and the state (Walker 1990).

As is typical in qualitative inquiry, my research is not so much driven by “variables” that I seek to measure but rather by an endeavour to understand phenomena within the contexts that they take place (Goodwin and Horowitz 2002: 36). Equally importantly, in seeking to understand the ways in which law works as a relation of ruling, I do not have a claim to be able to “isolate” the effects of law from other domains of influence. To the contrary, I aim to understand how law simultaneously assumes both regulatory and contentious roles “as an always potentially present dimension of social relations” (Hunt 1993: 3). Put differently, I consider law as being “seamlessly part of politics and culture;” and suggest that while “this notion of [law being] ‘seamlessly part’ [of politics and culture] undermines the ability to specify and verify causal claims about the constitutive capacity of law (Paris 2010: 29), it also opens room for a better grounded interpretive understanding. Therefore, following Michael McCann’s approach (1994) to law and legal mobilisation, I consider placing the phenomena I seek to understand within their broader political and economic contexts constitutes part of the analysis itself.

Research Tools

The primary methodological tool that I use is in-depth interviews with actors variously situated within the field: doctors, nurses, hospital administrators, as well as people working in the area of reproductive health in different positions (for instance, educators)

and activists from women's rights groups and professional organisations. I use the interviews "...not as windows on the informants' inner experience but in order to reveal the "relations of ruling" that shape local experiences" (DeVault and McCoy 2006:15). In other words, I employ the interviews for revealing the connections across local settings, hence to discern larger regulatory mechanisms that operate in and through local practises. To quote from DeVault and McCoy once more, my purpose "is not to generalize about the group of people interviewed, but to find and describe social processes that have generalizing effects" (*ibid* 18). Interviews work as tools for exploring which discourses, texts, and other coordinating mechanisms push actors to take on particular courses of action in a legally ambiguous environment, and how.

In addition to interviews, I undertook on-site observations in chosen healthcare institutions as permitted by the circumstances. Complementing interviews with on-site observations was meant to help me better comprehend and contextualise the "work knowledges" of my informants, that is, their own understandings of the working of institutions in which they are situated. In order to "extrapolate" from the ethnographic data thus collected to underlying socio-political structures and processes, I used secondary academic research and archival research of official state documents. Finally, to describe the abortion/caesarean controversy and adequately deliver the atmosphere that it created, I conducted a selective study of media coverage and public statements by both state agents and activists.

Site Selection

One part of my research took place in healthcare institutions, to which end I conducted

fieldwork during nine months in two cities in Turkey from Summer 2014 to Spring 2015. The names as well as characteristics of the cities are not identified in the dissertation for purposes of protecting the anonymity of my respondents, and are referred to as “Eastpointe” and “Westpointe” throughout. Those pseudonyms, while thoroughly unimaginative, were selected to connote the population compositions of the cities: Westpointe is a rather large and diverse city in the West of the country, whereas the smaller town of Eastpointe is in the Kurdish region of the country and comprises a predominantly Kurdish population. This distinction in fact was the determining factor in selecting these two cities as my broader interview sites; I hence chose pseudonyms that would be a reminder thereof.

The idea of including spatial diversity into the research design was meant, above all else, to ascertain that the phenomena observed were not contingent on any local specificity but originated in the legal, political and cultural context that I consider at the national level in this study. Furthermore, including multiple sites to the research would not only enable this verification, but it would also allow me to bring in a comparative dimension to the research.

The two most important axes of comparison that are relevant to my study in contemporary Turkey are class and ethnicity. The ways that class can figure into reproductive health are obvious: It is well documented that even in national contexts where abortion is strictly prohibited, women of means have little difficulty in accessing safe abortions performed by qualified experts (Kligman 1998). I therefore began my fieldwork with the premise of focussing particularly on two neighbourhoods in Westpointe: One working-class neighbourhood in the outskirts of the city and a

relatively affluent one situated at the city centre.

The Turkish state's discriminatory and oppressive actions in the Kurdish region of the country, which at times reached atrocious proportions, are well documented (Beşikçi 1991; Aygün 2011). What has drawn less scholarly attention is the state's population policy in the region. Indeed, Kurds in general and Kurdish women in particular have always been portrayed as the bearers of tradition in need to be "modernised" by the Turkish state; a variety of policies have been adopted throughout the Republican era to achieve this modernisation by educating Kurdish women both through formal schooling and through trainings in modern house- and child-care (Bayraktar 2009). Within this framework, high fertility rates in the region were singled out as one of the most important indicators as well as consequences of Kurdish "backwardness." While going into further details of this discussion is not relevant for my purposes here, I do want to underline its power within the national imaginary—not only in the Kurdish region, but also across ethnic boundaries. For instance, it is difficult to miss the racist tone in the sentence "Every Turkish family should have three children," which Erdoğan has uttered on several occasions: The fear that the Turkish population will be outnumbered by the overpopulating Kurds, indeed, is a familiar idiom for observers of Turkey. I henceforth decided to include a Kurdish-majority city in my research design in order to find out whether the emerging pro-natalism of the AKP targeted the Turkish population exclusively or whether it involved ethnic minorities such as Kurds as well. In other words, my decision to include Eastpointe in my study was shaped by the notion that divergent population policies could be implemented in the Kurdish and non-Kurdish regions of the country, or that healthcare employees working in Kurdish cities could

receive different messages from the Ministry of Health. For instance, while health workers in Westpointe felt that the government was hostile to contraception and abortion, those in Eastpointe could receive the opposite signals.

The process of fieldwork and analysis revealed that this comparison did not work the way I expected it to. Class differences in healthcare services emerged not at the spatial level but between the public and the private sectors: The state hospital and neighbourhood clinics in the affluent neighbourhood of Westpointe catered to working class patients commuting to the hospital from various different parts of the city, or even from nearby towns. On the other hand, private hospitals and clinics that had mushroomed in the working-class neighbourhood served a mixed population, depending on whether they were subcontracted with the Ministry of Health or not; contracted hospitals catered to working class patients, whereas middle- and upper-classes were served by non-contracted private institutions.

In a similar vein, the theme of Kurdish “difference” with respect to fertility repeatedly came out during my interviews in both Westpointe and Eastpointe. For instance, Şirin from Westpointe narrated an altercation that she once had with a patient, and explained the tension on the basis of her patient being Kurdish:

...She got angry, and said “You are trying to exterminate us.” That person was an Easterner. (Şirin, nurse at Westpointe neighbourhood family planning clinic)

For Şirin, Kurdishness (or as she calls it, being an Easterner) worked as an explanation for the provider–patient tensions and she did not accord much importance to the words of the patient: She used Kurdishness to explain not only the patient’s inadequacy in properly using contraception, but also her perceived aggressiveness, while she summarily

discarded the her patient's grievance about ethnic discrimination. Yet, the idiom of extermination holds a much more central place in Eastpointe: While impossible to conform, the idea that the Turkish state sought to limit the increase of Kurdish population through forced sterilisations and involuntary application of contraceptives resonates strongly with the local cultural repertoire in the Kurdish region. It does, however, not mean that people in Kurdish cities buy into this idea: Often, my respondents brought up this idea without being prompted—but not to uphold, rather, to refute it:

I see these as conspiracy theories. Of course, I haven't seen the 1980s, but I've seen the 1990s. ...Also, half of the Kurdish population lives outside of Kurdistan. Let's assume they are doing this [implementing anti-natalism] here, what will you do about Kurds living in other cities? People have to and apply to a doctor to get contraception, but you can't go to their homes to push this. So I don't think there is a basis for these claims. (Şeyhmus, Eastpointe family physician)

Indeed, in terms of the ways in which reproductive health services were offered and healthcare employees talked about their practises, I was not able to identify any notable differences. I therefore had to forgo the comparative angle of the original design and analysed together all the material that I collected. At the end of the day, including multiple sites to the research worked more as a mechanism of check rather than a comparative tool.

I am not arguing that class and ethnicity had no relevance for reproductive health delivery in healthcare institutions. Indeed, one of the themes that consistently emerged from my interviews was “education,” which health workers used as a proxy for talking about class (and to a certain extent, ethnicity) but which also worked in more complex ways. For instance, patients using public facilities were, as a rule, considered ignorant,

regardless of their actual educational background. Requesting an abortion was considered as undeniable proof that a woman was ignorant, because it meant that she did not know how to (appropriately) use contraception. Yet, those requesting contraceptive methods were not free from the same label. For instance, a woman's reluctance to be examined by a male provider was also a sign of ignorance. Yet, of course, even well-educated, middle- and upper-class women need abortions and contraceptive methods. In those cases, health workers would express surprise like Osman did:

For instance, earlier today a young girl came here, she's studying robotics at [very prestigious university]. You would expect her to know [about contraception] very well; she went to very good schools, she had a good education... But she said she had used morning-after pills three times over the past two months. And today, she says she had a risky intercourse two days ago, asks whether she could use it once more. . . . On the basis of my experience here, I know it very well, that university students are nowhere you would expect them to be.

(Osman, ob/gyn at public Westpointe neighbourhood clinic)

Unfortunately, I came to notice this theme only during the analysis stage. But insofar as this was not among the subjects in which I was initially interested, I had not followed it through during my interviews, and I discovered, to my dismay, that the material I had gathered was not rich enough for me to present an adequately sophisticated interpretation of class issues. Similarly, although daily routines and ways of making sense of/acting upon legal regulations were not significantly different in Eastpointe and Westpointe, maintaining that ethnicity did play no role at all in reproductive health delivery would be misleading. Rather, because my focus was closely on law and legal regulation, I ended up leaving the dynamics of patient-provider relationships, heavily influenced by class and ethnicity, to a large extent outside the purview of dissertation.

While in the original research design, I also projected to interview activists in these two cities, both time constraints and the unusual circumstances that loomed over the activist circles in the Kurdish region during the time of my fieldwork, I interviewed activists only in Istanbul, the largest city of the country. While reproductive rights activism flourished in many cities across the country during the summer of 2012, Istanbul can be considered as the most important hub of this mobilisation, not the least because it mobilised far greater numbers compared to any other city. Furthermore, the alliance that is the primary focus of this part of my research, namely, Abortion Is A Right Platform played a leading role in the process of mobilisation: On the one hand, they took on the most responsibility in the production of campaign material such as press releases, leaflets and visuals, which prompted them to engage in lengthy and thoughtful discussion about rights idioms, which is my focus in this part of the research. On the other hand, they also assumed the role of coordinating different cities for a countrywide mobilisation. While women Westpointe and Eastpointe also organised extensively in 2012, the political framework as well as most of the material they used also borrowed a lot of their material from the Istanbul-based platform.¹⁴

Participant Selection

Participants for interviewing were selected by a combination of theoretical and snowball samplings. In theoretical sampling, participants are selected not “randomly” to achieve representativeness, but purposefully so as to include participants representing different

¹⁴ One exception to this is Ankara, the capital city, where there also were heated discussions about the issue. The coalition built around the issue in Ankara was independent in articulating their own political framework. Due to time constraints, I was not able to include those discussions in the present study.

categories that are determined from the researcher's theoretical perspective. Data collection continues until the point of "theoretical saturation" is reached (Glaser and Strauss 2006 [1967]). The process of sampling is guided by, and the saturation point is determined on the basis of the research process and the emergent theory, rather than according to pre-determined criteria (such as a given number of cases) (Emerson and Fretz 2011).

As I discussed earlier in this chapter, my purpose with this study is not seek generalizability or representativeness, but to reveal the *generalising* effects that are produced by law. That is, rather than seeking to find out the most predominant interpretation of a given law among my respondents, I aim to explore how processes pertaining to law, like the abortion/caesarean debate and the rights mobilisation that ensued, generate certain new tendencies in reproductive healthcare delivery across different healthcare institutions. My criterion for selecting (rather than sampling) participants was therefore based on an attempt to include respondents who occupied different positions within the healthcare structure. I hence sought to interview doctors and nurses working at different types of public and private hospitals and clinics until new themes stopped emerging from those interviews.

My field entry into healthcare institutions was facilitated by my contacts within the Turkish Medical Association who initially served as references for me as I presented myself to my prospective respondents. My first round of respondents then became my contact persons for other interviewees. On certain occasions where I was unable to find contact persons, I simply went into the institutions that I had chosen in the afternoon

(usually a lighter time of the day in reproductive health provision) and presented myself to the personnel. Many consented to interviews even then.

My experience as a researcher was slightly different in Eastpointe than in Westpointe. While I easily passed as a “native” in Westpointe, I was equally visibly an “outsider” in Eastpointe. Rather than being an obstacle, this difference worked to my advantage in Eastpointe: While I was just another young woman whom my respondents helped by sparing their times in Westpointe, health workers in Eastpointe saw me either as a guest or an ally. Indeed, most, if not all, healthcare employees that I interviewed in Kurdistan were Kurdish, and most were sensitive to the issues of ethnic conflict. The sheer fact that I was wondering around by myself in a Kurdish city (as Rusen said, the fact that I had gone to Kurdistan without being afraid) led to their seal of approval, facilitating the rapport between myself and my interviewees.

Respondents from professional organisations were invited to the study through a similar approach. I sought to interview representatives from various professional medical and legal organisations that were involved in the debate, either through their own actions, statements, and stance that they took, or through giving support to Abortion Is A Right Platform.

Selecting participants from Abortion Is A Right Platform was both easier and trickier. As a member of a feminist organisation myself, I had participated in all the activities of the abortion campaign throughout the summer of 2012. I thus had personal connections with most people involved with the campaign. I sought to interview first and foremost those women who were active, to borrow their own term, in the “kitchen” of the organisation—that is, those who had devoted more time, joined working groups,

and were engaged in the political and strategic discussions that ultimately shaped the political and discursive framework of the campaign as opposed to those who only showed up during street protests. Not coincidentally, most activists in this group are members of feminist organisations, so feminists are in a sense overrepresented in my study. Yet, interviews with a relatively small number of women from political parties, labour organisations and other groups who were active organisers are also included into the analysis.

Data Collection

For purposes of responsiveness and flexibility that are core principles of institutional ethnography, I adopted an interview guide approach or, as some others call it, semi-structured interviews. This approach requires the interviewer to cover a predetermined list of topics, but allows her to make modifications during the interview in terms of wording and sequencing of questions, use of probes, conversational engagement etc. (Patton 2002: 343). Furthermore, such an approach allows the researcher to include new questions and themes that emerge during the early stages of the research. As expected, I modified my interview guides throughout the fieldwork: For instance, during my interviews with healthcare personnel, after a while I excluded the questions that pertained to ethnic difference. Instead, I began to ask more questions about experiences with legal institutions, as my respondents seemed to accord a great deal of importance to malpractice litigation. Appendix I displays the interview guides that I used, which I had to slightly modify before each interview to tailor it specifically to the person I would talk with. For instance, it would make little sense to ask practitioners at AÇSAPs the time

limits they observed about abortion because they cannot perform abortions at all. I therefore took these questions out before conducting an interview at an AÇSAP.

I interviewed 37 health workers and 14 activists. Appendix II shows the monthly interview schedule of my fieldwork. At the beginning of each interview, I orally delivered my consent request and asked permission for audio-recording the interview. While all activists (with the exception of one) consented to be voice-recorded, some of the health workers declined my request. I took extensive notes during those interviews and reconstructed them immediately after the interview. Interviews took, on average, about an hour. The shortest interview was a 20-minute session with a healthcare worker, which came to an abrupt end when my respondent's young baby cried and she requested to stop, and the longest one lasted almost an entire day with the voice recorder being turned on and off as I accompanied my respondent around the clinic during the day, which delivered a three-hour-long record. With two exceptions, all interviews with health personnel took place in the healthcare institution that the participants worked at. Interviews with activists took place in various settings: Party offices, Istanbul Bar Association's headquarters, and various coffee shops among other places.

In addition to interviews, I also conducted on-site observations in chosen institutions with the permission of the personnel, the duration of which ranged from a few hours to a few days. The selection was made, again, on the basis of theoretical sampling. I did not formally analyse the field notes that I took, but I consulted them regularly throughout the process of analysis and writing. As a result, these notes figure explicitly into the analysis only seldom in the following pages, but they have been extremely helpful for me in framing my analysis.

Discourses that were circulated publicly through mass media constitute an important dimension of the climate that emerged in the aftermath of the abortion/caesarean debate. What was especially relevant for me was the ways that legal talk became paramount in the controversy, and I sought to attend to how this legal talk was broadcasted to the larger public. Indeed, the mass media does not only disseminate information about law: At the same time, “[m]ass-manufactured legal knowledge constitutes and reconstitutes law itself” (Haltom and McCann 2004). Looking into the statements made by state actors and abortion activists was therefore important for me in order to scrutinise the ways that the parties to the debate used legal idioms as discursive tools. The study of media coverage of the abortion/caesarean controversy that I rely heavily on in Chapter 3 is mostly internet-based. Just days after the onset of the debate, I created Google alerts with the words *kürtaj* (abortion), *sezaryen* (caesarean), and *Sağlık Bakanlığı* (Ministry of Health). While this measure has brought an immense number of news entries to my attention, I sought to include one entry for each piece of information. Over the last years, neoliberalism has affected the press in Turkey as well: Fewer news outlets employ reporters and more of them choose to purchase their news from press agencies, most importantly from Anadolu Ajansı (AA) (Yeşil 2016). There was, therefore, little variation in the news reported in different newspapers,¹⁵ portals, and news websites. In selecting which news pieces to include into my archive, I picked the version that was the most detailed among the ones that surfaced on the Internet. The reader will thus see a wide range of different sources in Chapter 3, ranging from dailies that are seen almost

¹⁵ Certainly, this statement does not involve op-eds, the tone of which varies vastly according to the political leaning of the outlet in which they appear. I did not include the op-eds into the analysis, but only pieces that relayed information about new developments in the debate.

as party publications of the AKP to those associated with the Republican elite, from left-liberals to the explicitly socialist publications.

The official documents that I consulted are retrieved from the Ministry of Health website, the *Official Gazette*, the Grand Turkish Assembly website, and official websites of medical associations. While the abortion debate has revolved mostly around “the law,” which refers to the specific article concerning population planning in the Turkish Law, healthcare in Turkey is regulated largely through a conglomeration of codes, statuses, regulations, and ministerial notices. Although these official legal documents usually do not draw public interest, with their attention to minute detail, they inform the everyday activities of healthcare practitioners to a large degree. I did not conduct an extensive study of government documents, but I did search for and study specific regulations pertaining to my discussion, and those that were referenced by my informants.

At some points, I did also bring up quantitative indicators pertaining to reproductive health practises. I refrained from taking statistical data regarding reproductive health practises as unmediated truths: Indeed, in an area such as reproductive practises, which are not confined to official institutions, there is no way to track self-executed, home-based, or under-the-table treatments, therefore “...quantitative data on abortion and contraception, with all its unreliability, is best treated as signifiers, not as signifieds” (Halkias 2004: 45). Where needed, I reference the statistics from the national-level demographic research conducted every five years by Hacettepe University in Ankara (TNSA), and the Ministry of Health’s own records. Turkey. While another dissertation could have been written focussing primarily on how information coming from these sources is used by government officials and activists, it remained by and large out of the

focus of the present study. I hence reference them only to give a very general idea about the trends in reproductive healthcare in Turkey.

Analysis

I reconstructed all the interviews that were not voice-recorded immediately after the interview, and transcribed every voice-recorded interview during and after fieldwork. While I wanted to give voice to every person who participated in my research, I had to exclude five of the original 37 interviews from the analysis due to my own mistakes in storing voice recordings. Even though I feel remorse for not having been able to give voice to these respondents by quoting them directly, their contribution still figures into the analysis as they shared their insights with me, allowing me a window into the workings of healthcare institutions.

I analysed data using qualitative analysis software, ATLAS.ti. In analysing the data, I followed the conventional method of starting with line-by-line coding, identifying emergent themes, and working on this thematic classification through focussed coding. In other words, I had few pre-set codes and relied on open coding to identify the themes and patterns emerging from the interviews initially. I switched to focussed coding only after refining the initial codes. Even though I was specifically looking for themes relating to law, I did not have a formal pre-set list of codes, which allowed me more flexibility and openness in the initial stages of coding. While I sought to remain loyal to this mode of grounded analysis, I did not take my respondents' accounts as representations of "real" life or took them as "transparent" records of experience (Riessman 1993). Rather, by focussing on the inconsistencies within, and consistencies across interviews, I

endeavoured to advance my analysis of “relations of ruling” that generated those consistencies and inconsistencies in the first place. There were no significant divergent findings—that is, inconsistencies across—interviews pertaining to the arguments I present in the following chapters.

I did not undertake a similar kind of labour-intensive analysis when working with media coverage, but coded news pieces with reference to their main themes and retrieved them from database through these labels. All translations in the dissertation, unless otherwise noted, are mine.

In writing the dissertation, I attempted to give as much voice to my respondents as I could by directly quoting them. This is why I often present multiple quotes to illustrate key points. While their words had to go through the filter of my analysis, this seemed to be the best way to acknowledge their collaboration and valuable guidance. In other places, when different interviewee’s accounts were too similar to one another in terms of the ideas that they conveyed, I chose the quotes that were the most amenable to translation, as well as the most concise and articulate ones. For purposes of confidentiality, I gave pseudonyms to my respondents, deleted all identifying references and omitted certain details that could disclose participant identity.

A Note on Reliability

As a final note, I want to make it clear that as an interpretivist study, my dissertation does not aim at attaining “value-free objectivity,” which, as a scientific principle, has been contested as an impossible ideal by many (Porter 1995; Harding 1986). I endeavour, instead, to reach a deep and sophisticated understanding of the social world that we live

in through disciplined but critical research. Methodological rigour, coupled with flexibility and reflexivity, can yield compelling analyses and explanations of social phenomena, while avoiding the traps of unacknowledged biases.

This compels me to acknowledge my own standpoint at the beginning: As I noted earlier, I have been a feminist activist most of my adult life and I was not a disinterested observer during the debate or afterwards; I was an active organiser. Yet, I will maintain that this does not necessarily make me an unreliable reporter. To the contrary: I have vested interest in understanding how our actions as activists and organisers made a change and what could have been done differently, and better. My feminist background, in fact, motivated me to seek to be more rigorous and attentive in my analysis. I have tried to be as accurate and fair as I could be in reporting my findings, while at the same time I sought to go beyond mere description and craft a theoretical narrative.

CHAPTER 3

IRONIES OF LEGAL TALK: REPRODUCTION GOES CONTROVERSIAL

...I am saying this clearly: I am a prime minister who opposes Caesarean births. I see abortion as tantamount to murder. No one should have a right to allow this. Killing a baby inside its mother's belly or killing it after birth, there is no difference between the two. We are obliged to be more sensitive about this issue. We have to cooperate in our fight against this.¹⁶

Recep Tayyip Erdoğan on May 25, 2012

Then Turkish Prime Minister and current President of Republic Erdoğan's words, uttered in a speech on May 25, 2012, marked a breaking point in the politics of reproductive rights in Turkey. Not that the politicisation of women's reproductive capacities was unprecedented, nor did a statesman expressed his understandings about morality in such a forceful manner for the first time. But the public debate about abortion and Caesarean sections (and subsequently, about pregnancy follow-ups and contraception) that ensued was unmatched in the Republican history. Moreover, and ironically, rights activism pertaining to reproductive issues flourished for the first time in Turkey only upon this (and following) statement(s), which were explicitly aimed at criminalising abortion and caesarean sections.

This chapter will explore this irony by detailing the unfolding of the controversy pertaining to reproductive health practises over the Summer 2012. In this vein, it will begin by contextualising Erdoğan's statements, first within the state of affairs in reproductive healthcare provision, and then within the broader political and institutional

¹⁶ The speech was delivered as the concluding remarks at the International Parliamentarians' Conference on Population and Development. Retrieved from <http://www.hurriyet.com.tr/kurtaji-bir-cinayet-olarak-goruyorum-20630000> on December 12, 2016.

setting of the period between 2002-2012. By presenting the circumstances of reproductive health provision prior to the onset of the debate, I seek not only to offer background for the following chapters of this dissertation, but also to underline the fact that despite increasingly problematic access to abortion, feminists and health professionals were incapable of finding a way to politicise reproductive rights before Erdoğan's comments. The following section, by focussing on the AKP's gender policies in particular, will offer a partial explanation for this state of affairs. My argument is that the AKP's neoliberal welfare policies as well as its conservative gender politics were responsible for the increasing inaccessibility of abortion prior to the onset of the debate, and shaped to a large extent the provision of other reproductive healthcare services. Finally, I will detail the twists and turns that the controversy took throughout the Summer 2012. This final section will depict the ways that law was discursively mobilised by all parties involved in the controversy (that is, by government actors as well as political and professional activists), while this discursive mobilisation was accompanied by formal legal intervention to a very limited extent only.

From Banality to Inaccessibility

As I detailed in the introductory chapter, the restrictive policies on contraception and abortion in Turkey gave way to liberalisation in two waves, with the legalisation of contraceptives in 1965 and the legalisation of abortion on request in 1983. Both of these legal changes were initiated and implemented in a top-down fashion; and neither of them elicited a strong public response. Caesarean sections, on the other hand, were never seen as a legal matter until 2012. Consequently, there is no historical cut-off point at which

the practise of caesareans began in Turkey, they arguably were performed rather infrequently until the 1980s, and have become increasingly sought through the 1990s on.

Available statistical data on the post-1965 period¹⁷ suggests a steep increase in the number of women who received counselling about contraception and a moderate but continuous increase in the use of modern¹⁸ contraceptive methods countrywide: From 1963 to 2008, the prevalence of modern contraceptive use increased from 5.3% to 46% among married women between the ages 15-49. On the other hand, the legalisation of abortion in 1983 was followed by a period of relatively high numbers of abortion on request, and then showed a decreasing trend, as is typical in contexts where legal reform liberalises abortion (Senlet et al. 2001): From 12.1 abortions per 100 pregnancies in 1983, the prevalence increased to 23.6 in 1988, and then started to decrease steadily; until it plummeted at 10 per 100 pregnancies in 2008. Finally, caesarean section rates have steadily increased throughout the years on which data is available: While 8.1% of all births were caesarean deliveries in 1993, the number reached 36.7% in 2008 (41% when non-hospital births are excluded), well above the WHO-recommended rate of 15%. It is worth noting that these numbers do not show any significant difference from other national settings with similar economic and legal characteristics.

Relative silence about the issues accompanied these trends throughout the 1980s and 1990s; taken-for-granted legal status of contraception and abortion, and the non-legal

¹⁷ The figures presented here are retrieved from published TNSA reports between 1963 and 2008. TNSA is conducted every five years and the information it conveys accounts for the 5 years that precedes the study. Since I am focussing on the pre-2012 period in this section, I did not include the numbers that came from TNSA 2013.

¹⁸ The convention in medical literature is to draw a distinction between traditional contraception, which involves abstinence, *coitus interruptus* (withdrawal), and the calendar method; and modern methods such as tubal ligation, contraceptive pill, IUD, contraceptive injections, implants, condoms, diaphragm, and day-after pills.

character of caesareans placed these practises beyond the politicians', feminists', and the news media's attention. Conversation about contraception and caesareans was close to non-existent in non-medical circles throughout the 1990s and early 2000s. The legalisation of abortion on request prompted some reactions only during the days that immediately followed; as feminists criticised the law for the strict time limit it imposed and its spousal consent clause (Ovadia 1983).¹⁹

Media coverage of abortion during the 1980s, on the other hand, revolved mostly around the theme of high rates of abortion, with the implicit assertion that women, especially working-class and/or uneducated women, "lacked" the capacity to use effective birth control and consequently needed to seek abortion, overcrowding public hospitals and clinics.²⁰ At the heart of this critical tone lied not the immorality of abortion *per se*, but rather, the need to educate and "modernise" (ignorant) women. When abortion rates started to decline in the 1990s, media attention over the topic also decreased.

While research on perceptions and attitudes is scarce in Turkey, the existing literature suggests that abortion was perceived as a permissible practise by most people under

¹⁹ Another critique that feminists at the time voiced the concern over legal abortion encouraging irresponsible male responsibility (Ovadia 1983). This perspective, running quite contrary to contemporary feminist approaches, suggests that after the legalisation of abortion on request, men would feel even less pressure for using contraceptives. As I will discuss in the next chapter, my activist respondents did not completely abandon that theme; even though they were careful not to turn it into an argument against the legality of abortion, they nonetheless pointed at male irresponsibility.

²⁰ For instance, on January 11, 1984, one of the most widely read dailies, *Milliyet* published on its front page a news piece titled "Women Are in the Line for Abortion", next to a picture of a group of women wearing headscarves waiting in a hospital hall. The text relates the complaints of the head-physician of one of the public hospitals in Istanbul. Throughout the subsequent years, a handful of other news pieces on abortion made their way into the front page, sharing similar class and gender themes. Retrieved from <http://gazetearsivi.milliyet.com.tr/> on 12.13.2012.

some, if not all, circumstances (Gürsoy 1996). Frederic Shorter and Zeynep Angın's ethnographic work on working-class communities in Istanbul (1996) suggests that both contraception and abortion had not only been integrated into local cultural ideas and norms, but had also become part and parcel of the culturally specific ways of thinking and talking about love, sexuality, and gender. In other words, abortion and contraception were more or less widely used and openly discussed in these communities, without social stigma inevitably attached to them.

In a nutshell, during the last decade of the 1900s and the first decade of the 2000s, public interest in reproductive health services was dismal; abortion, which is typically the most controversial of these practises worldwide, was hardly a topic to be raised in the public space. On the other hand, abortion, contraception as well as caesareans were, at least in urban contexts, by and large normalised and "vernacularised." In the absence of public controversy around these practises, their use arguably became a rather "banal" procedure among both men and women.

Social workers and volunteers at the Purple Roof Women's Shelter (*Mor Çatı-MÇ*) were the first to notice that problems arose regarding with access to abortion in the late 2000s. MÇ was founded in 1990 by a group of feminists to fight against domestic violence, and today is the only women's shelter run by feminists in Turkey, independent from local or national government. As the first feminist institution in Turkey,²¹ its name

²¹ Oral histories on feminism in Turkey attest to the fact that feminism flourished in the post-1980 coup period, when women from leftist and Islamist organisations started to question their own experiences within those movements as the crackdown on oppositional politics closed the avenues for other kinds of political engagement. In the early 1980s, individual feminists came together for discussions, on the basis of which they started publishing articles first in left-wing magazines. In 1984, these women founded the Feminist Women's Entourage to translate the works of feminists in other countries into Turkish.

is almost equated with feminism countrywide, and it is widely accessible through the helpline of its Solidarity Centre: According to MÇ's website,²² on average 10 women reach the solidarity centre per day, not just for domestic violence complaints but for various other reasons as well. MÇ activists that I interviewed reported that throughout the years immediately preceding the 2012 controversy, the helpline was already receiving an increasing number of phone calls from women who had not been able to obtain abortion on request in public hospitals. However, they also report having been able, at the time, to locate other public institutions where the service was offered, and they had little difficulty in referring their applicants to these institutions. Therefore, during those days, the problem seemed less than systematic.

In 2009, an investigative journalist published an article in the left-wing daily *BirGün* (Denizaltı 2009), drawing the attention of medical as well as feminist circles to the issue but without attracting much interest beyond these communities. The article reported that most public hospitals in Istanbul did not offer abortion on request at all, and that single women were outright denied abortions. Feminists in Istanbul discussed the issue for a while, and their discussions led to a special issue on fertility and reproductive health practises in one of the feminist publications of the time, *Feminist Politika*, in 2010.

Around the same time, through the connections between Istanbul's feminist groups and Istanbul Medical Association's (*İstanbul Tabip Odası-İTO*) women's branch, İTO organised a panel on abortion at the end of the same year, inviting feminists, lawyers,

These efforts thus remained mostly intellectual in character until 1987, which is considered as the year the feminist movement moved into the streets with a campaign against domestic violence. The campaign, Women's Solidarity against Domestic Violence, initiated the process that heralded the establishment of MÇ in 1990 (Sirman 1989).

²² <https://www.morcati.org.tr/en/>

doctors, and public health experts as well as journalists. The proceedings of the panel were later printed in booklet format among İTO's publications. While there was some coverage of the panel in the news media, neither did it lead to widespread mobilisation nor did this effort catch the attention of the broader public. In so many words, whereas both feminists and health professional were well aware of the sea change, it was not possible for them to organise strongly around these themes even after evidence emerged that access to abortion became extremely limited, precisely because its legal status was seen as unproblematic.

The research on abortion that I conducted in public healthcare institutions between 2010 and 2011 confirmed those impressionistic accounts. Not that a consistent anti-abortion policy was imposed on health institutions from above. Rather, individual hospitals (or for that matter, individual physicians) had certain flexibility in determining their own policy with respect to abortion: The law specified the criteria for being eligible to offer abortion on request, but did not specify which institutions, which units, and which healthcare employees *had to* offer those, failing to provide the service when requested did not have legal ramifications. There was, therefore, a large room for what I called “institutional improvisation” for determining the criteria and procedures for offering and/or denying abortions in public facilities (Toksöz 2011).

The intriguing question was, why did the silence of the law about allocating responsibility did not pose a hindrance to the delivery of abortion services throughout the first two decades after the legalisation, but became an impediment to access only in the late 2000s? I suggest that the answer to this question is ingrained within the broader transformations of the national political context. Furthermore, these contextual

circumstances are also crucial in understanding the 2012 controversy and its effects. In a nutshell, the coming to power of the AKP, its implementation of neoliberal welfare policies on the one hand, and conservative gender policies on the other, to a great extent shaped (and continues to shape) the outlook of reproductive healthcare services. I will further delineate these transformations in the next section to single out these contextual factors surrounding the controversy and the provision of reproductive health services.

Politics of Gender under the AKP's "Unholy Alliance"

Much ink has been spilled on discussions about what the AKP years meant for women in Turkey. Those mostly revolved around the Islamic pedigree of the party: The AKP acceded to power in November 2002 elections as a newly established party by the reformist wing of the dissolving Felicity Party²³ (*Fazilet Partisi*–FP). Going against the grain of the tradition of National Outlook²⁴ from which it originated, the party presented itself as a “conservative democrat” organisation, committed both to the values of Western democracy and Turkish traditionalism alongside with free market capitalism. While this meant a break from more radical Islamist discourses on the part of the party officials (Coşar and Özman 2007), which allowed the AKP to entrench its position in centre-right politics and thus gain the support of large segments of society, commentators nonetheless expressed concerns about the party’s “hidden agenda”

²³ Political Islam, or at least one particular branch of it, namely the National Outlook movement came to be represented in Turkish politics through a succession of political parties under Necmettin Erbakan’s leadership from the 1970s onwards. Throughout the years, as the Constitutional Court of Turkey ruled for the dissolution of one of these parties after another, the same cadres simply organised under new names.

²⁴ Committed to the ideology of “Islamic just order,” the National Outlook movement advocated a revival of Islamic morality and values in both political and economic spheres, and was thus perceived as an anti-systemic effort against capitalism as well as secularism.

(Heper 2005).²⁵ As scholars note, almost inevitably in this climate, the “AKP’s position with regard to women’s issues worked as a litmus test for its liberal image” (Coşar and Yeğenoğlu 2011: 10), as women’s social status had always worked as a measure of modernity and development throughout the Republican history.²⁶

Observers of contemporary Turkey, putting the party through this test, present a mixed gender record. The party’s rule brought about a series of legal reforms that were beneficial for women, especially in its first years during which its politics were marked by its endeavours for European Union accession (Fischer Onar and Müftüler-Baç 2011). The amendments to the Constitution, establishing gender equality as a constitutional principle and recognising the supremacy of international agreements (hence rendering international legislation such as CEDAW, the Convention for Elimination of Discrimination against Women, operational law); the adoption of the new Turkish Penal Code, whereby the provision that exonerated a rapist in case where he married the victim was repealed; and the changes made to the Labour Law extending the period of paid maternity leave are counted among the AKP’s “positive” gender record (Çitak and Tür 2008). On the other hand, the removal of legal bans over headscarf in public institutions, which for years had hindered many women’s access to education in public universities as well as employment opportunities as civil servants, have a rather mixed reception: Some

²⁵ Allegedly, hiding one’s commitment to Islamic principles in order to achieve political advantage on behalf of the religion, *takiyye*, is an ingrained tradition in Islam. The term, literally meaning “dissimulation,” dominated public discussion over the first decade of the AKP’s rule.

²⁶ Deniz Kandiyoti (1988) argues that as the new Republic pursued its quest for its own symbols and discourses, “the woman” emerged as the mediating term between tradition and Westernisation –as is common in postcolonial and third-world nationalist contexts (Chatterjee 1986)– and constituted the backbone of the emerging Turkish nationalism. Within this framework, the (formal) “emancipation” of women served as the yardstick of progress, as it meant distantiation from the Republic’s Islamist past.

see this as a democratising step opening more room for women in the public space, while others argue that it allows families to put more pressure on their female members to cover their hair, taking away from young women a viable excuse for not wearing the headscarf. Finally, the debate about criminalising adultery that flared in 2004 is seen as an incontestable marker of the party's Islamic agenda (Ayata and Tütüncü 2008).

Consequently, renowned scholars like Yeşim Arat (2010) call the AKP rule a “democratic paradox,” not only because the Republic's entrenched democratic institutions led to the spread of Orthodox Islamic ideas in the mainstream politics through majoritarian processes, but also because women partially benefited from this situation—the threat of a reversal in this trend notwithstanding.

Alongside those studies that pit the “gains” and “losses” brought about by formal legal reform and party politics, other scholars sought to capture larger scale transformations that are created by the processes engendered by the AKP's policies and discourses. This body of literature consistently emphasises that the party's conservatism, rather than its alleged Islamism, brings about vast consequences for women in that it entrenches patriarchy in various ways (Coşar and Yeğenoğlu 2011, Kandiyoti 2016). Following the lead of Wendy Brown's eloquent theorisation of the “unholy alliance” between neoliberalism and neoconservatism (2006), these scholars trace the ways in which neoliberal dismantling of the welfare state is both enabled and legitimised through conservative discourses and policies: As the state “retreats” (Eder 2010) from the provision of welfare, those responsibilities are transferred onto private actors. Within this framework, non-governmental organisations such as charities and private institutions become key actors in poverty alleviation and the provision of social services, whereas

care work is assigned to families. Patriarchal family norms that are entrenched through state policies, in turn, ensure that these responsibilities are allocated to women within families, whose unpaid labour cover for the societal demand for care work. In this way, the family works “both as a discursive tool in state politics, as well as a key site of state institutional practises, underlining its critical role in the restructuring of the state within a global context” (Yazıcı 2012: 110). Below, I discuss in further detail this politics that I call *familial*, and the corresponding form of including citizens into the polity on the basis of their position *vis-à-vis* the family, *familial citizenship*.

The neoliberal turn in Turkey is conventionally traced back to the late 1970s, when the shift from a national economy based on import-substitution industrialisation toward open markets was initiated. This transformation gained momentum with the IMF-backed economic transformation package of January 24, 1980. The radical transformations sought through the package were enabled by the 1980 military coup (Buğra 1994), which, through its unprecedented violence against all shades of political dissent (Mavioğlu 2005), left behind a depoliticised climate whereby workers’ and left movements were effectively subdued. Subsequently, the 1980s witnessed the integration into the global market through structural readjustment programmes and the uplifting of former market restrictions, which entailed the end of protectionism, a gradual decrease in public expenditures along with privatization of state assets and services, active encouragement of the private sector, and on-going marketization (Boratav and Yeldan 2006).

The transition triggered a series of political and economic crises throughout the 1980s and 1990s, culminating in a major economic crash in 2001 (Öniş 2003). These shock waves escalated into a legitimacy crisis of all political actors by the end of the

millennium, which promoted the dramatic rise of the AKP in the 2002 elections (Cizre and Yeldan 2005). After its ascent to power, the AKP was capable of overcoming those crises precisely because it accomplished to integrate neoconservatism into its neoliberal economic policy to an unmatched degree; it has henceforth been the most successful carrier of neoliberal policies in Turkey. Indeed, the moralised state power that neoconservatism promotes on the one hand, and privatisation of social problems that neoliberalism both prescribes and necessitates on the other tend to feed into and facilitate one another (Brown 2006). Consequently, a “successful” blend of the two does not only accelerate the erosion of democratic and egalitarian values within society, but it also restructures extant inequalities. Scholars commonly acknowledge that the reconfiguration of gender relations is one of the main pillars of this political project. As the “gender revolutions” of the 1970s gradually gave way to newly conservative gender ideologies, familialism emerged as a dominant paradigm in the government of societal relations.

Certainly, the AKP did not so much invent the family as a political tool, so far as “normative ideals about what the family is or should be, the roles and responsibilities of members of the family, and the proper relationships between the family and the state [...] are integral to [...] the ‘state/culture’ nexus” (Thomas 2011: 4) in all polities, and has been so in Turkey well before the AKP came to power. Indeed, the cherished republican reforms of the 1920s and 1930s increased women’s public presence and visibility significantly over the 20th century; yet, what they primarily sought was to “to equip Turkish women with the education and skills that would improve their contributions to the republican patriarchy by making them better wives and mothers” (Arat 1994:58)

rather than insuring their participation in public life as equal citizens. Likewise, female employment was considered secondary to that of their male counterparts as women's dependence was ingrained in both ideology and law. In this vein, Nükhet Sirman (2005: 148) describes familialism, an ever present element in Turkish politics, as a "gendered discourse in which the ideal citizen is inscribed as a sovereign husband and his dependent wife/mother than an individual, with the result that position within a familial discourse provides the person with status within the polity."

What distinguishes the politics of the AKP, therefore, is not familialism itself. Yet, familialism under the AKP rule was decidedly brought to new level through a series of both discursive and institutional practises. Under this new configuration, two mutually reinforcing trends became prominent: On the one hand, appropriation of (unpaid) female labour in and through family was accelerated, and on the other hand, women's prospects for eschewing this appropriation through paid employment were thoroughly constrained. In the remaining part of this section, focussing on the areas of paid employment and social services, I will trace the ways in which these trends operate.

Turkey presents an exception to the global trends of increasing participation of women into the formal work force with a 10 per cent decrease in the female employment from the late 1980s onwards (Buğra and Yakut Çakar 2010). One explanation for this phenomenon pertains to the effects of macroeconomic changes in the labour market: Over the last decades, the share of agriculture in the labour market shrunk, pushing many women employed as agricultural workers out of formal labour. The decrease in female employment was further accentuated by the increased the share of service sector

jobs, which characteristically require flexibilisation,²⁷ and are therefore more difficult to reconcile with family life. This macroeconomic shift posed a significant barrier to women's employment in the formal sector on both supply and demand side (İlkkaracan 2012). While a number of state incentives for employers to hire women workers have been implemented under the AKP regime, they remained rather shallow and have even been more harmful than beneficial. For instance, the women-friendly parts of the 2003 Labour Law extended paid maternity leave from 12 to 16 weeks, which only intensified employer unwillingness to hire women (Dedeoğlu 2012). At the same time, there is evidence that the increasing prominence of conservative values also constituted a setback to women's employment (Göksel 2013).

The decreasing trend in the formal sector was partially offset by women's participation into the informal labour market, mostly through piecemeal, home-based work (Dedeoğlu 2008).²⁸ Albeit typically very low, income generated through such jobs can bring immediate relief to women participating in the informal sector. Yet, from the lens of familialism, it can be argued that such work does neither interfere with women's domestic duties, nor does it threaten men's primary earner status within family—hence

²⁷ In *The Corrosion of Character*, Richard Sennett (1998) identifies flexibilisation as the main tenet of post-Fordist economy, which is reflected onto individual workers' lives in two ways: On the one hand, workers are required to become flexible in their skill sets—that is, to be ready to abandon one job and take on another as life-long careers in the same type of work become obliterated by rapid technological development. On the other hand, workers are expected to be flexible with their working conditions and be willing to work odd hours, work over time, and take on (sometimes more than one) part-time jobs, as service sector jobs typically require a non-regular work day.

²⁸ At the same time, it is important to note that the increasing availability of cheap female labour in the informal sector, especially in sectors such as textiles, both underpins Turkey's integration into the global market in the “race to the bottom” to cut labour costs, while at the same time serving the interests of the AKP's constituency of small-scale enterprise owners and thus cementing its political capital.

leave patriarchal norms intact (Toksöz 2012). In a nutshell, AKP's labour policies created an institutional environment that encouraged women's employment only selectively. This selective inclusion adhered to neoliberal principles in that it made cheap female labour widely available, while at the same time strengthening familialism. The labour policies that the AKP introduced thus have dubious emancipatory potential for women.

On the other side of the coin, AKP's welfare policies reinforced rather than counterbalanced familialism. Based on employment status rather than universal citizenship principle, Turkey's welfare system has historically been inegalitarian and corporatist, leaving large segments of society who do not participate in the formal labour market out of its security nets (Buğra and Candaş 2011). The AKP's major the social security reform that was implemented in 2008 was presented as a shift from this corporatist, paternalistic welfare apparatus toward an inclusive and egalitarian one. In line with global trends, the egalitarianism of the package was based on taking away certain rights and entitlements accorded to certain groups, thus establishing equality of disadvantage rather than broadening the scope of entitlements toward marginalised sectors of society (Şahin 2012). For instance, the 2008 reform increased the retirement age for women to that of men's, 65 years. This facially gender-neutral equality overlooked women's "second shift" at home and the fact that women's employment histories tend to be typically fragmented due to marriage, childbirth, and care work. It thereby pushed the chances of ever retiring beyond many women's reach, and by extension, diminished the lure of formal employment for many women (Kılıç 2008a). Other "special rights" enjoyed by women, such as maternal leave payments and breastfeeding assistance have also been reduced by the 2008 reform package. Within the

area of health insurance, “[t]hat women are no longer entitled to health security as dependents of their families forces them either into marriage, to benefit from insurance as dependent of a husband, or into accepting unfavourable working conditions” (Coşar and Yeğenoğlu 2009). Thus, by treating women as equal participants into labour force without intervening into extant substantive inequalities in real life, the package as a whole rendered women more vulnerable. As formal employment became both more inaccessible and less desirable, women’s dependency to family intensified (Kılıç 2008b).

Even when they acknowledged extant gender inequality, AKP’s social policies “reflect[ed] a patriarchal value system in which the traditional gender division of labour within the family is taken for granted and used as a point of reference” (Buğra and Yakut Çakar 2010: 519). Throughout the AKP years, state provision of child-, patient-, disabled-, and elderly-care was further curtailed. These needs were thus referred to private providers, among which family is particularly stressed as an option. Families were encouraged to meet those needs themselves through social assistance plans such as conditional cash transfers, as the alternative was to purchase care services from the private sector, a luxury that few could afford even when formally employed (Yazıcı 2008). Unsurprisingly, an overwhelming majority of social assistance recipients are women, as women are considered “deserving poor” so far as the prospect that they will spend the monies they receive for the good of their families rather than themselves is supposed to be stronger (Türkiye Aile Platformu). Programmes like Return to the Family (2005), which sought to “help” children institutionalised in state’s residential homes return to their families by presenting monetary incentives to families represent other attempts to lure women into taking on care work within family through social assistance.

Finally, AKP's gender violence policies, through their ineffectiveness, also reflect this familialism. Throughout the AKP rule, as laws instructing governmental bodies to open shelters were feebly enforced, the number of women's shelters remained decidedly low. Furthermore, ethnographic research suggests that women who sought help to rid themselves off of violent partners were consistently and methodically referred back to their families by shelter personnel (Yazıcı 2012; Ekal 2012). While the numbers of shelters remained substantively low, the late 2000s witnessed the establishment of hundreds of Family Guidance and Counselling Bureaus (*Aile İrşat ve Rehberlik Büroları*) across the country. Operated by the Directorate of Religious Affairs (*Diyanet İşleri Başkanlığı*),²⁹ the bureaus seek to "protect the family unit and values" according to their mission statement, and in practise work to deter women and men from seeking divorce (Sümer and Eslen-Ziya 2017).

These institutional practises, which generate material effects in women's daily lives, are bolstered and legitimised by discourses that invoke the familial as the key element in social and economic life. While the party's programmes, since earliest versions on, consistently highlighted the importance of family and women's vital role within it, the rhetoric of the family came to be increasingly stressed in the speeches and statements of

²⁹ *Diyanet* was established in the early years of the Turkish Republic as the official overseer of religious affairs to educate, allocate and pay religious professionals, and to supervise the content of Friday sermons among other duties. In a country that was allegedly founded on strictly secular principles and had no official religion, the state favouritism for Sunni Islam was thus institutionalised since the early years of the republic (Gözaydın 2008). The recent years also witnessed a tremendous increase in *Diyanet*'s budget, placing it among state institutions with the most expansive resources with a budget larger than many Ministries. For instance, according to the *Official Gazette*, *Diyanet*'s budget (retrieved from <http://www.resmigazete.gov.tr/eskiler/2014/12/20141226M1-1-12.pdf> on March 5th, 2017) is twice as large as the Ministry of Health's budget (retrieved from <http://www.resmigazete.gov.tr/eskiler/2014/12/20141226M1-1-26.pdf> on March 5th, 2017).

high-profile government officials in the latter part of the 2000s. Erdoğan's March 8, 2008 speech is singled out as a cornerstone in this process, whereby he voiced for the first time his belief that "every Turkish family needs to have at least three children," which he insistently repeated numerous times over the years.³⁰ The symbolic importance of the fact that this comment about families was made during the celebrations of International Women's Day highlights that it was women, rather than men, who were perceived as the actors to follow the party's prescriptions about ideal family size, not only through bearing but also by taking on the principal role in raising children (Kurtuluş Korkman 2015). At the same time, the party's aggressive discourse discarding gender equality in favour of the notion that "men and women are complementary"³¹ further naturalised the gender division of labour within families. The party's selective use of religious idioms became the most prominent in such statements about gender and the family, as Islam works as a "fertilizer" (Brown 2006) for the party's neoconservative discourse cherishing traditional gender roles and promoting the family as the cure for social problems, depoliticised through religious idioms (Yılmaz 2015).

In this vein, the party's religion-inflicted conservative discourse has cemented the seamless loop of neoliberal/neoconservative policies. The fact that discourses on the family are methodically turned into practise through the social and economic apparatus of the state, which in turn is further legitimised by religion-based family discourse, strengthened familialism in Turkish politics to an unprecedented degree. The definition

³⁰ Retrieved from <http://bianet.org/biamag/toplumsal-cinsiyet/105451-erdogan-kadinlar-dogurun-turk-milletinin-kokunu-kaziyacaklar> on January 15, 2017.

³¹ Erdoğan declared that he did not believe in gender equality in the Summer of 2010 for the first time, during his meeting with representatives of women's NGOs. Retrieved from <http://www.gazetevatan.com/-kadinla-erkek-esit-olamaz---318006-siyaset/> on January 15, 2017. Over the years, he repeated these words several times.

of women's status as citizens on the basis of their position within the family, inherent in familialism, thus became entrenched under the AKP rule, emphasising women's roles as wives and mothers at the expense of all possible alternative identities and ways of existing within society that they could assume.

The increasing inaccessibility of abortion prior to the 2012 controversy becomes intelligible when considered against this background. Both neoliberal transformations in the welfare structure, especially in the healthcare sector, and the AKP's familialism emerged as serious barriers to women's access to reproductive health services in the mid-2000s. At the same time, Erdoğan's initial statements about abortion and caesarean sections, the ways that other party officials furthered these remarks, and activists' responses to those assaults—that is, the abortion/caesarean controversy of Summer 2012 itself needs to be considered against this context. Indeed, the 2012 controversy was not the onset of the struggle over gender ideologies and practises in Turkey, even though it arguably was a turning point within it.

The Hot 2012 Summer

Mayhem erupted in news press and social media upon Erdoğan's May 25 statements. The next day, pushing back on these reactions, Erdoğan upheld his initial remarks, proclaiming "I see abortion as murder, and I call upon those circles and members of the media who oppose my comments: You live and breathe Uludere. I say every abortion is an Uludere,"³² by referring to the killing of 34 Kurdish civilians by Turkish military

³² Retrieved from <http://t24.com.tr/haber/erdogan-her-kurtaj-bir-uluderedir-diyorum,204853> on January 8, 2017.

drones near the Uludere (Roboski) village at the Turkish–Iraqi border the previous December.³³ In response, Istanbul’s feminist groups organised a sit-in in front of the Prime Minister’s Istanbul Office on May 27.³⁴ The press release that was read during the sit-in as well as the banners and slogans that were used brought together a variety of themes: On the one hand, the AKP’s patriarchal politics were denounced, and women’s historical struggle for abortion rights was evoked. On the other hand, the link that Erdoğan made between abortion and the Uludere incident was condemned as racist and the incident’s character of state crime was underlined.³⁵

Erdoğan responded to feminist protestors on May 29: “Some stand up and say, ‘having an abortion is a right. It’s women’s own right, you can’t interfere with it.’ Then you need to allow people to commit suicide. Why are you interfering with the guy throwing himself down the bridge, let him enjoy his right. This is absurd.” Pitting anti-abortion mobilisation in the USA against struggles for abortion rights, he alleged that laws controlling abortion in Western countries were stricter, implying that regulations needed to be made stricter in Turkey regarding both abortion and caesareans, and stated

³³ Roboski incident has been one of the most sensitive issues in Turkey over the last years. The chief of staff reported that the army had received intelligence pertaining to a group of PKK guerrillas crossing the border, and sent their drones as they detected movement across the border on the presumed guerrillas. It turned out that the guerrilla were not in the area, and army bombs fell on a group of smugglers finding their way home back from Iraq, most of whom were children. It seems hardly plausible, though, that the Turkish army, one of the best equipped in the region and even in the world, does not have the capacity to sort civilian smugglers apart from armed guerrilla forces. Erdoğan and his government fiercely defended army officials after the incident. Government investigation of the massacre that ensued was—arguably—intentionally incompetent, which was harshly criticised by the political opposition, by the Kurdish movement and human rights advocates in particular.

³⁴ Retrieved from <http://www.hurriyet.com.tr/basbakanlik-ofisi-onunde-kurtaj-protestosu-20638014> on January 8, 2017.

³⁵ Retrieved from <http://t24.com.tr/haber/feminist-kadinlardan-kurtaj-cylemi-rahmimiz-bizim-sezaryen-da-oluruz-kurtaj-da,204929> on January 11, 2017.

he had sent an order to “his” (then) Minister of Health Recep Akdağ to start working on new legislation on these two issues.³⁶ Recep Akdağ confirmed this initiative, detailing that the upper time limit of 10 weeks would be revised and potentially an outright prohibition might also be introduced. In a twist that later became one of the hot buttons in the debate, he added that if prohibition were to pass, children born out of pregnancies resulted from rape would be taken in state custody.³⁷ The President of the Human Rights Commission of the Turkish Parliament, Ayhan Sefer Üstün, supported Akdağ’s stance on pregnancies resulting from rape, saying that it was a question of human rights of the unborn.³⁸

As statements from high-end government officials attacking abortion and caesareans followed one another, mobilisation against them also grew. Different political groups launched street protests and demonstrations in various cities throughout Turkey over the last days of May. While discussions among activists followed different paths in Istanbul and Ankara, in both cities large coalitions were established by the first week of June. On June 1st, various women’s groups in Istanbul—feminist organisations, women branches of several political parties, unions and professional associations, and women from various left-leaning groups—held a meeting and discussed initiating a joint platform to

³⁶ Retrieved from <http://www.radikal.com.tr/politika/erdogan-kurtaj-yasasini-cikartacagiz-1089484/> on January 8, 2017.

³⁷ Retrieved from <http://www.radikal.com.tr/turkiye/bakan-akdag-tecavuz-bebegine-devlet-bakar-1089651/> on January 8, 2017. Akdağ and Üstün were not the only party officials to take this stance about the topic. Ankara major Melih Gökçek, for instance, made an appalling comment, saying that women should kill themselves if they are raped, but not the baby. Melih Gökçek is a very public figure of the AKP, known for his disreputable comments, especially on social media. Along these lines, pregnancies resulting from rape were one of the most frequently resorted tropes during the debate.

³⁸ Retrieved from <http://www.aksam.com.tr/guncel/tecavuze-ugrayan-da-kurtaj-yaptirmamali--118800h/haber-118800> on January 11, 2017.

fight against a potential ban on abortion. Under their initiative, thousands of women and men gathered together on June 3rd in Istanbul for the first mass demonstration of a series that was to follow countrywide over the Summer 2012. A petition opposing a potential ban on abortion, endorsed by 829 organisations internationally, was signed by 55 thousand individual signatories within two weeks.³⁹ A popular media campaign initiated by the news portal *bianet*, which invited women to write the slogan “My body, my choice” on their bodies and share their pictures also gathered enormous interest.⁴⁰ Among high-profile Muslim women, while these slogans suggesting ownership of one’s body were sternly criticised for violating Islamic understandings, a strong sentiment against abortion ban was voiced through the news media (Kubilay 2014).

Professional organisations did not only raise their voice against anti-abortion and anti-caesarean comments, but they also supported the initiatives by women’s and feminist groups, sometimes by joining their alliances. In early June, many professional bodies, from the Turkish Medical Association⁴¹ and Turkish Obstetricians’ and Gynaecologists’ Organisation⁴² to Turkish Psychiatry Association⁴³ issued statements and press releases, condemning the attacks on these practises. While these statements were framed as scientific and expert views based on objective data on reproductive health practises, they all began and ended with declarations of support for women’s rights.

³⁹ Retrieved from <http://www.sosyalistfeministkolektif.org/eylem-etkinlik/900-orgut-kurtaj-yasaklanamaz-imzalari/> on January 11, 2017.

⁴⁰ All photos are accessible at <http://benimkararim.org/> last visited on January 8, 2017.

⁴¹ Retrieved from <http://www.ttb.org.tr/index.php/Haberler/haber-3194.html> on March 5th, 2017.

⁴² Retrieved from <http://www.tjod.org/turk-jinekoloji-ve-obstetrik-dernegi-tjod-kurtaj-raporu/> on March 5th, 2017.

⁴³ Retrieved from http://psikiyatri.org.tr/uploadFiles/246201214022-kurtajbasin_duyurusu.pdf on March 5th, 2017.

Faced with strong mobilisation against a potential rescinding of abortion right, other party officials intervened so as to soften the government's stance. Women MPs were in the frontlines of this endeavour. On June 8, Nursuna Memecan stated that even though education about reproductive health issues was an urgent need, banning abortion and caesarean births outright would pose more serious threats to women's health than their practise.⁴⁴ In mid-June, the Minister of Family and Social Policies Fatma Şahin assured the public that while her office was working jointly with the Ministry of Health and Ministry of Justice on draft legislation to replace the 1983 law, an absolute ban on abortion and caesareans was not on the agenda.⁴⁵

Once concrete efforts for new legislation were announced, rumours and speculations soared in the news media about what the proposed draft entailed. For instance, it was alleged that the time limit for abortion was going to be pushed down to eight, or even four weeks. Others claimed that the eligibility criteria for abortion providers were going to be altered; and that there was going to be legal ramifications for caesarean providers. Around the same time, a series of news pieces about health personnel making phone calls to the houses of women who showed positive on pregnancy tests, informing women's family of their pregnancies without their consent, made their ways into headlines. The MoH rejected the claim that there was a programme "profiling" pregnant women; nationwide collection of health data—pertaining to all test results, not just pregnancies—was a system initiated years ago, and phone calls to people's houses did not partake in it. However, these declarations did little to appease the fears, and many

⁴⁴ Retrieved from <http://www.milliyet.com.tr/ak-parti-li-memecan-kurtaj-yasaklanmasin-siyaset-1550936/> on January 9, 2017.

⁴⁵ Retrieved from <http://www.haber7.com/guncel/haber/891278-bakan-sahinden-rahatlatan-kurtaj-aciklamasi?wr=1> on January 9, 2017.

organisations stated opposition to the Ministry’s data collection programme on the grounds of sensitivity of information.⁴⁶ The government’s “hunt for pregnant women” thus became a catch phrase among activists, and together with the rumours that the time limit for abortion on request was going to be shortened, it incited further diligence; and a series of vigilant protests countrywide followed.⁴⁷ The Federation of Family Physicians’ Organisations issued a statement titled “We Will Not Engage in Unconstitutional Practises,” decrying the idea of profiling women and contacting their family members without women’s consent as disrespectful of women’s rights.⁴⁸

Presumably daunted by the strength of the mobilisation, party officials stepped back from their initial stance promptly. On June 19, it was announced that while there were efforts to prepare new legislation, the draft did not entail any changes to the time limit for abortion on request.⁴⁹ The novelties sought with the draft were about the eligibility criteria for abortion provision, both at the level of physical space and personnel;⁵⁰ mandatory information sessions for women/couples applying for abortions; and stricter regulations on caesarean births. Alongside the draft legislation to replace the Law no.

⁴⁶ Retrieved from <http://bianet.org/bianet/print/139390-bakanlik-yalanladi-tabipler-odasi-buldu> on January 11, 2017.

⁴⁷ Under pressure, the MoH consequently made a declaration that it would enact disciplinary action against health personnel making such phone calls to anybody except pregnant women themselves. Retrieved from <http://www.hurriyet.com.tr/sir-veren-doktora-ceza-20844798> on January 11, 2017.

⁴⁸ Retrieved from <http://www.ailehekimleri.net/index.php/haberler/haberleri/82-ulusal/5828-aile-hekimleri-dernekleri-federasyonu-anayasaya-aykr-i-yapmayacaz> on March 5th, 2017.

⁴⁹ Retrieved from <http://www.cnnturk.com/amp/2012/turkiye/06/19/kurtaj.suresinin.degistirilmemesi.ongor-uluyor/665722.0/index.html> on January 11, 2017.

⁵⁰ To be more specific, while the Law no. 2827 designates general practitioners who receive birth control training eligible for providing abortion on request with menstrual regulation, the draft proposed only expert ob/gyns could perform abortions. Similarly, free-standing clinics would lose their eligibility, and only general hospitals would be eligible.

2827, there were also talks about altering the Penal Code and set higher penalties for rape and incest.⁵¹ In the following days, all three ministers involved in the effort kept giving statements to the news media about the draft they were working on. Yet, as days passed, and the draft was brought neither to the Parliament nor to the Cabinet, question marks arose; to which Recep Akdağ continuously responded by ascertaining that changes were under way.⁵²

Amidst the dust raised by the back-and-forth about abortion, legislation concerning caesareans passed without much clamour on July 4th, on the last day of the Parliament's 2011-2012 session. The Law no. 6354, an omnibus bill pertaining to various healthcare practises, contained two sentences on caesareans, instructing that in cases of medical indication, caesarean deliveries would be performed;⁵³ and that doctors would not be liable for any undesirable consequences following delivery due to complications.

The caesarean law was passed amid considerable turmoil in maternity wards. The news about “caesarean deaths,” a misleading label which refers to the deaths that occur during labour because of doctor unwillingness to perform caesareans despite complications had, began to find their ways into the front pages shortly after the onset of the debate. Between July and August 2012, the death of six infants and two women in very similar circumstances were reported in the national news media. Interestingly enough, while groups mobilising for abortion rights consistently mentioned these

⁵¹ Retrieved from <http://www.star.com.tr/yazar/kurtaj-duzenlemesi-netlesiyor-tecavuze-agir-ceza-geliyor-yazi-617073/> on January 11, 2017.

⁵² Retrieved from <http://www.ntv.com.tr/turkiye/akdag-kurtaj-duzenlemesi-mutlaka-yapilacak,Ga-jLo3caU274HoJMZTMWA> on January 11, 2017.

⁵³ While the law sets the contours for the practise of caesareans, details about what counts as medical indication are defined in MoH's guidelines. After the Law no. 6354 passed, MoH issued guidelines that defined indication broadly so as to include excessive fear on the part of the pregnant woman.

incidents in their campaign material, the passing of the law itself did not lead to strong reactions, on the part of neither women's groups nor professional organisations.

The passing of the Law no. 6354 did not put an end to the debate. Throughout the months of July and August, further details from the draft legislation on abortion that finally made its way to the Cabinet's revision in mid-July were leaked to the press. These leaks involved little beside what was known at the outset: The draft instructed the time limit for abortion on request to remain intact but eligibility criteria be made stricter; consultation with doctors and social workers, as well as mandatory waiting periods be introduced for women seeking abortions; and the right to conscientious objection for health workers who did not want to partake in abortion provision be recognised. Yet, strikingly, it also proposed jail time for women obtaining abortions over the legal period.⁵⁴

By mid-summer, and with the Parliament's yearly break, the debate begun to lose steam. While some of the leaked details of the draft legislation, for instance the notion of "persuasion rooms," provoked reaction from activists, street actions no longer attracted large masses as they did in June. Activists thus used the rest of the summer for working on and refining their set of demands and their language, acquiring further information about the healthcare system, and producing new material in preparation of the new legislative year, which presumably was going to witness further struggle when the draft would be voted in the Parliament.

The Parliament opened in September, and the Cabinet resumed its regular working. Despite Recep Akdağ's persistent statements that the draft was already discussed in the

⁵⁴ Retrieved from <http://www.haberturk.com/polemik/haber/759732-kurtaj-yaptiran-kadina-hapis> on January 11, 2017.

Cabinet and changes to the Law no. 2827 were under way, no concrete steps were taken. Public interest on the issue, both on the side of the news media and among the public at large, which was raised with the opening of the Parliament started to fade again in the absence of governmental action. The topic was not altogether dropped, as some AKP officials continued to make allusions to new abortion legislation in the following months; rather, it was allowed to die slowly and quietly, as anti-abortion comments by state officials became increasingly rare. As strong discursive attacks and concrete efforts at limiting abortion rights receded, urgent political matters of the day replaced the controversy in newspapers' front-page coverage.

At the face of waning public interest, rights activism also dwindled. Initiatives that mobilised only against a potential abortion ban, seemingly having achieved their goal, petered out altogether. Activists from Abortion is a Right–Decision Is Women's Platform, who sought not only the preservation of the extant law but also an expansion of rights pertaining to reproduction changed their strategy from organising street actions to disseminating information about the shortcomings in the healthcare system. For instance, in January 2013, they reached out to female columnists and pundits who wrote for various newspapers and journals. Presenting them the report that they drafted on abortion, activists recruited women journalists to write articles about the issue or interview activists, so as to draw attention to the fact that even though the law did not change, access continued to be a problem for women seeking abortion.

Yet, as it primarily focussed on the notion of abortion rights, the platform lost its momentum when the anticipated legal change did not occur. Before it turned a year old, the platform no longer held regular meetings, even though activists maintained contact

with one another over their list serve. The list serve facilitated organising reaction each time there was a renewed attack on reproductive rights; for instance, upon Erdoğan's statements declaring contraception as "treason against the nation" in December 2014,⁵⁵ but these reactions were as limited as the attacks themselves. The opportunity to organise large-scale mobilisation to claim and expand rights pertaining to reproduction, ironically first presented by Erdoğan's attacks on those rights, thus slipped by.

Conclusion

The study of the media coverage of controversy offered in this chapter suggests that from its beginning on, the abortion/caesarean controversy orbited law. Erdoğan and his counterparts made unremitting references to official laws and impending legal change to those. Concurrently, as mobilisation against these statements grew, activists' language became increasingly focussed on the status of abortion as a right, inciting responses from their opponents offering alternative narratives on what counts and does not count as a right. In other words, legal talk in general and rights talk in particular was the predominant element in abortion/caesarean controversy, even as both sides mobilised complementary discourses alongside with it. Perhaps not so surprisingly, as legal talk dominated the debate, abortion took the leading role in the controversy.

Paradoxically, the only legal change that ensued from the controversy pertained not to abortion, but to caesarean. This paradox generated puzzling consequences: Caesarean rates did not show any significant decrease after the passing of the Law no. 6354 which

⁵⁵ Retrieved from http://www.bbc.com/turkce/haberler/2014/12/141222_erdogan_dogum_kontrolu on January 15, 2017.

sought to lower them. In contrast, professional medical organisations as well as abortion rights activists report that access to abortion, as well as to contraception, were even more constrained after the debate, despite the fact that the law did not change.

This puzzle, which I will tackle in the subsequent chapters, raises a set of questions about the effects and effectiveness of rights mobilisation. The next chapter will delineate the ways that rights were framed and deployed within activist discourses by focussing on the coalition among feminists and women's groups that was organised in Istanbul under the name of Abortion is a Right—Decision Is Women's Platform, and spearheaded coordinated demonstrations and production of material like brochures, posters and slogans with other cities. The platform, unlike the initiatives that mobilised against abortion ban, sought to seize the opportunity presented by the debate and pressure the legislature and healthcare institutions to ensure better and regular delivery of these services. In other words, the controversy enabled feminists and women's rights groups to bring to the forefront the grievances that were previously not amenable to public discussion, in the pursuit of expanding women's reproductive liberties. They sought to achieve this end through a campaign that relied heavily on rights language, but they stayed away from the courts. How did organisers strategically deploy rights language but no other legal strategies? Before turning into an exploration of the circumstances in healthcare institutions, I will first seek to explain this peculiar rights mobilization through focussing on organisers' accounts of the campaign.

CHAPTER 4

TALKING RIGHTS

“Abortion is a right;” we are now uttering this so offhandedly, but back then there were differences among ourselves about what we ought to put forward. Before we agreed upon a slogan, we first had to come to an agreement about our approach to the issue of abortion. It’s not a technical issue about the slogans. ...First we reached consensus about representing the matter as a rights issue, these ideas then became slogans anyways. (Zarife, Istanbul Feminist Collective)

After Erdoğan’s initial statements, several groups countrywide staged spontaneous protests promptly, each group mobilising its own immediate circle at first. In the days that followed, though, attempts were made to bring together those relatively small, reactive actions into a large-scale, organised opposition to what seemed to be the government’s stance on reproductive health matters. In Istanbul, over 100 women from around 40 organisations held a meeting on June 1st. The idea of forming a coalition was first spelled out during that meeting. According to the minutes from the meeting, “[we] decided to make a call to come together as a platform ... with an inclusive name to allow women from all backgrounds to participate. The platform will have its own name instead of listing the names of all participating organisations.” Finally, on June 5th, after several meetings, the platform announced its name and main slogan as “Abortion Is A Right–The Decision Belongs to Women.”

The minutes from the platform’s meetings in early June attest to the fact that women saw the situation as an opportunity from the outset: Participants time and again stressed that the campaign should not seek merely to oppose a potential ban on abortion and caesareans, but to expand the accessibility of the former and ameliorate the conditions of

the latter. In other words, there was a wide consensus among women that the campaign's demand would not be to maintain the extant state of affairs, which were deemed inadequate in the first place, but to advance more expansive demands both in terms of concrete service provision by the state and in terms of propagating ideas pertaining to women's freedoms and agency.

How to seize this opportunity and turn it into an inclusive, expansive campaign? The question dominated the formative period of the platform. For reasons that will become clearer later in this chapter, abortion became the focal point of the campaign as organisers perceived it to be an area more amenable to achieve both of these purposes. Yet, as Zarife's words above suggest, choosing the concept of abortion rights as the main pillar of their campaign was not an intuitive choice for the platform's activists, but a decision that was reached only upon long discussions, which lasted during several days' meetings. What did these discussions revolve around? How did organisers finally decide, despite all reservations, to build their campaign around the concept of rights?

The question of rights, and more particularly, whether rights language and strategies helped or hurt social movements to achieve their political goals, has been perhaps the longest lasting and most heated debate in law and society scholarship. Stuart Scheingold's now classical *Politics of Rights* ([1974] 2004), which counterpoised the "naïve" belief in the merits of court-sanctioned rights against conceptualising rights as resources for social movements, set the tone for this continuous debate: Are social movement activists who resort to rights captivated by the myth of rights, that is, by the erroneous belief "that litigation can evoke a declaration of rights from courts; that it can, further, be used to assure the realization of these rights; and, finally, that realization is tantamount to

meaningful change” (2004: 5)? Or were activists aware of the limitations inherent in liberal rights, but nonetheless mobilised them as “political resources of unknown value” to articulate alternative political aspirations in the quest of their goals?

This chapter partakes in this on-going dialogue. Using minutes from the platform’s meetings, material that the platform produced during Summer 2012, and interviews conducted with organisers two years after the formation of the platform, I first explain how the rights frame came to be perceived by organisers as more favourable than other possible frames. Then, going further, I explore the specific ways in which activists articulated the concept of rights creatively with other political arguments and demands. The third section of the chapter delineates the reasons why they claimed the rights on the streets, but not in courts. In other words, why did activists adopted legal language but not legal strategies? Organisers’ accounts and the material that they produced for the campaign suggest that the deployment of rights, as well as not resorting to courts, were deliberate and strategic choices that the activists made rather than unthinking reflex on the part of the organisers.

Choosing the Right(s) Frame

The value of rights and rights claiming has been a contentious issue among feminist activists and scholars for decades. Indeed, throughout the world, the idea of using law and legal reform for enhancing women’s liberty and equality has been one of the key components of the feminist and women’s movements throughout such movements’ history, so much so that the term “women’s rights” came to be equated with the women’s movements (Mitchell 1987; Thomas and Boisseau 2011). While the early uses

of this strategy, like the suffragette movement, are considered to be successful, disappointment later arose from the recognition that much wanted legal rights reforms might not always fulfil their promise and can fall short of producing significant social change. Feminist critiques of law explained the inadequacy of rights claiming as a strategy from various theoretical and political perspectives. Most notably, Marxist feminists asserted that since law is a tool of patriarchy, it necessarily serves to conceal and naturalise the oppression and exploitation of women; and cannot, as such, incorporate the interests of women within its functioning. But these theorists did not abandon the struggle on the legal plane altogether: They suggested that law must be transformed and brought closer to women's standpoint through, for instance, the formulation of new rights drawing on women's experiences rather than mirroring legalistic premises (Olsen 1984; MacKinnon 1983). Poststructuralist critique, on the other hand, stressed that power operates in more subtle and complicated ways than sheer oppression, especially through language and discourse, and described how legal language devalues and disqualifies women's experiences and accounts of reality. Accordingly, so far as in contemporary societies, law subordinates and controls women in ways other than explicit bias and denial of formal legal rights, rights claiming as a strategy was deemed to be unproductive if not detrimental (Smart 1989: 139) so far as bringing women's concerns before the law means to invoke a power which is already charged against them (*ibid*, p. 2).

Against the backdrop of these well-publicised contentions, it is not surprising that feminists across the world today are cautious when resorting to law in general and in rights claiming in particular. The formative stages of the Abortion Is A Right–The Decision Belongs to Women Platform were not an exception to this general rule. Seen

from this angle, that there were lengthy discussions about the name, slogans, and demands of the platform is not so surprising.

In this section, I will bring a close focus on these discussions, identifying the arguments that have been decisive in the decision-making process. While many different arguments were brought both in favour of and against using a rights frame, all of these can be encapsulated within three broader themes—namely, the unifying capacity of rights, their empowering quality, and lastly, their educative aspect. In all three areas, activists looked for ways to use rights for movement building and enhance a collective identity and struggle. Activists offered accounts of these discussions in great detail, presenting two sides of every argument, and explaining which side ended up being considered more favourable in each step and why during the interviews. I will follow this same approach while presenting these arguments in the following pages.

A Language That Unites

Perhaps the most influential consideration that eventually shaped the platform's decisions pertained to the importance of reaching out to as many women as possible, from an as wide societal spectrum as possible, through the campaign. This focus led to a departure from feminist slogans like “our bodies belong to us,” which were thought to be too radical, and potentially disagreeable to some groups, pious women in particular. The concept of rights, compared to more radical ideas about female body and agency, seemed to better serve the campaign's goals in that it was thought to be meaningful and acceptable to most women:

I think rights language is a middle ground, compared to more radical things we could have said as feminists. I mean, what we said was “This is our right,

we are rightfully demanding it, it can't be banned;" a language that everyone can accept. (Meltem, Mor Çatı Women's Shelter)

The underlying idea here was that rights provided a language that is familiar to many people, widely recognised as valid and commonly accepted (Minow 1990, Silverstein 1996). So far as the audience that the platform sought to reach was not people who were already well versed in political language and arguments, but a diverse range of women from different sectors of society, the familiarity and acceptability of rights offered a valuable resource. Organisers reasoned that reproductive rights, most importantly abortion rights, were a topic that interested all women: Regardless of class, ethnicity, and worldview, any woman could be obliged to resort to abortion at some point in their lives. Activists believed that with an appropriate approach and language, the campaign could enlarge its mass base tremendously, which could lead to not just success for this particular campaign, but also a historical uptick for the women's movements in Turkey. This required leaving behind potentially divisive, radical visions and mobilising around a unifying idea instead. Rights language was perceived to be the ideal candidate for this purpose,

[b]ecause we can reach women from different sectors when we talk with an emphasis on law. "This is your right," or "That is our right." It has validity, how should I put it; all sectors of society have acceptance toward this. This discourse helps us to explain it not as the problem of just a small group of women. . . . That is, we chose it because we thought that this was the most suitable language that would reach the largest audience, without facing much negative reaction. (Bade, Labour Party)

While right-wing critics such as Mary Ann Glendon (1991) stress what they see as the non-social, individualising and divisive nature of rights, and the processes through which rights claiming, by disrupting the status quo, can lead to backlashes based on politics of resentment have been extensively studied (Dudas 2005), scholars also time and again

pointed at the constitutive capacity of rights language: By offering a respected language to articulate demands, and a shared normative ground upon which to organise, rights claiming can as well work to bring together those who are marginalised by law (Milner 1986; Matsuda 1987). Similarly, campaigners saw in rights language a power to bridge the differences by providing a commonly accepted objective, hence to facilitate building alliances.

There nonetheless were doubts about the unifying potential of rights language. Some had questions about describing a practise like abortion, typically seen as undesirable, as a right. Indeed, were rights not associated more easily with positive entitlements such as right to life and right to healthcare? Those latter, rather than opposing to the rights frame in general, opposed to using “abortion rights” as an idiom, but argued rather in favour of a slogan to express abortion’s essentiality for women’s right to life. Indeed, wouldn’t an abortion ban lead to back-alley abortions, as examples from various places around the world suggests? Besides, in a society that is presumed to be conservative and bound by a code of “women’s honour,”⁵⁶ wouldn’t restrictions on abortion risk pitting women against their families, limiting their abilities to control their own sexual lives away from the intervention of their kin? In this vein, the proponents of this perspective maintained that if abortion were to be related to rights, it should be related to with women’s human rights.

⁵⁶ While taking this presupposition of “conservative society” for granted presents dangers of its own (Koğacioğlu 2004), it is worthy keeping in mind that male violence against women is rampant in Turkey: According to Ministry of Justice statistics publicised in response to a motion in the Parliament, from 2002 to July 2009; 4,063 women had been killed by men, with an increase of 1400% in seven years (Başaran 2009). These numbers are rather out of date as the MoJ, in response to strong popular reaction to these statistics, restricted access to these statistics since 2009.

Nadire was among the most vocal critiques of the abortion rights frame during these initial discussions. Nor did the arguments in favour of the abortion rights frame as the campaign's main slogan really convince her. Because she did not want to stall the platform's actions, she yielded, but not without noting her opposition. When I asked her why she had such a strong stance against the abortion rights frame, she narrated the encounter that she had with an elderly Kurdish woman, who approached her during the first feminist protest:

She held into my arm and said, "You are doing very well responding to [the prime minister], but why are you calling abortion a right? Abortion is not a right, abortion is an exigency!" After that I started thinking that calling it a 'right' did not resonate even with those... I mean, that woman admitted that women needed abortions, but she did not want to call it a right. I think there are many women like her. (Nadire, Women's Initiative for Peace)

These reservations led to lengthy, serious discussion as the minutes from the meetings over the first week of June attest. Yet, many in the platform still felt that rights language had more unifying than dividing potential despite the reservations, in that even those who did not approve of the practise of abortion could support it as a right. Smbl explained:

Even members of the Capital Women's Platform,⁵⁷ despite not being in agreement with our perspective from a political standpoint, said they would support our demands within a rights framework. ... [It's like] my giving support to women who wear the headscarf. I can work with them on the basis of rights [even though I do not share their worldview, I can say] "Yes, they have a right to do it." I concur that it is their own bodies, they can wear what they want, and their lives shouldn't be constrained because of this. ...It was a similar situation. (Smbl, Mor atı Women's Shelter)

⁵⁷ *Başkent Kadın Platformu* is an organisation constituted mostly by pious women, some of whom self-identify as Muslim feminists, seeking to "resolving the problems emanating form religious interpretations, understandings and assumptions that entrench the traditional image of women and from discrimination against pious women." Retrieved from <http://www.baskentkadin.org/tr/?cat=6> on February 20, 2017.

In sum, the designation of the primary goal of the campaign as reaching out to a large audience, and the perceived amenability of rights language to serve that purpose, was decisive in the activists' discussions. From their perspective, rights language offered a strong yet non-radical, widely acceptable, and equalising discourse. This argument, in and of itself, would not be sufficient to appease Nadire's reservations though, were it not for other compelling arguments in favour of rights frame.

An Empowering Language

Meeting minutes suggest that Nadire's criticism against the rights frame was shared by quite a few within the platform. Yet, the most detailed and eloquent expression of this perspective came not from the inside, but outside of the platform: Aksu Bora, a renowned feminist scholar of Turkey, published an online piece criticising her fellow feminists in early June. While part of her criticism focussed on what she disparaged as a "reactive" way of doing politics,⁵⁸ the other part was directed at the deployment of rights language when talking about abortion:

Is abortion a right? Is it a right the way the right to education, right to health, right to bodily integrity, right to life are? ... How does "Abortion is a right, we'll get our due alright!" sound like? Do we have to turn abortion into a right in order to oppose a ban on it? Is a woman who is making a difficult choice such as having an abortion enjoying a right? (Bora 2012, my translation)

The critique of assertiveness, echoed in Bora's commentary, has indeed found itself large representation within the scholarship on rights (Glendon 1987). From this angle, "[t]he recourse to legal remedies and the assertion of rights and autonomy by individual women

⁵⁸ The "reactive way of doing politics" here refers to the incapacity to set the political agenda in one's own terms, but to build one's arguments and actions off of opposing what the "hegemon" says and does.

are often viewed as isolating and individualizing moves, especially when posed against the affective solidarities offered by family and community” (Rajan 2003: 165). While organisers saw a certain value in this criticism, they counterpoised against it another strong argument in favour of using the abortion rights frame: its empowering quality. In this latter perspective, the emphasis on women’s right to life in relation to abortion depicted women as victims, not worthy of their own decisions but allowed certain rights for the sake of bare survival. In this vein, they objected to highlighting the presumed difficulty of taking this step for women, so far as this notion presented women as natural mothers who would, under but the most terrible circumstances, carry any pregnancy to term once it was conceived. Instead, campaigners wanted to normalise the decision not to be a mother and assert the notion that women had the agency to make this decision on their own—during the meetings, some even shared their own experiences of having felt great relief upon successfully terminating a pregnancy rather than guilt and shame. Accordingly, the notion of abortion rights, coupled with an affirmation of women’s own decision-making capacity over their fertility was seen as a more empowering alternative than an emphasis on women’s right to live:

...Calling it a difficult choice, saying that women are traumatised by this decision, traumatised by what comes afterward and so forth... Doesn’t it reinforce the state’s language representing the embryo as a baby and purporting that it has a right to life? (Merve, Socialist Feminist Collective)

Merve’s words here are reminiscent of Carol Gilligan’s claim that women, who are raised to be selfless caretakers from an early age on, could develop their sense of self through the assertion of rights: “[T]he essential notion of rights [is] that the interests of the self can be considered legitimate. In this sense, the concept of rights changes women’s conceptions of self, allowing them to see themselves as stronger and to consider directly

their own needs” ([1982] 1993: 149). In a similar vein, organisers saw in rights language’s assertiveness not a pitfall but a tool for challenging dominant norms of womanhood.

At the same time, activists were careful not to evoke the same backlash that feminists fighting for abortion rights in the West have faced; namely, the mobilisation for the foetus’ right to life. As I detailed in the previous chapter, during the abortion/caesarean debate, government officials speaking in favour of an abortion ban made comments about foetal rights, but these arguments were—if the pun be forgiven—premature. Activists reasoned that using the language of women’s right to life risked provoking the opponents to develop a better substantiated argument in favour of foetal rights, and was thus to be avoided carefully.

This particular approach to abortion as well as this contextual specificity runs counter to the widespread tendency shared by women’s movements across the world to capitalise on the notion of women’s rights as human rights, and to draw on supranational agreements and institutions for establishing certain standards for women’s status (Fusch 2013). Even though activists did not refrain from occasionally referring to international agreements such as CEDAW and call on the government to abide by its language, they refrained from giving too much weight to these conceptualisations to avoid a language that emphasises women’s victimisation. Indeed, international conventions tend to defend reproductive rights on the basis of the perils to women’s health posed by unsafe practises such as back-alley abortions, hence rely on the same idea that these practises should be made available for health and safety reasons. While not denying the importance of this dimension, organisers sought to emphasise the political character of reproductive rights. As will be shown below, campaigners maintained that abortion rights originate in extant

gender inequalities rather than in universal human right to survival, the latter being perceived as depoliticising by organisers.

Furthermore, alongside its empowering potential for individual women in their decisions *vis-à-vis* their personal lives, it was also argued that the rights language was empowering at the collective level with regard to women's struggle for liberation. As Elizabeth Schneider (1986: 625) suggests, "[t]he articulation of women's rights provides a sense of self and distinction for individual women, while at the same time giving women an important sense of collective identity. Through this articulation, women's voices and concerns are heard in a public forum and afforded a legal vehicle for expression." Indeed, while exercising this right can be an indispensable necessity in individual women's lives, organising around the right to abortion deploying the shared experiences of sexuality, fertility and struggle by women across the board made a point about women's belonging to the polity as equal citizens:

Laws don't work to women's benefit. But insisting on [legal rights], it's like [saying] "We are citizens of this country, we are tax-payers, and we have this right in front of the law. It shouldn't be marginalised," (Bade, Labour Party)

In this vein, abortion was considered not solely a practical necessity for individual women experiencing unwanted pregnancies, but the affirmation of women's agency as full citizens in deciding whether or not to give birth affects all women regardless of their fertility status. Moreover, organisers argued that the struggle for acquiring this affirmation generated a collective identity among women. Türkan, emphasising this latter dimension, said:

I think [saying that] "Abortion cannot be banned" is insufficient. Why? Because it doesn't stand for anything liberatory about the future. But [saying] "Abortion is a right, and the decision belongs to women," says something about women's collective struggle for emancipation, about women's

liberation. I think there is such a big difference between the two. (Türkan, Istanbul Feminist Collective)

To sum up, the abortion rights frame was favoured because, on the one hand, it was thought to empower women by dismantling the “mommy myth” (Douglas 2004) as it broke down the depiction of abortion as a traumatic event, and counterpoised women’s agency to these views. On the other hand, by bringing women from all venues of life together, thus enhancing solidarity and struggle, it was also seen as an empowering language at the collective level.

Knowing One’s Rights

The final set of arguments in favour of deploying rights language was framed in terms of its educative aspect. As the debate about abortion and caesareans had created a climate of ambiguity and confusion pertaining to the legal status of these practises, some activists found it important to underline that technically speaking, these were still deemed as rights by extant laws. Still, some thought that putting the emphasis on the status of abortion as a legal right was a step backwards, in that it did not advance any new demands but simply described extant circumstances. Nevertheless, others insisted on the importance of reminding women of their rights because

Using a legal language, or referring to the laws makes one feel more secure. I mean... to be knowledgeable about your rights, knowing the limits ...of what you can do and what they cannot do to you. (İpek, Socialist Feminist Collective)

In this vein, some activists imposed an educative purpose on the campaign slogans. Yet, the importance accorded to having the rights on the books did not amount to a belief that formal rights in and of themselves were a solution to women’s predicaments. To the

contrary, organisers were keenly aware of the “gap” between law on the books and law in action (Pound 1910); they were hence eager to not hold on to extant laws but keep organising for further demands. But the rights on the books were indispensable so far as they gave leeway to women for furthering their liberties:

Were women fully enjoying their reproductive health rights, abortion rights prior to these debates? No, it wasn't the case. But when they try to change the law, when they attack [our rights] in this way, of course it is crucial to demand a legal framework. After all, we are allegedly living under rule of law, and these [rights] are the pillars of our struggles. Hence laws are indispensable, they're vital. (Derya, Socialist Democracy Party)

Within this frame, even the educative purpose of the slogan does not seem to pertain to the individual level: Indeed, organisers were well aware that non-enforcement of rights did not stem from women's ignorance about their own rights and their lack of willingness to demand them. As they conceptualised accessing those services as a political, rather than a legal question, it would help little to “teach” women of their rights. In this vein, the educative aspect worked rather as a call for struggle; a reminder to women that they were rights bearing subjects, that they should not feel helpless when those rights were denied, but should resist it. As Martha Minow (1987: 1867) famously stated, “ ‘Rights’ can give rise to ‘rights consciousness’ so that individuals and groups may imagine and act in light of rights that have not been formally recognized or enforced.” Similarly, activists sought not only to dismantle confusion about the current legal status of abortion, but also bring to the fore women's rights-bearing subjectivity through the campaign:

[t]he goal [of the campaign] was two-fold; dismantling disinformation [that those rights were rescinded] on the one hand, and putting together a strong mobilisation so that women could enjoy in practise the rights they possessed on paper. (Meltem, Mor Çatı Women's Shelter)

Therefore, on the one hand, activists were well aware of the dangers that legal ambiguity presented to the practical access to the rights women had on paper—a foresight that will be corroborated by the chapters to follow. On the other hand, by articulating the dismantling of misinformation with the collective empowerment perspective, they sought not only to “raise” rights consciousness but also to mobilise it for advancing the campaign’s tactical and strategic political goals. In this vein, the goals that they sought through the educative aspect of rights hint suggest not a “strategy of rights as such”, but a perspective on rights as an “ancillary tactic to be used in combination with other approaches to political mobilization” (Scheingold [1974] 2004: 209).

By and large, the arguments in favour of using rights concepts, revolving around each one of the three general themes that I presented above, emphasise women’s collective subjectivity and their collective struggle, rather than comprising a dry legalistic stance. As such, it seems that rights were not considered by organisers as ends in themselves but as “ancillary weapons” to political mobilisation. Indeed, in all respects, what the organisers brought forth was their attempt to reach out to large numbers of women, to mobilise them for the campaign’s short-term goal (blocking a potential abortion ban), and in the long run, to bring more women into the movement. In this endeavour, organisers had to go beyond using “abortion rights” frame as a sheer slogan and to substantiate their own usage of the concept. This was a creative process that entailed tying in different strands of political arguments and demands together. Indeed, rights language provokes discussion and debate, and enhances dialogue among people coming from different backgrounds (McCann 1994, Matsuda 1987). The platform benefited from this aspect of rights, as it helped activists smoothing out their differences through debate as they

analysed political issues together. The next section will bring a closer focus on this process.

Substantiating Rights

Activists recognised, as I detailed above, multiple ways in which deploying a rights language would help their cause; to enlarge the campaign's mass base, to empower women in the decisions they make, and to counter the government's discourse that criminalised abortion and caesareans by emphasising extant laws. Then again, after the decision was made to adopt "Abortion Is A Right" as the platform's name and main slogan, the discussions did not come to an end: It was now time to qualify and substantiate the "rights" in question. Indeed, as activists did not want to hold on to extant laws, which they perceived as being too restrictive, they sought to use the notion of rights as the basis off of which to advance new demands and achieve more extensive goals. At the same time, as the discussions above make the case, they were wary of the concept of rights in of itself, and felt compelled to craft their own definitions for explaining what they meant by rights. This section will elucidate the ways that platform organisers envisioned abortion rights, imbued rights language with more specific demands, and articulated it with other political ideas.

Quality, Free, Accessible

Perhaps the most powerful critique against using a rights language within feminist scholarship pertains to the abstract nature of rights, whereby having the entitlements on paper usually does not guarantee enjoying them in practical terms, let alone ameliorating

inequalities that are prevalent in any given society (Tushnet 1984). As the discussions about formal versus substantive equality resonates not only with feminist academics (Persadie 2012), but also with activists who witness the shortcomings of abstract rights on a daily basis, this aspect has inevitably been one of the main elements in the reconstruction of rights for the campaign's purposes. Türkan, explaining why the campaigners placed so much emphasis on the quality of abortion as a right despite this framework's inadequacy, and through which means they sought to overcome those, said:

If you demand a legal framework, and if this framework is liberating for [women], I call it a right. Of course, we do not define right to abortion simply as such. We are demanding right to free, accessible and safe abortions. ...We emphasised these qualifications throughout [the campaign]. (Türkan, Istanbul Feminist Collective)

Indeed, the language that the organisers utilised in addressing their audience abounds with the emphasis on those rather concrete aspects of abortion rights that Türkan mentions:

We have a right to free and safe abortion! Because current regulations are insufficient for guaranteeing access, we demand those to be expanded to recognise our right to free, safe and accessible abortion, and the time limit to be moved to at least the 12th week of pregnancy, as is the case in many other countries.⁵⁹

Advancing such concrete demands requires going one step further than simply formulating slogans, and coming up with proposals for new configurations of societal arrangements—in this particular case, the structure of the healthcare provision. İpek, outlining the contours of the kind of healthcare arrangement that they demanded, explained:

⁵⁹ From the platform's call for the rally in late June 2012. Retrieved from <http://istanbul.indymedia.org/tr/haber/kürtaj-haktır-pazar-günü-yürüyoruz> on February 11, 2017.

Our vision... It's like, from first-level healthcare services to all other things... I mean, women's access to services in all areas, from contraception to abortion, or if she wants to give birth, to caesareans or to vaginal birth, whatever... In all cases, a healthcare structure whereby every woman can receive services that will allow her to achieve what she wants safely and for free. This is the right-to-health side of it. (İpek, Socialist Feminist Collective)

Muazzez, a lawyer employed by the Istanbul Medical Chamber and a very active organiser in the platform, brought these ideas further, detailing:

Even if we were to draft a law ourselves... we can't look at what was being done previously and go back to that, because [healthcare service provision eroded to such an extent over the past years]⁶⁰ . . . So what's left now? Only hospitals. Therefore, the hospitals need to be [reorganised to provide these services] more extensively. . . . But we also demand women's centres; these can be a part of that. I mean, think of our demands like rape crisis centres, whereby doctors, lawyers and so forth would be employed. [Abortion provision] could be a part of those. (Muazzez, Istanbul Medical Chamber)

In this vein, activists sought to generate expansive as well as feasible demands. Thanks to the support (and sometimes active participation) of women working with various professional organisations and the savvy of the MÇ shelter's social workers, they quickly became acquainted with the specificities of the healthcare structure and framed their concrete demands accordingly.

Organisers framed these concrete demands as the right-to-health dimension to the campaign, which encompasses the practical side of the question: whether all women, regardless of their economic means, family circumstances, and physical location will have access to non-risky abortions. Going beyond an abstract right to reproductive health in general and to abortion in particular, which usually ends up not serving those who lack

⁶⁰ I took the liberty to replace Muazzez's actual words here with a less specific but more accessible language, so far as the intricacies of the healthcare structure in Turkey have not been discussed yet.

the means to acquire quality health services, activists underlined the state's responsibility in providing those to all women regardless of financial and spatial circumstances.

At the same time, as many of my informants repeated time and again, they did not want to limit their conceptualisation of abortion rights within the right-to-health framework and the practical questions of price and accessibility. Instead, they sought to create a framework that would not only advance short-term gains, but would also help articulate a comprehensive criticism of the social structure at large—that is, patriarchy. Put differently, it can be said that activists engaged in tactical meaning making as they advanced the right-to-health argument, so far as they sought to insure access to a (sometimes much needed) medical procedure for themselves and their peers. This short-term goal was expressed through voicing women's needs and delineating the ways through which the government could and should meet those needs. Pursuing practical interests, however, seldom says anything about the unequal gender structures and does little to challenge them: As Rosalind Petchesky (1990: 630) suggests, “[t]he claim for ‘abortion rights’ seeks access to a necessary service, but by itself it fails to address the social relations and sexual divisions around which responsibility for pregnancy and children is assigned.” Activists thus resorted to other frames to substantiate the rights they sought, and turned to more systemically critical dimensions of abortion rights.

Abortion Rights as a Collective Right

Another much discussed aspect to the definition of abortion rights pertained to the nature of the right that was at stake. By and large, the oft-referred notion that abortion was not a positive right akin to other ones such as the right to education provoked these

discussions. Significantly, these discussions were also informed by the experiences of women's rights advocates elsewhere around the globe, particularly the feminist debates about the US Supreme Court decision in *Roe v Wade*. The Court's decision, in line with the dominant paradigm of sanctity of privacy in Western countries, did not recognise any positive entitlement on the part of women seeking abortions but ruled that the state did not have a right to interfere with the "private" decisions that women made with regards to their pregnancies. This framework has been widely criticised by feminists within and outside of the United States for decades (Fegan 2002). Activists in the Abortion Is A Right Platform, emphasising the state's responsibility not only in negative terms of not interfering with the right to obtain an abortion, but also in positive terms of providing and facilitating access to quality and free services, distanced themselves from the privacy pathway. Yet, they followed up on this discussion in order to reach a more general framework of rights and what the struggle for rights meant for women's movements:

Now, what is a right? Regulations that are contoured by law, which partially liberate and ameliorate the circumstances of women. That is, rights don't emancipate women, they don't grant complete freedom. This is our perspective on social rights. Women are facing a long, great struggle ahead, but their lives cannot be bearable without some partial gains today. We therefore find social rights important in that they improve our lives. (Türkan, Istanbul Feminist Collective)

Organisers were keenly aware of the dangers that this framework posed: Indeed, state intervention geared toward supporting and protecting women typically comes at the expense of greater surveillance of and intrusion into women's (and sometimes their male counterparts') lives (Bumiller 2008). In the Turkish case, state provision of reproductive health services risked enhancing state control over female sexuality as evidenced in the government's data collection programme. Organisers nonetheless underscored to

importance of state recognition of, and active promotion for, women's agency over their fertility. Insofar as rights themselves were not guarantees but an area of struggle, fighting against state surveillance was regarded as part and parcel of the very same struggle rather than a reason to abandon it.

Going beyond the social rights framework, campaigners also sought to distance themselves from the Western arguments based on an ostensibly free choice, which reinforce the privacy paradigm. It is not that the idea is completely foreign to the Turkish audience; in fact, the online news portal *bianet*, in a campaign based on the "my body, my choice" idiom, drew tremendous participation countrywide from both men and women over the Summer 2012. During my interviews, however, while recognising *bianet's* success, activists time and again underlined the difference between their own approach from theirs:

In reality, we were lukewarm to that campaign, because... Well, certainly, it's my body and my choice, but we had to politicise [Erdoğan's] attack. We wanted to take the conversation away from individual rights, away from the "I do whatever I want with this body that is mine" attitude, away from such liberal perspectives. Instead we wanted to show that this attack was intrinsic to patriarchal structures, that we hence had to collectivise our struggle. So instead of saying "my choice," we said "*our* decision." (Sümbül, Mor Çatı Women's Shelter, emphasis added)

Thus distancing themselves both from the privacy and the free choice arguments, campaigners instead sought to frame abortion rights as a *collective* right. The collective right framework encompassed the social state aspect, in that it advocated for certain entitlements for women to be provided by the welfare state. Yet, at the same time, it implied state's active sanctioning of women's freedoms over their fertility, regardless of any individual woman's actual fertility status. In other words, the collective dimension of abortion rights underscored the symbolic significance of abortion, which is understood

as the state's recognition that women are full citizens capable of making their own decisions *vis-à-vis* their capacity to give birth. This symbolic aspect affects women as a group, rather than, or perhaps in addition to, affecting them as separate individuals. According to my informants, it was precisely this symbolic aspect that brought abortion rights, rather than reproductive rights, to the core of the campaign:

Today abortion is typically framed as a subheading of reproductive rights. Is this designation enough for us? It isn't, because in addition to being a reproductive right, abortion means delinking sexuality from fertility, pregnancy from maternity. So [abortion right] signifies *for all women* the right to have agency over their bodies. (Zarife, Istanbul Feminist Collective, emphasis added)

This particular aspect of the abortion rights frame that the campaigners created can help explain the support of LGBTQ+ groups to the campaign. Notable feminist scholars like Wendy Brown disparage rights claiming strategies because “rights procured specifically for women tend to reinscribe heterosexuality both as defining what women are, and defining what constitutes women’s vulnerability and violability,” and abortion rights specifically because “framing reproductive freedom primarily in terms of accidental and unwanted pregnancy – the need for abortion ... [allows] heterosexuality [to] continue to be naturalized and normalized (...) while other sexualities are marginalized” (Brown 2002: 425). Platform activists, on the other hand, stressed time and again that not building the entire campaign off of the right-to-health argument and framing the issue as one of women’s citizenship status regardless of their fertility status allowed greater room and visibility for LGBTQ+ persons within the campaign. Indeed, even those women who did not face the risk of an unwanted pregnancy on a regular basis were still affected by how law defined women—whether exclusively as mothers or as active participants to the polity who bear the agency to make their own decisions.

In this vein, by emphasising abortion as a collective rather than individual right, activists both expanded on the right-to-health argument by underscoring state's responsibility and conceptualised it as a social right, as well as capitalising on the symbolic force of abortion as a means toward liberating women as a group by affirming that women are not reducible to their birth-giving capacities. As the next section will make the case, this framework also allowed them to make bolder claims about women's sexuality: While the rights language was preferred in the first place precisely because it was not too radical so as to scare women away, campaigners found ways within the rights framework to promulgate more radical ideas about sexuality.

The Decision Belongs to Women

Of course, abortion is a right and it's important to say "We are not going to let you take this away," but I think it matters a lot that we juxtaposed it with "It's our decision." To say that the decision lies with us is to say that we have agency over our own bodies, to determine ourselves. That strikes me as even more important than saying that it's our right. (Zarife, Istanbul Feminist Collective)

While I underlined in the previous section activists' tendency to moderate radical feminist claims that "our bodies belong to us," organisers still sought to emphasise that the rights framework in question did not refer merely to the legal entitlement as defined in law, which demarcates and protects access, but a more empowering concept about the women's agency to determine their own lives, including sexual lives and maternity. This stance is partially related to more practical concerns, as MÇ employee Meltem suggests:

There needs to be a system where the woman is at the centre; where her own experience and decision is at the centre. For instance, there shouldn't be a spousal consent [clause]. Because many women get pregnant as they are seeking a divorce, they then have to seek the permission from a man by whom she's been subjected to violence, from whom she has been separated... And of course she

can't, which means that she just can't get an abortion. (Meltem, Mor Çatu Women's Shelter)

But there also are those who see this as a liberating principle for women beyond those practical concerns:

I think the sexual liberation aspect is very important. Because we think delinking sexuality and marriage, marriage and reproduction is fundamental to women's freedom. ...An approach through which women can enjoy sexuality without being anxious about getting pregnant, about being helpless when they get pregnant, and sexuality is not confined within marriage. (Türkan, Istanbul Feminist Collective)

The brochure that the group put together and widely distributed both in hard- and soft-copy format in Summer 2012 placed marked emphasis on this dimension of the campaigners' stance:

We are not obligated to get pregnant each time we have sex, we are not obligated to give birth each time we get pregnant! When women's sexuality is mentioned, the first thing to come to mind is fertility. What about sexual pleasure? ...We want to enjoy sexuality with whomever we want, whenever we want, without any pressure, without guilt, without worry, to achieve emotional and physical pleasure. Our right to make decisions over contraception and abortion is thus paramount.⁶¹

The perspective of sexual liberation here entails, on the one hand, a certain criticism of heterosexist/patriarchal marital relations, whereby the denial of women's agency both strengthens compulsory heterosexuality and reinforces men's authority within heterosexual relationships (Delphy 1984; Walby 1990). On the other hand, a persistent demand to revocation of the spousal consent clause in the Law no. 2827 is also part of this understanding. In a relatively more controversial twist compared to other aspects brought forward by the campaign, this perspective drew attention to the fact that pregnancy is never a question of equal involvement of partners so far as it occurs within

⁶¹ Retrieved from <http://www.kurtajhaktir.org/2014/02/e-kitap-brosur.html> on February 21, 2017. My translation.

a women's body. This assertion represents a radical break from the liberal perspective based on an abstract understanding of gender equality, in that this latter promotes an ostensible equality between male and female partners in deciding whether to terminate a jointly conceived pregnancy.

By demanding that married or not, all women should have absolute authority over the decision of whether or not to bring a pregnancy to term, activists did indeed take on a radical stance—not only with respect to its sex positivism within a rather conservative social climate, but also with regards to the weight campaigners gave to women's decision on issues pertaining to fertility over their male partners.

“Abortion Is A Right, Uludere Is Massacre”

As I detailed in the previous chapter, Erdoğan's initial comments on abortions and caesareans bore reference to the Roboski (Uludere) massacre. This discursive move led to a split within those who opposed the former prime minister's politics: While many promptly reacted to the component of these remarks as they pertained to reproductive rights, some commentators maintained that Erdoğan used the issue of abortion just as a manoeuvre to “change the agenda”—that is, a mere “distraction” from “real” politics (f.i., Barası 2012). Indeed, this has been a general trend in Turkish politics over the last few years, where in many instances Erdoğan's attacks on women's rights and freedoms have been singled out as tactics geared towards shifting the agenda away from hot topics that made Erdoğan and the AKP vulnerable (Kurtuluş Korkman 2016). Campaigners disagreed with such views, in that they saw Erdoğan's comments not incidental but intrinsic to his and his party's political position. They were quick to denounce the

masculinist tone in the distraction argument, which depicted women's issues in general, and in this instance reproduction in particular, as not "properly political" and secondary to more "serious" issues—in words of one respondent, "[a]s if abortion was not political at all." To the opposite, they highlighted time and again that regardless of their "true" intentions, Erdoğan's comments had created the opportunity to bring reproductive issues, particularly abortion, to the political agenda.

Then again, the urgency that they felt to expand the discussion on reproductive matters did not lead them to lose from sight the racist undertones, which they found important to keep on the agenda as well. The connection was made with the Roboski massacre in their press releases and in their slogans like "Abortion is a right, Uludere is massacre", "Abortion is my decision, murder is your weapon." The written material they produced also made incessant references to not only the Roboski massacre, but to the problems pertaining to state violence and the Kurdish issue:

...It was suggestive that [Erdoğan] linked Uludere with abortion. That is, misogyny with racism. All this time, no measure had been taken to resolve the Uludere case, and he was putting forth another kind of oppression in order to conceal the oppression of the Kurds: further restricting women's agency over their own bodies. . . . In this instance where discrimination against women and discrimination against Kurds are being so obviously intertwined, saying "Abortion is a right, Uludere is a massacre" is meaningful and unifying. (Baytok 2012b)

Taking into consideration the historically close (albeit contentious at times) alliance between the left, the feminist, and the Kurdish movements in Turkey, this stance is not surprising. Indeed, Kurdish women's movement was an enthusiastic ally within the Istanbul-based platform as well as a partner during the simultaneous countrywide actions in Kurdish cities. Keeping the issue of racism in the platform's language did not only

reaffirm this alliance, it also underlined once more that the issue at stake was one of democracy, which underlay both the abortion/caesarean controversy and the Kurdish issue, which can be traced to various other feminist writings of the period:

The blend of nationalism and militarism, provoked by the war, narrows down the democratic space, draws strict lines over what can be said and done. This oppresses women in distinct and overwhelming ways; at the same time, it puts different experiences of women in dialogue. For instance, the silencing of a woman who is prohibited from speaking her mother tongue in the public space, and the silencing of women who cannot politicise reproductive rights as they are rendered secondary within the climate of war, albeit different kinds of experience, emanate from the same source (Toksöz and Yıldız 2013).

This language drew the parallels not only among the different women's experiences, but also between women's and ethnic minorities' citizenship. The campaigners thus enriched the arguments about the relationship of women's freedoms to democratic participation. All in all, as the perspective on abortion rights as the affirmation of women's status as a group and the connection that organisers made between women's and minorities' status fed into each other, the right-to-health argument complemented this rather symbolic aspect of the campaign's political stance. Thus, departing from the issue of abortion, the campaign produced an expansive political reading of politics in contemporary Turkey that unified women activists from a wide political spectrum.

Whither Litigation

The above sections argued that activists deliberately decided to use a rights language and that they engaged in a creative process of generating frameworks through which to deploy it in order to reach their short- and long-term goals. I will now turn to the question of why the campaigners stayed away from other legal strategies such as litigation while adopting a legal language through the deployment of rights. Indeed, historically

speaking, dissident movements and organisations in Turkey are no strangers to courtrooms—from the political defences by left-wing militants in the 1970s⁶² (Parslow 2015) to feminists’ endeavour to acquire intervener status⁶³ in rape and murder cases in the 2000s (Baytok 2012a), both leftist and women’s organisations have been regulars in courthouses. Why, then, did they not go back to this familiar territory during the mobilisation for abortion rights?

This section will make the case that this decision was not haphazard but deliberated as well, just like the decision to resort to the language of rights. Indeed, organisers weighed various strategies for bringing the issue to the courts, not only abortion but issues pertaining to caesareans and pregnancy follow-ups as well. All in all, they came across numerous barriers to litigation, the efforts necessary to surmount which would not match the potential benefits that such an undertaking would bring about. I will now go through the options that the campaigners appraised—sometimes together with their allies in professional organisations—and the reasons why eventually each one of these potential avenues proved to be dead-ends.

The major obstacle that precluded attempts at bringing those issues to courts was the absence of any concrete legal change, with the exception of the caesarean law of July

⁶² During the court-martials of the 1970s and 1980s, leftist guerrillas and militants used the courtroom to propagate their arguments against what they maintained was unconstitutional and illegitimate use of state power. Similar to the idea of “rupture defence” (Thénault 2012), in political defence, the defendant does not deny having committed the alleged acts, but challenges their designation as crimes and the court’s eligibility to try them.

⁶³ Criminal cases are, as a rule, public cases. Yet, the Turkish Penal Code acknowledges the right of the victim or another party harmed by the crime in question—be it a real person or an entity—to intervene in the case as a plaintiff alongside with the public prosecutor. To acquire the intervener status, the victim or the third party has to file a secondary criminal case, at which point the intervener status can be awarded or denied by the court (Centel 2008).

2012. Had there been any actual legal change restricting access to abortion or requiring healthcare workers to profile pregnant women and notify their families about their pregnancies, those could have been brought to either the Constitutional Court of Turkey (CCT) by one of the parties represented in the Parliament,⁶⁴ or to a lower court by a professional organisation.⁶⁵ The completely non-official nature of the legal skirmish around reproductive health services made these options unattainable.

Constraints on abortion and so forth, none of those really happened. I mean nothing really changed on paper. So legally speaking, we couldn't have filed a case. Were there a new piece of legislation, we would have brought it to court; that, we had already agreed about [in the platform]. . . . For a while, there were talks about draft legislation... But it was never signed, and it's been so long that it became obsolete. Therefore, there was no legal order that we, as the Istanbul Medical Chamber or Turkish Medical Association, could file a lawsuit about. (Muazzez, Istanbul Medical Chamber)

Organisers thought it was not happenstance, but a deliberate strategy that the government developed at the face of the protests: Rather than passing legislation which then would be prone to attacks in the courts and possibly in violation of the international

⁶⁴ At the time, three political parties, the AKP, the MHP (*Milliyetçi Hareket Partisi* – Nationalist Action Party) and the CHP (*Cumhuriyet Halk Partisi* - Republican People's Party) were represented in the Parliament. In addition, the Labour, Democracy and Freedom caucus in the parliament, comprised primarily of Peace and Democracy Party members elected as independent candidates, had 35 MPs. Both the CHP and the LDF caucus were allies with the women's and professional organisations' mobilisation over the Summer 2012 and would be easily amenable to bring cases to CCT in collaboration with the campaigners. Shortly after the onset of the abortion/caesarean debate, on September 23, 2012, the rules of standing were modified and the right to individual application to the CCT was also granted with the explicit intention to diminish the caseload brought to European Court of Human Rights (ECHR) by mainly Kurdish human rights activists.

⁶⁵ Some of the women's organisations could have also taken that path thanks to the feminist efforts of the early 2000s, which earned official feminist and women's organisations the intervener status in cases that pertain to their area of work. The platform itself, as it is not an official entity, couldn't possibly have filed a case. But for instance the MÇ shelter, because it has its own foundation, is recognised as an eligible entity to petition cases or to partake in on-going cases as intervener. Nonetheless, requests for intervener status by women's organisations, including MÇ, have been more often than not denied over the past years (Centel 2008).

agreements that Turkey ratified, access to abortion was restricted through extra-legal means, thus closing the path to litigation:

In practise, women come up against individual healthcare workers. When someone says “We are not offering [abortions] here, sis,” you can’t do anything. It all happens at an individual level. Women are defeated one by one. From the government’s perspective, this is a much more clever move than completely banning the practise [of abortion]. (İpek, Socialist Feminist Collective)

On the other hand, with the caesarean law, bringing the legal language to the CCT did not prove much helpful either. The CHP, in collaboration with the TTB, did challenge the parts of the Law no. 6354 that pertained to caesarean sections in the CCT, which ruled that the law did not violate the constitution and avoided issuing a staying order.⁶⁶

The path to civil courts and the CCT thus blocked, the one remaining alternative for the campaigners to litigate was to use administrative courts. In Turkey’s legal system, administrative courts operate in parallel to civil and criminal courts, and hear complaints of unlawful actions on behalf of state institutions or personnel. Filing a lawsuit against a public institution or a public employee for refusing to offer abortions, or for contacting a pregnant woman’s family members, were contemplated within the platform for a while.

⁶⁶ Ceren Belge’s analysis (2006) of the CCT suggests that even though the court was powerful enough to stand up for human rights, historically, it has been activist only selectively: Belge argues that the court was a partner in what she calls the “republican alliance”; that is, the groups brought together by their shared devotion to the model of top-down modernisation promoted by Mustafa Kemal Atatürk—the civilian and military bureaucracy, the CHP and the intelligentsia. Finding the necessary support to challenge the legislative and executive bodies in this alliance, the CCT favoured civil rights and liberties in matters that infringed on the political power of these groups but not in cases brought forth by Kurdish and Islamic dissidents. This history can help explaining why recourse to the CCT is not a popular strategy among dissident groups in Turkey. Keeping in mind that the constituents of the Abortion Is A Right platform were overwhelmingly left wing and pro-Kurdish, it is perhaps not surprising that the recourse to CCT was not seriously considered among the Platform members. In contrast, professional organisations have been closer to the republican alliance, and tend to bring their grievances to the higher court, even though it has time and again proved unhelpful over the recent years.

Lawyers evaluated the *de facto* denial of provision of services as illegal, therefore judging the chances of winning in courts high, were it possible to litigate the issue:

I think these practises are not in line with the law, even with the restrictive legal framework that we have in Turkey. It could thus be pushed on this front. When [a woman's] request for a service was denied, we could put together a case on the basis of obstructing access to healthcare. (Ümit, Istanbul Bar Association and Foundation for Patient's Rights)

Yet, the plans to litigate never materialised, because of requirements to prove harm and legal interest. For harm to be proved, a real person who has been denied service, or experienced undesired communications with her family needs to apply to the court, but “[n]o one stood up for this,” (Türkan, Abortion Is A Right Platform) because

...nobody wants to get lost in the labyrinths of the Turkish law; nobody wants to deal with those. Because filing a lawsuit initiates a very difficult process on the part of a woman, she has to take the challenge of facing these processes. Even when there is support and solidarity... It still means that she will risk being identified. (Meltem, Mor Çatı Women's Shelter)

It is not that there were no women who were facing difficulties at healthcare institutions.

During the Summer 2012, the platform received a number of complaints and help requests from women who could not secure abortions on their own through either the platform's email address or through applications to the MÇ shelter. Sumbül explicated that from an ethical standpoint, they could not pressure these women to file lawsuits, thus they only attempted to support women in acquiring the services that they sought by using their connections. Çiğdem, who was a valuable resource in establishing these contacts, explained:

This process has dynamics of its own. . . . And you know, the primary concern here is time, as there is a time limit. Women have to deal with this problem within a very short period of time, during which bringing forth complaints becomes secondary. And once the problem is resolved, if it's resolved at all, women have already reached a point when they don't even

want to think about it anymore, and don't bring charges. (Çiğdem, Istanbul Medical Chamber)

Finding the courage and the willingness to sue is only one side of the coin though. Proving legal interest in a case of denial of abortion is dreadfully difficult in a country where the legal limit for abortion on request is the 10th week of pregnancy, as court cases tend to last much longer than this and emergency hearings are not granted under the Turkish law. Hypothetically speaking, if a woman who requested an abortion at a state hospital and was not granted one brings a complaint to the administrative court, by the time the hearing takes place, her pregnancy will have already exceeded the time limit. So far as she will no longer be eligible to obtain an abortion on request, she will not be considered as having legal interest in the case. Women's organisations, on the other hand, could argue that they have interest in the issue, but could not prove harm.

Belgin, a lawyer with the Istanbul Bar Association's Centre for Legal Support for Women, compared the situation to a lawsuit that they filed against the article barring women from remarrying within the first 300 days after divorce:⁶⁷

Putting the right to marriage side by side with right to abortion... You can marry afterwards, after all. ...This gives us a number of legal options. But we have no chance of waiting in case of an abortion request, because of the ten-week limit. We have none. ...We'll file the case, a few months will elapse before even the communications take place; then we probably will have to ask for sending the case to the CCT, the judge will decide... It's at least two or three years. This is no answer for urgent problems. And if the problem is not urgent, legal interest will be debated. So it's very difficult to achieve this [goal]

⁶⁷ The article's purpose reads as "preventing confusion about paternity," and no similar obligations are cited for men. A woman is entitled to apply to Family Courts with documentation proving that she is not pregnant at the time of divorce to skip the mandatory waiting period under the law. Belgin explained that the Centre brought the case to the court primarily for principled reasons, to get the article revoked altogether, as they deemed it discriminatory and derogatory toward women. The woman on whose behalf they petitioned had, in actual fact, no intention to remarry, after all.

through the courts. Very difficult. (Belgin, Centre for Legal Support for Women)

My respondents made clear that while deliberating litigation, they did not base their strategy on the expectation that the administrative court's affirmation of a woman's right to acquire an abortion in a public institution would guarantee access for women in the future. Not only because there always was the possibility of losing in court, but also because they were well aware that lower courts' decisions can easily be eschewed by Turkish "street level bureaucrats." In other words, they were far away from naively believing that the sanctioning by the courts would guarantee implementation, let alone imagining that it would trigger the broader social transformations that they sought: As they were quick to note, the political critique and the demands that they produced through the rights language could not be contained within the question of access to health services.

Rather, the goals that they would seek through litigation were, on the one hand, to voice their substantive arguments in an official setting and inscribing them "on the record," and on the other hand, to attract more and sustained public attention to the issue through the litigation process. As the barriers to litigation seemed to be too arduous, they forwent the former goal and focussed on their previous strategies to ensure the latter—that is, street protests, recruiting women columnists, and disseminating campaign material to propagate their arguments.

Conclusion

This chapter sought to elucidate the processes through which organisers from the Abortion Is A Right Platform adopted rights language as the main tenet of their

campaign and creatively deployed rights language in advancing their political arguments and demands. A close focus on these processes suggests that far from being blinded by the lure of the “myth of rights,” activists adopted rights talk strategically and sought to overcome the shortcomings inherent in rights framework through articulating rights with alternative political visions. Within the increasingly conservative social climate that I depicted in the previous chapter, rights framework indeed seemed to be the most favourable way for generating an acceptable, accessible, and legitimate language to both reach out to women and to hold the state accountable: “People can only demand change in ways that reflect the logic of the institutions that they are challenging” (Crenshaw 2011 [1988]: 269).

While the platform was only one among many initiatives, it quickly expanded into several cities countrywide and other initiatives shared the political framework that was generated through the discussions in Istanbul. This effort, which was street-based in contradistinction to other initiatives like petitions and social media activism, brought thousands of women throughout the Summer 2012 to the streets in mass protests. Arguably, one consequence of this large-scale mobilisation has been the government’s withdrawal of plans to restrict abortion—a victory that is commonly counted to activists’ credit.

The following chapters, instead of undertaking the impossible task of assessing the truth of this latter claim, will turn attention into healthcare institutions and will seek to explore the consequences of the abortion/caesarean controversy on the routine delivery of reproductive healthcare services at hospitals and clinics. Toward this aim, I will first lay out the organisational structure of healthcare in contemporary Turkey, then focus on

health workers' accounts in order to better appreciate the effects produced by the legal talk that was adopted by both government actors and by women activists. Thinking activist uses of rights language and the health workers' accounts together, which I will undertake subsequently, will allow a fresh perspective for discussing the impact of rights claiming.

CHAPTER 5

UNDERSTANDING HEALTHCARE IN TURKEY CIRCA 2000S: AN INTERLUDE

Having described the political and legal skirmishes that erupted around reproductive health services since 2012, it is now time to turn into the effects that these heated interventions produced on the ground, that is, at the level of the routine service provision in healthcare institutions. But before going into how the politicisation of reproductive health services through legal talk transformed everyday activities for healthcare workers, which is the topic of the next chapter, it is worth offering a brief sketch of the organisation of healthcare in the Turkish context.

As I briefly discussed in Chapter 3, healthcare has gone tremendous changes under the AKP rule, through the implementation of the Transformation in Health (*Sağlıkta Dönüşüm-TiH*), a project seeking wholesale restructuring of the healthcare system that was launched in 2004 and is still under way today. Prescribed and financially supported by the World Bank and the International Monetary Fund, the TiH entails massive privatisations and private-public partnerships (Buğra and Keyder 2006) while “the state remains as the major actor in financing healthcare services; indeed, there is a trend towards strengthening state regulation of access to and provision of services” (Ağartan 2012). At the same time, through a strategy of “neoliberal populism,” (Bozkurt 2013) the changes that the TiH engendered in the area of social insurance also brought about a certain degree of unification across different types of institutions, diminishing the

differences among the benefits received by different sectors in society.⁶⁸ These contradictory tendencies, perhaps inevitably, created new kinds of pressures and tensions within healthcare provision.

Before identifying and discussing these tensions, I first describe the rather complex structure of healthcare in Turkey. In outlining this organisational diagram, I try to rely more on the accounts of my respondents working in the healthcare area than on official sources. There are obvious difficulties that come with this, as it will become clear in the next section: Health employees themselves are often confused about the structural changes that are transforming the institutional setting in which they work. I therefore also consult Ministry of Health resources and secondary accounts in order to reduce factual errors. Doing so also helps me identifying areas that seem to be consistently misunderstood by health workers.

In a nutshell, the chapter presents the broader transformations brought about by macro processes of neoliberalisation, which drive a host of changes at the micro level of service provision in healthcare institutions. It thus provides context for the next chapter, where I discuss everyday healthcare practises, without which making sense of the dynamics at play on the ground would be impossible.

One important point that will emerge from this chapter is the fact that there already existed a number of structural obstacles to smooth and satisfactory access to certain reproductive health services even before reproductive health practises were shrouded in legal language. The ways that the legal skirmishes of the Summer 2012 affected

⁶⁸ Commentators argue that the TiH has successfully fulfilled its populist goals and contributed enormously to the AKP's success over the 2000s (Buğra 2011).

reproductive healthcare provision, in turn, cannot be understood without being situated within these systemic constraints.

Difficult Times for Conducting Research

Osman: You should go talk with an AÇSAP.

Ayşe: I thought AÇSAPs were closed.

Osman: That's correct, they are closed. But this one open. (Osman, ob/gyn at public Westpointe neighbourhood clinic)

Looking back, this conversation that took place at the very initial stages of my fieldwork seems to encapsulate the argument that will be presented below: A great amount of confusion exists about how things work in the healthcare sector, even among the healthcare employees themselves. Many of my subsequent informants made comments about this, but the candid remarks that Sibel, an ob/gyn at a private Westpointe hospital gave me in response to my questions about the structure of the healthcare system capture these common feelings the most aptly: “You are doing this study at a very difficult time. There is so much confusion about the healthcare system right now. Even we ourselves don't quite understand what is what.”

At the root of the confusion is the TiH, under the sway of which new regulations and ordinances frequently appear, making it difficult for healthcare workers to follow up and adopt themselves to the new rules. Below, I will begin by looking at the situation prior to the onset of the TiH and the changes that it brought about. Attending to the characteristics of the previous system seems important, not the least because the TiH does not advance a brand new structure but functions through modifications made into the old one, all of which do not work out smoothly. A brief historical sketch is therefore

in order for an accessible account of both the current configuration of healthcare institutions and services, and the confusions that the project created.

Healthcare System Before the 2000s

The healthcare system in Turkey was built on the basis of the institutions inherited from the Ottoman Empire. With the introduction of laws formalising medical education and establishing a centralised and hierarchical structure under the Ministry of Health (initially the Ministry of Health and Social Assistance—*Sağlık ve Sosyal Yardım Bakanlığı*), the healthcare system both expanded and was rationalised over the first decades of the new Republic. Yet, it was not until the 1960s that the attempts at centralisation were turned into a unified project. This project, known as the “socialisation in healthcare,”⁶⁹ envisioned the organisation of the healthcare system as a three-level structure. The first level comprised of preventive health services, such as vaccinations and hygiene trainings, and was considered as the backbone of the healthcare system. Curative and rehabilitative services would be only complementary to this first level, and would be offered by state hospitals offering inpatient and outpatient services (second level) and state research and expertise hospitals as well as university hospitals (third level). In this vein, the first Development Plan (1961)⁷⁰ instructed the establishment of various kinds of

⁶⁹ The term “welfare state” is translated into Turkish as “social state” (*sosyal devlet*), and was one of the leading principles of the 1961 Constitution, prepared in the wake of the 1960 military coup. The term “socialisation in healthcare” thus refers to this principle rather than any allusion to socialism. Turkish socialisation of health entailed a population-based system, which emphasized public health, and defined the responsibility of the state more broadly than earlier approaches (Kurt and Şaşmaz 2012).

⁷⁰ The Republic followed a liberal economic model in its first years, which shifted toward a state-led development economy with the onset of the global economic crisis in 1929. After the 1960 military coup, and with the establishment of the State Planning Agency (*Devlet*

neighbourhood-level clinics offering a variety of services. For instance, *Sağlık Ocakları* (community clinics), employing at least one general practitioner and assistant staff, would be responsible for a wide range of preventive and curative services from vaccinations to the diagnosis and treatment of simple illnesses; *Verem Savaş Dispanserleri* (dispensaries for struggle against tuberculosis) would focus on the diagnosis and treatment of tuberculosis; and *Ana-Çocuk Sağlığı Merkezleri* (mother-child health centres) would offer pregnancy follow-ups and motherhood trainings for women as well as new-born and infant care. First-level health services were to be free for all; that is, no insurance coverage was required to access those services (Fişek 1966).

That said, the socialisation programme achieved little in terms of remedying the corporatist and inegalitarian access to healthcare: From the early days of the Republic on, expertise and university hospitals were accessible to civil servants in a way that was unattainable for the formally employed and the self-employed, who had access to lower quality state hospitals only (Buğra and Candaş 2011). Furthermore, those who were not (formally) employed were left out of the upper-level health services.⁷¹

Planlama Teşkilatı – DPT), the fragmented industrial plans of the previous decades gave way to more unified and comprehensive planning, known as the planned economy period of 1960-1980 in Turkey (Boratav 1988).

⁷¹ The corporatist welfare system of Turkey excluded those who are not formally employed or dependent of a formally employed person from healthcare. Nonetheless, there is evidence that the poor still had access to certain basic healthcare services through the neighbourhood clinics (Üstündağ and Yoltar 2013) limiting the access of those who were not covered through their employment status to state hospitals. This state of affairs continued until the introduction of the Green Card scheme in the 1990s. Green Card was akin to Medicaid, a mean-test based healthcare assistance programme from which only the non-(formally) employed poor could benefit. Still, by 2002, it was estimated that 20% of the population was not covered by any plan, including the Green Card Scheme (Buğra and Adar 2007: 28).

By the mid-1970s, the goals of the programme were not nearly met, but a number of local-level clinics were operating nationwide. In order to complement the neighbourhood-level clinics, many state hospitals, including research hospitals, opened polyclinics to offer first-level health services. In addition, private enterprises started to flourish, especially in larger cities—a trend that only accelerated and became widespread across the country after the liberalisation of the economy in the aftermath of the September 12 military coup in 1980. Private businesses were also included into the state's three-tiered scheme as first- and second-level health institutions. But private practitioners and institutions, on the condition of meeting MoH criteria for every service to be offered, themselves determined their own scope of services as well as price range. Consequently, a large number of full-fledged private hospitals started not only to offer complicated rehabilitative inpatient services, but they also offered those side by side with preventive care as well as major surgery, all the while appearing as second-level institutions on paper.

Reproductive health services, within this complicated healthcare structure, could be accessed in various institutions—depending on which service was sought, where one lived, and the resources one had. From 1965 onwards, with the passing of Law no. 557 which legalised contraception, *Ana-Çocuk Sağlığı Merkezleri* were turned into *Ana-Çocuk Sağlığı/Aile Planlaması Merkezleri* (Mother-Child Health/Family Planning Centres – AÇSAPs), and the provision of contraceptive counselling and methods were included in their duties in addition to pregnancy and infant care. *Aile Planlaması Klinikleri* (Family Planning Clinics), operating among state hospitals' polyclinics, offered contraceptive services as well. After 1983, and the legalisation of abortion with Law no. 2827, both

types of facilities started to provide abortion on request, so far as they met the personnel and physical requirements criteria established by the law.⁷²

Gynaecology/obstetrics departments and maternity yards in state hospitals, in addition to numerous maternity hospitals countrywide, oversaw more demanding pregnancy care and hospital births (including caesarean sections), and terminated pregnancies that posed a threat to pregnant women's lives or entailed serious foetal deformity. The law did not prohibit gynaecology/obstetrics departments or maternity hospitals from offering abortion on request, but with their already substantial workload, most expert ob/gyns working in the public sector shunned this practise.⁷³ Finally, any of these services could also be purchased from the private sector, at a price rate determined by providers themselves and to be paid either out of pocket or through private insurance.

⁷² According to *Rahim Tabliyesi ve Sterilizasyon Hizmetlerinin Yürütülmesi ve Denetlenmesine ilişkin Tüzük* (Guidelines for Practise and Oversight of Uterine Evacuation and Sterilisation Services), published in December 1983, ob/gyns can offer abortion on request anywhere they practise their profession, and general practitioners, under the supervision of an ob/gyn, can offer abortion on request using menstrual regulation (MS) in official healthcare facilities under the supervision of an ob/gyn. An appendix to the *Guidelines* details the list of medical equipment that needs to be available in a facility, be it private or public, to offer abortion on request.

⁷³ Within the set of laws, ordinances, and guidelines that regulate provision of abortion on request, while the limits as to who *may* provide abortions is laid out in detail, who *will* be responsible for offering them is never specified. Therefore, no personnel, in theory, have a legal obligation to provide abortion on request – allowing ob/gyns to refuse abortions even without recourse to a conscientious objection clause. It is also unclear on what basis family planning units are established in public hospitals, and to which of those or to which AÇSAPs practitioners and expert doctors are assigned. The second item of the article no.15 of the *Nüfus Planlaması Hizmetlerini Yürütecek Personelin Eğitimi, Görev, Yetki ve Sorumlulukları Hakkında Yönetmelik* (Code for the Education, Duties, Authorizations and Responsibilities of the Personnel Executing the Population Planning Services), enacted in 1983, states that “The Provincial Health Director prioritizes the allotment of the personnel trained and certificated in population planning to places where population planning is performed,” which does not provide much information about the criteria used for those. I explained elsewhere my endeavour to find those criteria out, which eventually proved futile (Toksöz 2011; 54-61).

Transformation in Health, 2004–Present

As the above account attests, before 2004, the organisation of healthcare in general and the provision of reproductive healthcare in particular had a patchwork nature. This did not only make it difficult for ordinary citizens to understand and navigate health institutions,⁷⁴ but also rendered the structure as a whole inefficient. One of the central goals of the TiH was to reduce this complexity and by extension inefficiency, which afflicted not just reproductive health services but the entire healthcare structure, most importantly first-level services. To this aim, the family physician system was introduced in 2010.⁷⁵ According to this new arrangement,

...things work on the basis of population registrars. Every family physician has [a given number of] patients who are registered with her through the ID number;⁷⁶ when a patient comes here, she is directed to her own physician. (Şeyhmus, Eastpointe family physician)

Indeed, the claims at universal healthcare coverage were the main selling line of the TiH during the planning and implementation stages. However, based on a compulsory premium scheme,⁷⁷ the new insurance system did not necessarily bring about universal

⁷⁴ In the area of reproductive health, evidence suggests that women typically overcame the difficulties posed by this complex organisation through consulting other women in their personal networks who had previous experience with the reproductive healthcare system (Shorter and Angin 1996).

⁷⁵ The first pilot family physician scheme was implemented in one city in 2005, was then expanded to other provinces. Since December 2010, the programme has been implemented in all 81 cities countywide.

⁷⁶ The individual-specific citizenship ID number with 11 digits is the basis of the contemporary Turkish state's information storage, and it is also a fundamental element of a person's official existence—one has to use her ID number in almost every step of daily life, from receiving treatment in a hospital to opening a bank account. That is to say, having a citizenship ID number is not only a legal, but also practical necessity (Bozbeyoğlu 2011).

⁷⁷ Premiums are compulsory for those all citizens earning above the poverty line, at a rate ranging from 12,5⁰% of minimum wage to 12,5⁰% of six times the minimum wage. Households making less than 1/3 of the minimum wage per capita will be considered as poor and their premiums will be paid by the state. Those who are not considered poor

health coverage. As Üstündağ and Yoltar (2013) suggest, while eliminating former inequalities between the formally employed and the unemployed, the TiH instituted new kinds of hierarchies between those who can and who cannot pay premiums, excluding those who cannot pay premiums from all levels of healthcare including the first level.

Despite its failure to deliver on its promise in practise, the original restructuring plan sought to attain universal coverage through attaching each and every citizen to one family physician. In addition to constituting the bedrock of universal healthcare coverage, family physician system would also promote the unification of healthcare services: By offering a forthright entry point to the healthcare system for every individual and establishing a robust referral chain, family physician programme was designed to preclude multiple visits to different doctors at different institutions. Accordingly, this measure was meant to insure that

[a] person always sees the same doctor. This is a good for the patients themselves. Because you get to know the person, her allergies, the general state of her health, the health circumstances of her family, of her life... And this is the goal [of the family physician system]. Take the patient not simply as an organism, but holistically within her environment, with her economic and social conditions. ...In the old system... the doctor would see [the patient] on that one day. Would only see her though physical and verbal examination [of acute symptoms]. (Zafer, Westpointe family physician)

Accordingly, the introduction of the family physician system would render the existence of various kinds of first-level healthcare institutions redundant. Institutions such as *Sağlık Ocakları*, and—because contraceptive services and pregnancy and infant care are considered as first-level services—AÇSAPs were scheduled to close concomitant to the

according to this means-test scheme, whether formally employed or not, are also obligated to pay the premiums. This scheme has thus been criticised by medical associations and labour unions (as well as feminists) as it pushes the low- and irregular-income persons and families (thus affecting poor women and single-headed families disproportionately) out of the healthcare structure (Kılıç 2008a).

onset of the new system. By the same token, through increasing diagnostic and preventive efficacy, such a holistic approach to first-level healthcare would alleviate much of the burden from the upper level institutions: So far as patients would access effective preventive care from their family physicians, they would not need to flock hospitals with spurious requests. State hospitals, in turn, would be accessible only upon a referral from a family physician.

Private healthcare services, as I stated above, only clumsily fit into the three-tiered system suggested by the MoH. The TiH sought to integrate them into its overall organisation through another strategy. Historically, there has never been any impediment for anyone to purchase private care at any level, anywhere they liked—so far as they were able to afford it, whether paying out of pocket or through private insurance. The thriving private healthcare sector worked alongside the public sector for decades, but was accessible only for a small portion of the population. In order both to alleviate the burden from state hospitals, as well as to increase the quality of healthcare by extending the market principle of competition from the private into the public sector, the TiH instituted a scheme of subsidising private enterprises (Eder 2010: 170). Accordingly, private hospitals and clinics that enter into a contract with the MoH offer certain services for much lower out-of-pocket fees for the beneficiaries of the public healthcare scheme, and the remaining chunk is covered by the state. Benefiting from this scheme, on the part of the patient, is dependent upon acquiring a referral from a family physician or another first-level public healthcare worker. While the kind of benefits they offer vary, over the last years an increasing number of private healthcare institutions became contracted hospitals, whereby

...employees can now come here and pay only a small fee even if they don't have private insurance. The state pays for them. ...previously, the [formally] employed could not benefit from the private sector [only] with their health coverage.” (Sibel, ob/gyn at private Westpointe hospital)

Figure 1: The changes brought to the three-level structure by the TiH

		Old system		New system	
		Facility	Access	Facility	Access
1st level	Sağlık ocağı		free, open to all	Family physicians clinics	free, open to those who are registered through the MoH
	Verem savaşı dispanseri				
	AÇSAP				
2nd level	State hospitals		free, open to all	State hospitals	free in case of referral, limited access without referral
	Maternity hospitals			Maternity hospitals	
	Private hospitals	fees apply	Private hospitals (no contract)	fees apply	
3rd level	State research and university hospitals		free in case of referral, limited access without referral	State research and university hospitals	free in case of referral, limited access without referral
	Expertise hospitals			Expertise hospitals	

Figure 1 summarises how the provision of healthcare services was planned to function in the TiH project's original design. One should approach this figure with caution, though. I am seeking, for purposes of clarity, to offer a neat and sketch of the structure both in my narrative as well as in the figure. Yet, this neatness is more ideal than real. The reality is messy, as I was warned in remarks about the inopportune timing of my research.

For one thing, at the time of research, more than four years after the onset of the family physicians programme, many of the first-level family planning institutions were

still open and functioning. That is, the plans toward standardising the entry into the healthcare system have not materialised. Some of the former AÇSAPs, now their maternal and infant care duties officially withdrawn (hence practically turned into free standing neighbourhood family planning clinics) but still bearing the signs reminiscent of the olden days, were open and functioning; some were closed. On the other hand, polyclinics at state hospitals, including family planning clinics, also continue their services as before. Unlike the main departments in state hospitals, these latter do not require a referral from a lower-level institution and patients are admissible to these latter regardless of their place of residence and where they are registered with a family physician.

One respondent reasoned that AÇSAPs and family planning clinics could not be closed because according to MoH regulations, family physicians and nurses were required to receive contraceptive training and acquire a certificate in the area in order to be qualified to offer counselling and apply methods, most importantly, IUD insertions. Until every family physician and nurse in the country received this certificate, AÇSAPs and family planning clinics needed to fill the gap. Besides, it was the personnel working at those two types of institutions who offered those trainings, making it unlikely that AÇSAPs can be closed at any point in the near future—unless a new system is introduced for training family physicians in reproductive care.

Therefore, part of the reason why the simplification that the TiH sought has not yet come true might be due to the fact that more time is needed for successful implementation of certain components of the project. Then again, I will suggest that the TiH brings in more systemic drawbacks as well, and reproductive healthcare services are afflicted with both sets of problems.

Despite this on-going complexity, women seem to have many options for receiving reproductive health services under this new structure: Contraceptive counselling and provision of methods can be acquired in family physicians' clinics, in the AÇSAPs that are still open, and in state hospitals' family planning polyclinics in the public sector, as well as in numerous private businesses. Fewer options exist for abortion on request than contraceptive services, so far as in the public sector abortion on request is by and large confined to hospitals that comprise a family planning clinic and where one gynaecologist (either holding a permanent position in the clinic or rotating) oversees the practise. To reiterate, obstetrics/gynaecology departments in any public hospital meet the criteria for offering abortions, but as they are not *mandated* to offer this service. Consequently, most ob/gyns refrain from it, mostly because their workload is already substantial without the addition of another type of service. But many private facilities, qualifying gynaecologists' offices as well as hospitals, do offer abortion on request on a wide price range. For women who desire to have a child through a healthy and minimum-risk pregnancy and delivery, the option of choosing and sticking with a doctor working in the private sector during pregnancy to monitor their health and their foetuses exists. Those who cannot afford it are guaranteed to receive regular follow-ups from their own family physician, and they can be referred to second-level hospitals for riskier pregnancies. And finally, women can also choose between a private and a public hospital's maternity yard to give birth in; caesarean sections, as indicated, are available in all maternity yards and hospitals.

Judging from this organisational diagram, women have indeed various options for accessing any reproductive healthcare service.⁷⁸ How is this appearance reflected to the on-the-ground reality? The next section will document how access to abortion on request, and more surprisingly, contraceptive services pose problems of access, especially in the public sector. At the same time, it will show how pregnancy follow-ups, despite their seeming straight-forwardness, come to engender a series of dilemmas on the part of health workers as well as women seeking reproductive healthcare. Before delving into the ways that law and politics leak into the daily routines of healthcare workers in the next chapter, it is worth focussing on the structural problems brought about by the TiH, which frame and circumscribe those routines in the first place.

Difficult Times for Accessing Reproductive Healthcare

Even though its full design remains yet to be implemented, certain characteristics of the overarching Transformation in Health project need to be identified in order to examine the kinds of hindrances that it introduced or reproduced. This section will focus on two main (and contradictory) tendencies of the TiH, namely integration and decentralisation, and attest to (some of) the ways in which these two tendencies compromise easy access to some reproductive healthcare services, while rendering the provision of some others problematic.

⁷⁸ In advancing these hypotheticals, I depart from the ideal scenario proposed by the designers of the TiH. As mentioned above, in reality, women who fall out of the welfare net do not have access to any of those unless they can afford to pay medical expenses out of at private institutions. An unlikely occurrence, although not necessarily impossible. Yet, the following section will focus on how the system poses problems of access to reproductive healthcare even if universal health coverage were established through the TiH.

The first tendency to note is integration and unification of healthcare services that the TiH sought. One component of this tendency was the attempt to render the overall organisation of healthcare more efficient through redesigning the three-level structure, as discussed above. But a second component of unification deserves mention as well, not least because it has had a considerable place within the 2012 debates as well as within my respondents' frame of reference: the mandate that all healthcare facilities share information pertaining to patients⁷⁹ through a centralised database.⁸⁰ This scheme has been, as could have been expected, extremely controversial due to privacy concerns, primarily because under its scope patients are not notified, let alone asked consent, that their information will be shared, with the Ministry or any other body. Despite the on-going controversy, and even though the inclusion of private facilities within its scope is still debated, many health workers in both public and private sector routinely submit data to the database. Additionally, there are other electronic data-sharing software with smaller scopes that are used at first-level healthcare facilities in the public sector, as a rule afflicted with the same privacy issues.

⁷⁹ It should be noted that here, patient information refers to a very broad set of data both with regards to who is included and the kind of information collected: On the one hand, because most citizens get into contact with the healthcare system at some point in their lives (today, usually at birth), the concept does not necessarily imply a finite group of sick people but the citizenry at large. On the other hand, not only information pertaining to one's health status, but many other types of information, including personal identifiers, are also collected by this system (Kuzeci 2010).

⁸⁰ Electronic collection of data by the Turkish state started during the early 2000s, in healthcare as well as in other areas. But the issue of patient information took a new twist in 2011 when, with the executive order number 663, the MoH was given the right to collect, process, and share personal information of all individuals receiving any service from any healthcare institution, public or private. A year later, the Ministry started to send out circulars, ordering all health institutions to send all information concerning their patients to the Ministry's central database on a daily basis through the software *SağlıkNet2*, which was the most recent update at the time of research (Toksöz 2014).

The second tendency that needs scrutiny is decentralisation. Its efforts at unification notwithstanding, the TiH also ordained decentralising the public healthcare structure, following the principle of marketization as recommended by the IMF. The most important elements of this trend are the constitution of the family physicians system as—to quote from an Eastpointe family physician—“a half-private arrangement” and the performance-based salary scheme implemented at various state institutions at all levels. Since these two novelties introduced by the TiH turned out to entail significant consequences for the reproductive health practises that I am interested in, they deserve to be laid out in greater detail.

Under the new structure, family physicians are state employees and their clinics are official state institutions. However, the arrangement is made to enable the MoH to pass a variety of its own managerial responsibilities onto family physicians themselves. Accordingly, paying rent, utility bills, personnel selection, and supplies purchase, among other tasks, are no longer decisions that are made centrally, but are ascribed to individual practitioners:

The state provides [us] with an operating budget so that we can pay the rent and our bills, but it's on us to make things work, such as finding a building to rent. Nurses who are on the Ministry's payroll system need to find a family physician's clinic and they sign contract directly with a family physician, even though they are subsequently paid by the state [and not by the doctors themselves]. We hired one additional nurse and two personnel; we pay their salaries ourselves. (Zafer, Westpointe family physician)

Furthermore, rather than seeking standardisation across family physicians' clinics, the system ranks them on the basis of the qualifications that practitioners working at a given clinic possess and the scope of the services that they can offer according to the physical criteria that a given clinic meets or fails to meet. To be more precise, while non-

classified clinics offer solely the basic services like vaccinations, doctors at a family physicians' clinic need either to accrue more job qualifications or broaden the capacities of their clinics to climb up the classification ladder. By and large, the scope of first-level services that a family physician will offer to her clientele is left to individual physicians' professional and economic ambitions.

There is one incentive (hence economic ambitions) for family physicians to broaden the scope of the services that they offer: The TiH introduced a new salary scheme, based on an employee's "performance," covering all doctors working in the public sector from family physicians to expert doctors employed at main departments of state hospitals at all levels.⁸¹ Accordingly, those personnel accrue "performance points" for each service they provide every month on top of their base salary. The MoH publishes lists of all medical interventions offered in healthcare institutions, whereby a definite amount of performance score is assigned to each one; the list is updated regularly. The base salary, on the other hand, is determined according to the institution a doctor is employed at and their level of expertise/tenure. For instance, for family physicians, the base salary increases as their clinic moves up the classification ladder, whereas expertise hospitals offer higher base salaries than second-level state hospitals. Clearly, the system promotes fast delivery of services to a large number of patients rather than focussing on the quality of services or the success of treatments.

State hospitals are affected by the performance-based system in another way than through the salaries of their employees as well. Indeed, the expectation that public hospitals should function on the basis of market principles, in a self-contained manner

⁸¹ This scheme does not encompass nurses or other assisting personnel, but only physicians starting from general practitioner up to expert doctors.

and without support from the central budget is not new: The designation of public hospitals as revolving fund institutions [*döner sermaye kuruluşları*] dates back to the 1982 Constitution. In this vein, it was the junta government (the importer of neoliberalism into Turkey) which had first instructed that public hospitals were to seek profit as any other capitalist enterprise, and be financially self-sufficient without recourse to state funding. Yet it was not until the sweeping legal changes under the AKP government that this principle has really been achieved (Acar 2009). Consequently, individual doctors as well as hospital administrators are led to seek profit through their practise, selectively offering and withholding services on the basis of their profitability. In other words, healthcare has been effectively reduced into a market transaction under the new structure.

How are women's access to and experiences with reproductive healthcare influenced by the new organisation that the TiH brought about? In particular, how do the two overarching tendencies of the project—namely unification and decentralisation—shape and constrain access? Below I expound on three particular points in order to scrutinise the hindrances to reproductive health services in particular that are produced by the tensions that the TiH engendered.

Imperfectly Functioning Central Planning

If women have all sorts of different options for accessing reproductive healthcare, how can it be possible that they may not locate the right place to receive certain services? Although the answer to this question is tied to the two other points that I am going to raise below, in this section I will focus on the setbacks pertaining to centralised planning,

which deserve to be treated as the source of one set of problems in and of themselves. I will follow examples of abortion and contraception in order to explain this particular point.

Abortion on request is, as I stated above, currently available in the public sector only in family planning clinics of state hospitals. Previously, AÇSAPs were eligible to offer abortion on request in so far as they met the personnel and physical requirements criteria, which included not only certain physical characteristics and medical equipment but also the presence of an expert ob/gyn to oversee the practise. According to health workers' testimonies, the practise continued until the early 2000s.⁸² Yet, even prior to the transformation in the healthcare system few AÇSAPs met those qualifications; with the TiH in full swing, it became increasingly difficult for those facilities to become eligible, most importantly because expert personnel was no longer allotted to those first-level facilities (Toksoz 2011). Consequently, at the time of my research, there were no more AÇSAPs providing abortion on request in either of the two cities where I conducted fieldwork.

State hospitals are not exempt from the problem of inadequate allotments, as shown by many indices. The phone interviews that *Mor Çatı* volunteers conducted while I was doing my research, and an academic research by Mary Lou O'Neill (2016) concluded that Istanbul, the most populous city in Turkey, had only two public hospitals offering abortion on request. Not surprisingly, the most recent wave of the population and health survey conducted every five years by Hacettepe University, the most systematic and

⁸² A MoH ordinance from 1999 instructs “encouraging AÇSAPs to offer abortion services more widely across the country,” attesting to the government willingness to make available these services more widely available and less reliant on hospitals.

large-scale study conducted in the area of reproductive health in Turkey, attests that not only the rates of (registered) abortions on request are in decline, but that abortion is also most frequently accessed through private providers countrywide. (TNSA 2014)

At the time of research, in Westpointe and Eastpointe, there were three and one public facilities offering abortion respectively (the number later dropped down to two in Westpointe). As a matter of fact, not all public hospitals comprise family planning units, and among those that do, most do not employ adequate personnel or abide by the minimum physical requirements that would make the units suitable for offering abortions:

No, there is no [provision of] abortion on request [in our hospital]. I mean, we used to do it previously. But then our team dispersed, and there has never been a build-up after that. (Jale, nurse at family planning unit in Westpointe public hospital)

Gönül: No, here [in this unit] abortion was never offered. But there are only one or two places offering it in the city anyways.

Ayşe: Do you know what the reason for this is?

Gönül: Maybe the environment is not conducive, or perhaps the decision makers don't approve of it... As far as I know, hospital administrators are not sympathetic. (Gönül, nurse at family planning unit in Westpointe public hospital)

Drawing attention to the fact that this is a trend rather than a temporary deficiency, Çiçek, a practitioner who has worked in the area of family planning for almost 30 years, and who provides abortion on request in one of those three Westpointe state hospitals, lamented:

The situation is plain to see... The entire area of family planning is slowly being drained. I will soon retire myself. They don't replace the doctors who retire. ...We did all this work with idealist commitment. But when we retire, there will be nobody left to carry these out... (Çiçek, practitioner at family planning unit in Westpointe public hospital)

While she, just like many other respondents, explained this decline on the basis of the

government's negative attitude toward family planning, she also emphasised that as the family planning clinics at state hospitals were left out of the performance scheme, she was earning far less than most family physicians. Çiçek asserted that this was a considerable disincentive for new medical school graduates to gravitate towards family planning.

Non-transparent bureaucratic decision-making processes, combined with professional trends driven by the incentive structure of the TiH seem to have led to a substantial shortage of qualified personnel in family planning units at state hospitals and AÇSAPs, resulting in incredibly reduced access to abortion on request in public institutions. But abortion is not the only practise that is afflicted with the problems pertaining to central planning. Contraceptive services, which in theory are available in many different types of public facilities, have also become problematic through a similar process.

Shortage of supplies was the foremost theme pertaining to contraception that came out from my interviews. Public hospitals and neighbourhood family planning clinics receive all of their equipment from the provincial health directorates, and are not supposed to use any other material.⁸³ Family physician's clinics, in contrast, are required to buy their own materials for most purposes; yet, contraceptives are an exception to that general rule, and they too are required to procure those needs from state supplies. In other words, all public healthcare institutions at all levels, even those that operate in a quasi-private manner, are obligated to rely on state provision of contraceptive material.

⁸³ Maybe a better choice of words would be "buy any other material": They are free to use the IUD that a patient purchases and brings to the hospital/clinic with her. But they themselves cannot go and buy equipment for use in the hospital/clinic.

One particular instance that was corroborated by many informants was the fact that for a few months during the 2012-2013 year, there was a serious shortage of materials. Whereas the hindrance had been remedied in some institutions afterwards, some informants reported that it was a chronic rather than an episodic problem in the institutions that they worked at:

I wasn't working during that period. Right now we have plenty of supplies. It just arrived last month, and it was plenty, a lot of it. (Seher, nurse at family planning unit of public Westpointe hospital)

It's irregular; birth control pills are sometimes supplied by the state, sometimes not. I mean, they are supposed to be delivered regularly but... [they are not]. (Zafer, Westpointe family physician)

The routine practise is that the Ministry provides us with supplies. I mean ... we are constrained by [the amount of] supplies we receive [from the Directorate]. There have been times we didn't have any pills. There have been times we didn't have any condoms. [As an institution] we are geared toward inserting IUDs, there have been times we didn't have any IUD sets. (Zeliha, practitioner at public Westpointe family planning clinic)

For those who experience this problem on a continuous basis, those shortages themselves were a sign of government negligence, if not hostility toward their practise, alongside being an almost insurmountable obstacle preventing them from providing services to their clientele:

After those three children, five children statements by Erdoğan, we weren't able to get anything from the Provincial Health Directorate. We still aren't. We buy everything ourselves out of the municipal budget. I don't believe we will receive anything [from the state] from this point on any more. (Leyla, practitioner at Eastpointe municipality clinic)

Well... for instance, previously, our own storage used to be full. Now, even the Health Directorate's storage is empty, and we ask material from each other, from other neighbourhood family planning clinics. ...And we communicated it to them several times, both by word of mouth and by written [requests]. (Zeliha, practitioner at public Westpointe family planning clinic)

Gönül: There are periods where things are very difficult. For instance, last year, we didn't receive any material for an entire year. We had nothing left. We just came here to sit around all day.

Ayşe: What do you do at the family planning clinic do when you have no material?

Gönül: Nothing. I mean, we can still give counselling. If [a woman] purchases her own IUD, we can insert it here. We can recommend that she use pills, and tell her she can buy those from a pharmacy. (Gönül, nurse at family planning unit in Westpointe public hospital)

There is no way to determine the cause of these obstacles on the basis of the data collected through my research: They could be intended policy by the central government, discretionary actions by Provincial Health Directorates, or just accidental shortcomings. But it is worth noting that reading into these obstacles, health workers develop a certain interpretation of how their practise is being perceived by governmental and ministerial authorities—such as Gönül, quoted above, suggesting that “hospital administrators are not sympathetic” towards abortion. This reading constitutes the backdrop against which they decide the limits to their practise. At the end of the day, those problems relating to shortage of personnel as well as equipment, which undoubtedly signal at a structural deficiency institutionalised by the TiH, produce effects on accessibility of reproductive healthcare both directly (where there is no personnel or equipment, there is no access) and indirectly (by transforming the professional environment, as the next chapter will further illustrate).

The Broken Referral Chain

Even though some of the public facilities lack adequate personnel and equipment, there are undoubtedly those that do not and continue their practise smoothly. Do these shortages really pose an obstacle for women who seek access to reproductive healthcare,

especially when every citizen has a primary care giver?³ This subsection will explain how the facilities that function as intended may not be easy to access, and therefore fail to meet the potential demand for reproductive health services.

To reiterate, one of the most celebrated transformations sought with the TiH was the reduction of the complexity of healthcare system, single and straightforward entry into the healthcare system for all citizens through family physicians, and smooth movement within the system through the referral chain. Yet, as this subsection will suggest, this idealised scenario of universal entry into the healthcare through family physicians itself turns into a drawback when it comes to reproductive health services, contraception and abortion in particular.

Counselling and provision of abortion on request, formerly accessible at AÇSAPs, are completely left out of family physicians' purview. To reiterate, abortion on request can be performed by general practitioners only under the supervision of an expert doctor. The family physician system does not stipulate employment of expert ob/gyns at family physician's clinics. This section will thus particularly focus on contraceptive provision, which is promoted to a larger extent than abortion under the TiH, to single out the shortcomings of the healthcare structure even when it comes to those healthcare services that look, on paper, widely available.

Contraceptive counselling and method application, in contrast to abortion, are prescribed to be made available at family physicians' clinics according to the TiH structure. However, it is a plan that cannot be implemented as of yet, so far as family physicians are required to receive special training in contraceptive counselling and

applying methods to be eligible to offer these services, a qualification that not all family physicians possess.

In terms of the demand for contraception, AÇSAPs that are still functioning would have indeed filled this gap, at least temporarily, had there been an effective referral chain between family physicians who do not offer reproductive health services and AÇSAPs that do. This was not the case, however. As I inquired about how they refer patients in case they cannot respond to their demands pertaining to reproductive health, all family physicians reported lacking any sustainable solution. For instance, Şeyhmus said,

I don't know any names [offering those services] in Eastpointe. I tell my patients to go to [a hospital's] obstetrics/gynaecology clinic, be it for abortion or IUD insertion. I don't recommend anyone, even to my best friend. At the end of the day, it's an invasive operation, things can go wrong, then you will feel responsible. ...I just tell them to go to a [hospital's] clinic, without recommending a particular name. (Şeyhmus, Eastpointe family physician)

Şeyhmus did not know of any AÇSAPs operating in his city, but there were a few still functioning. This attests, rather than to Şeyhmus' inadequacy as a healthcare worker, to the fact that the chain of referrals, instead of being reinforced, has been broken within the new system, at least with regards to reproductive health services. On the one hand, there does not exist a formal referral system among different first-level healthcare institutions; that is, family physicians cannot officially refer their patients who seek contraceptive services or abortion counselling to another institution. As they have no formal obligation, few family physicians seem to have taken this responsibility on informally. On the other hand, and even more crucially, the TiH moved AÇSAPs into the grey zone of healthcare structure: They are open but not quite—not only because they can be closed at any moment but also because most people, potential clients as well

as health workers at other institutions, do not know that they are open. Most of my respondents working at AÇSAPs complained about being underworked and were uncertain about the future of their employment. Waiting for their institution to be closed any moment, through some obscure bureaucratic process, was a common theme across those interviews.

Above and beyond, few reported being able to continue their practises at the pre-2010 levels not only because of their in-between status, but also because of their inconvenient location, lack of advertisement, or their inability to cater to patients' needs out of personnel and equipment shortages. For instance, an AÇSAP practitioner, whose clinic was relocated in a remote corner in Eastpointe after 2010 said,

This institution is idle. It's been so ever since the family physician system began. The average number of patients that we see a day dropped from 40-45 to 5-6. ...At first it was ordered that all AÇSAPs be closed, then they said no, they should remain open for a bit, and then they said they were going to rebooted... This is the process over the past seven or eight years. ...For instance, the [other] AÇSAP [in Eastpointe] was somewhere out of the way. They transferred it to a central location; they reformed it. They now say the same thing will happen here. ...But they've been saying this for a year. We'll see if it's really going to happen. (Ferzat, practitioner at public Eastpointe family planning clinic)

On the other side of the coin, precisely because of the limitations imposed on AÇSAP's functioning through personnel and equipment shortages, being referred to an AÇSAP by a family physician may not be the end of the journey for a woman even if it were common practise. Yet, there also is a second missing link in the broken referral chain: AÇSAPs cannot refer patients to hospitals or any other healthcare institution either. Many AÇSAP workers report trying to mitigate this situation by informally referring patients to practitioners whom they may or may not personally know:

We are left completely out of the chain of referrals. (Zelal, nurse at public Eastpointe family planning clinic)

[I tell them to go] to an ob/gyn. To any one she wishes to go. ...I don't suggest names. I just recommend, for example, when I encounter something that I don't know how to deal with... I recommend my professors, because it's people whom I know. (Şirin, nurse at public Westpointe family planning clinic)

This in-between situation of AÇSAPs in particular, and the exclusion of certain reproductive health services from the referral system in general, therefore, turns the ideal of easy entry into and swift movement within the healthcare system impossible for women seeking reproductive healthcare. Can these shortcomings be remedied as more and more family physicians receive trainings and become eligible to offer contraceptive counselling and methods? The next subsection will delineate how many family physicians who do have certificates in contraceptive counselling and application nonetheless do not offer these services. But even leaving this fact aside, certain problems still persist. For one thing, women would still be left with little guidance in terms of being referred to a facility where they can obtain abortion on request.

Lastly, from a long-term perspective, the TiH design also brings in a catch-22: It is AÇSAP practitioners and nurses themselves who offer reproductive health counselling and contraceptive application trainings. From this angle, AÇSAPs and their employees are indispensable for the system as a whole not just temporarily but rather systemically, so far as there will always be new medical school graduates coming into the area of family medicine. In addition, as Zeliha notes,

They reason that, generally speaking, so far as every one will have a family physician, she will receive all sorts of services, including family planning, from the family physician. But mother-child health, family planning, these are not just individual services; they also entail substantial public education [efforts]. Besides, there are many undocumented individuals...

With all these caveats, the broken referral chain and “disfunctionalising” of AÇSAPs seem to be inherent problems of the TiH organisation—just like the shortcomings of the central planning. In other words, the way in which first-level facilities are isolated from one another and from upper-level institutions, and the way that AÇSAPs that are crucial for the system to function are pushed into this grey zone are not problems that time itself and more rigorous implementation of the project will fix.

To summarise, there exists at least two sets of structural shortcomings of the TiH project that impinge on reproductive healthcare, contraception and abortion in particular. On the one hand, problems pertaining to central planning leave many institutions and healthcare employees ineligible to offer abortion and contraceptive care. One of the most notable problems that arise from the new structure is the “disfunctionalisation” of AÇSAPs, which used to shoulder most of the reproductive healthcare demand prior to 2004. On the other hand, by failing to institute a robust referral chain among different types of health institutions, the new structure makes it even more difficult for women to identify places where they can acquire reproductive health services. But there is more to the story of problematic access to reproductive healthcare. The two previous subsections focussed on structural shortcomings of the healthcare system that render access problematic. But the new system also generates a series of individual-level dynamics, as individual healthcare workers feel compelled to act in certain ways and not in other because of the new system. The next subsection will turn attention toward these individual-level dynamics that the TiH has institutionalised through its incentive structure.

Perverse Incentives

While the two previous subsections showed that the unifying component of the TiH either brought in certain drawbacks or failed to deliver on its promise, this subsection will discuss how both of its decentralising and unifying components institutionalise a series of perverse incentives for practitioners, which curtail adequate and satisfactory delivery of reproductive healthcare services. While those incentives exist and impinge on the practises of doctors working in hospitals as well, as they are most visible in the family physician system, I will mostly focus on this group of doctors.

As I laid out in detail above, the family physician system is based on the transfer of a number of responsibilities from the MoH to physicians themselves. Family physicians are not pleased about having to shoulder the burden of making all the financial and practical arrangements in their clinics, which they perceive as time stolen from their practise. With substantial numbers of patients registered with each family physician,⁸⁴ time is indeed a scarce resource in their trade. Most have to continue offering polyclinic (running tests and diagnostics, writing prescriptions, making referrals) and preventive care services (vaccinations; vitamin K, iron and calcium drops for new born infants; trainings for pregnant women) all day long, and are anything but enthusiastic about adding contraceptive counselling and application into their workload.

Many respondents, including health workers employed in other types of institutions and professional activists, suggested that this unwillingness stemmed at least in part from the fact that reproductive health services, most importantly contraceptive counselling and demanding method application such as IUD insertions, were left outside of the

⁸⁴ According to the Law About Family Physicians, the number of patients registered with a given family physician will be between 1000 and 4000.

performance points system. To reiterate, even though it is a quasi-private system, family physicians are nonetheless state employees, receiving their salaries according to the performance-based payment scheme. For family physicians, performance-based salary scheme means that

[t]here is no [change] to the salary, [family physician's] salary is standard. ...Of course, when we skip a vaccination, or a pregnancy follow-up, we receive negative performance points, and a reduction in our salary... Both my salary and our nurse's [gets cut]. (Zafer, Westpointe family physician)

One qualification to this notion of standardised salary is the ranking of family physicians' clinics according to the capacities of the facility, whereby having a higher ranking implies higher salaries for the employees. Class A clinics, in addition to other requirements, need also to employ at least one personnel with a certificate in reproductive and contraceptive care; which makes the contraceptive trainings offered by veteran AÇSAP workers high on demand among this class of doctors. Then again, whereas pregnancy and infant follow-ups are among the services included in the performance system through negative performance points effected in case of failure to carry those out, contraceptive counselling and application do not bring additional performance points, nor the failure to deliver those lead to negative points. Özgür, who works for an NGO specialised in reproductive health, thus noted:

You get your IUD certificate, you place a gynaecological exam table in there, and you receive a class A rank. When you receive it, the money that the state pays you goes up. But they don't ask you whether you really are inserting IUDs or not after that point. What happens next? Half of the family physicians in Westpointe have IUD certificates, maybe even more. But they don't apply it. Why? Because this is a system based on monetary incentives. And it does not pay [anything extra] for IUD insertion. They then say, "Why should I apply it?" (Özgür, Reproductive health NGO)

In other words, it is not only that contraceptive services do not bring in additional

performance points—that is, higher pay. But they are also seen by family physicians as diverting attention and resources from those practises which, if not carried out, can result in reduced payment. Health workers from family planning clinics or public health centres, especially those involved with the certificate training programme bitterly complained about their co-workers at family physicians' clinics:

And the way they do it, unfortunately... For instance, they don't invest time. They simply give condoms, and then send [the patient] to me for advising. Give the pill; send her to me for advising. ...We put together those certificate programmes, we work so hard for it, we say 'you see, now you are capable to do that.' ... But yes, it's right. They have certificates, but they don't want to deal with this. (Zeliha, practitioner at public Westpointe family planning clinic)

Among the family physicians that I interviewed, only one reported that IUDs were inserted in their clinic (albeit irregularly), whereas the rest, although they had obtained the certificate, were not offering the service:

Because we are a class-A clinic, we also offer IUDs. In actual fact, most class-A clinics don't do it; you can check it from Public Health Centre's records. Albeit in small numbers, we do it here... Our practitioner who has the training was male, so there was not much demand. Now another lady practitioner working here also got the certificate, so maybe the demand will go up from now on. (Şeyhmus, Eastpointe family physician)

IUDs—we don't insert IUDs here, but there are places [family physicians' clinics] where it is offered. ...We don't have enough personnel; we have only two. That's why. ...Also, I mean, we don't trust it much, those things need to be done in more hygienic spaces. At the end, these are open areas. I prefer not to do that. ...There can be an infection, or things like that. But we would do it if we were in a village. (Zafer, Westpointe family physician)

The next chapter will delve deeper into family physicians' accounts to further elucidate why they shirk those services; for the moment, suffice it to say that many family physicians, including those who do have a training certificate, do not routinely (or at all)

provide contraceptive counselling and IUD insertions.⁸⁵ Taken together with the breaking of the referral chain that was the topic of the previous subsection, this reluctance leads to increased difficulties for women to access contraceptive counselling and methods.

While in the case of contraception, inaction is incentivised through the performance-based salary scheme; in case of pregnancy follow-ups, the reverse is true. Pregnancy follow-ups are services that family physicians are required to offer; that is, every family physician is responsible for ascertaining that every woman registered with them receives at least four exams throughout her term. The aim is to ensure that every pregnant woman, regardless of her means and background, will receive medical care during pregnancy. In this vein, the TiH introduced pregnancy-monitoring schemes, which are city-level data sharing programmes. Setting up these schemes is a duty that the Ministry of Health allocates to Provincial Health Directorates, thus the schemes take different names in each city, but their implementation is consistent throughout the country. Nationwide, all clinics, hospitals, and laboratories providing blood pregnancy tests are required to record every pregnancy that they detect into the national database. Software that family physicians are obligated to purchase, and through which they report follow-up exams that they conducted, also retrieve information from the database, and alert family physicians of pregnancies that were detected among their assigned clientele. There is a mandatory minimum of four exams throughout a woman's pregnancy term that her

⁸⁵ Indeed, IUD is not only contraceptive method that can be provided in the first-level facilities. But the potential adverse effects of distributing pills and vaccinations without adequate counselling left aside, family physicians are also bound with the amount of supplies that they receive from the central state. As discussed in more detail above, this amount is not always sufficient.

assigned family physician must carry out. In case a woman chooses to see a doctor in the private sector throughout her pregnancy, their obstetrician is required to enter the information about her pregnancy history into the database. Seeing the information about these visits on their computers, family physicians are not required to take any further steps after that point.

While the exams have been mandatory on paper since the nation-wide introduction of family physician system in 2010 (and even earlier in pilot provinces), this obligation did not have material consequences for family physicians until the Summer 2012. That is, there was no immediate ramification to a family physician if they skipped one or all four of these exams. In 2012, pregnancy follow-up schemes were linked to performance system, entailing a fee deduction from the physician's salary for each missed exam. Family physicians and their personnel thus became more vigilant about pregnancy follow-ups.

This vigilance led to numerous instances of privacy invasion: As mentioned in Chapter 3, throughout the Summer 2012, newspapers were filled with news reporting that family physicians were making phone calls to their women patients' houses to make appointments for pregnancy follow-up exams, and time and again shared this private information (of their pregnancies) with other family members, usually husbands or fathers. As discussed in the two previous chapters, the question of privacy and the government's "hunt for pregnant women" was a prominent theme in the debates that erupted in Summer 2012. While I have no intention to engage with those conspiracy theory-like arguments, I do want to point out that under the TiH's incentive structure, such invasions could not have been expected to *not* become systematic.

Conclusion

This chapter sought to offer an organisational chart of healthcare structure in general and reproductive health services in particular, in order to give the reader a sense of the background against which the narrative that will be presented in the following chapters unfolds. Currently, the entire structure of the Turkish healthcare system is undergoing a huge transformation under the sway of the TiH, a project that entails widespread neoliberalisation of healthcare. In discussing the TiH, I did not only explain the changes that it brought about, but I also drew attention to the inherent hindrances that its marketization component created, which disproportionately afflicted reproductive healthcare. While some of these hindrances stemmed from central planning, some others pertained to individual-level dynamics, which were nonetheless institutionalised through the TiH's incentive structure.

Describing the overall structure of healthcare, as well as discussing the problematic aspects of the TiH is important for three reasons: To begin with, the healthcare structure, despite the attempts at simplifying it, remains rather complex and there still exist multiple entry points within it—some of which do not necessarily lead to the procurement of the services sought. So this chapter, first of all, provides a road map to the healthcare system for the reader. Secondly, by presenting the drawbacks that neoliberalisation generated, it offers a snapshot of the climate within which health workers make their decisions pertaining to their daily practises. It is utterly important to keep this atmosphere in mind in order to follow the discussion about health worker actions (and inactions) that will be the topic of the next chapter. Lastly, the chapter stands as a reminder that the findings of the next chapter, which, despite bearing critical

theoretical significance, need to be considered with caution as they do not represent the universal reality of the Turkish healthcare system: Health workers who are in a position to provide abortion on request or contraceptive services are a minority, so far as many qualified facilities do not employ eligible personnel at all, while many health workers are employed either in non-qualifying institutions or are not qualified to offer those services themselves.

With this cautionary note, in the next chapter I turn to discuss how even favourable conditions do not necessarily imply favourable service provision in healthcare facilities and why. While this chapter described the macro-processes that transformed healthcare, it is crucial to remember that neoliberalism is not contained within government policies but entails a wholesale transformation of micro-level interactions: As Wendy Brown (2003: 9) suggests, “[n]eo-liberalism does not simply assume that all aspects of social, cultural and political life can be reduced to such a calculus, rather it develops institutional practises and rewards for enacting this vision.” While the focus of the next chapter will be the ways that healthcare workers engage with law, it is important to keep in mind that this engagement takes place against the backdrop of neoliberal transformations. The subsequent chapters will develop this argument more extensively.

CHAPTER 6

NEGOTIATING LIMITS, NAVIGATING LEGALITY: EVERYDAY PRACTISES IN HEALTHCARE INSTITUTIONS

How is it possible for the calculations, strategies and programmes formulated within [the ‘government’ in great buildings and capitals] to link themselves to activities in places and activities far distant in space and time, to events in thousands of operating theatres, case conferences, bedrooms, classrooms, prison cells, workplaces and homes? Clearly a plan, policy or programme is not merely ‘realized’ in each of these locales, nor is it a matter of an order issued centrally being executed locally. What is involved here is something more complex.

–Nikolas Rose

After having presented the institutional context within which health workers carry out their professional duties, it is now time to focus on these daily practises themselves.

While the previous chapter focussed mainly on institutional dynamics that marked the constraints on reproductive health practises, this chapter will focus on another form of constraint that uniquely affects reproductive health among all healthcare activities:⁸⁶ namely, laws that seek to draw limits to those practises.

Typically, laws pertaining to reproduction minutely detail under which the conditions certain reproductive health practises will be offered and obtained legally, by whom, and where. The process through which these laws are implemented poses intriguing questions for social scientists. Indeed, neither the conversion of legal texts into actual practises is a straightforward matter, nor is “law” merely contained in legal texts. Rather, “it is also the agents [of the state] themselves who make policy of the state [and] by

⁸⁶ Indeed, all medical practises are bound with a series of medical rules, standards, guidelines and principles, the breach of which can lead to professional and even criminal investigations. Yet, as health workers repeatedly emphasised, laws setting up time limits, age limits, and sanctioning particular methods and not others are peculiar to the area of reproductive healthcare.

feeling more or less constrained by the scope of their job and resources, by taking more or less initiative with respect to the regulations imposed on them” (Fassin 2015: 5). To put it differently, in many areas as in reproductive healthcare, laws and policy need to go through the filter of “street level bureaucrats” (Lipsky 2010) in order to effectively turn into actual social practises. Nikolas Rose, quoted at the beginning of this chapter, departs from an inquiry into the nature of the links between centrally-made decisions and on-the-ground activities, and reaches the conclusion that what is at stake is a process of “translation” through which “alignments are forged between the objectives of authorities wishing to govern and the personal projects of those organizations, groups and individuals who are the subjects of government” ([1999] 2004: 48).

It is this chapter’s task to explore how health professionals, who are the street level bureaucrats of reproductive healthcare, align their professional practise with the law. This is, as Rose suggests, a rather complex process: There is always a gap between a written rule and its real-life application, which opens up room for discretion in all bureaucracies. At the same time, law is never limited to the written rules to begin with, but should be “understood as particular traditions of knowledge and communicative practise;” hence “the intersubjective power of legal discourses, conventions and practises in constructing meaning” is also crucial in this process (McCann 2006: xii). In this case, reproductive health workers in contemporary Turkey do not only have to master the old conventions. As the abortion/caesarean debate of 2012 sent messages of government hostility toward their practise, their professional turned domain into a minefield—which healthcare professionals now need to navigate with constant vigilance about legal limits.

Then again, not all legal limits are equally explosive from health workers’ perspective.

Below, I begin by presenting the accounts by health workers that suggest a complex process of translation, which entails a series of negotiations with “the law.” Through this process, they interpret legality and legal limits to their professional practise not in isolation but within a certain professional environment and a given frame of reference. I sought to describe (at least certain major elements of) this frame of reference in previous chapters: the larger political (Chapter 3) and professional (Chapter 5) environment within which health employees operate, as well as the controversy of Summer 2012 (Chapters 3 and 4). As I will show below, taking cues from these broader surroundings of their professional domain, health workers craft intricate plans of action, plans that are neither restrictive nor permissive in their entirety. Instead, some legal (as well as extra-legal) limits to certain healthcare practises are considered very strict and are observed staunchly, whereas others are seen as negotiable.

In the following, I first offer a descriptive account of these negotiations. Based on health professionals’ accounts, I detail what are considered the limits to their routine practises, and identify which of these are considered as lenient and which others as rigid. There is, in fact, a remarkable consistency across institutions and individual health workers in terms of demarcating those limits. In the following sections of this chapter, I seek to explain this consistency by analysing the dynamics shaping these negotiations.

Negotiating Limits

...No, [the abortion ban] was not passed [into law]. But let’s say, all these talks affected the doctors. Even those who had been performing abortions for years all of a sudden started to say that abortion was a sin... I don’t want to say that service provision stopped completely—although it almost did for a while, immediately after [the debate]. Let’s say, it was on the rocks. For instance, I remember a woman, it was her 11th pregnancy, and she had

her spouse with her and everything. She wanted to have an abortion. They didn't want to do it there [in the public hospital]. I don't know what happened to her afterwards, whether she was able to get an abortion or not. (Ruşen, nurse at public Eastpointe family planning clinic)

Ruşen quit her job as a nurse in one of Eastpointe's largest public hospitals shortly after the abortion/caesarean debate started, to pick up the head nurse position at a neighbourhood family planning clinic in the same city. The clinic was a single-storey building in the middle of a concrete courtyard, independent and physically distant from the city's hospitals. Over our teacups on a November morning in the clinic, she described the climate of fear that she witnessed in the hospital after the onset of the debate, which led her to look for a job elsewhere. This was exactly what I expected to find while proposing this research, and what I kept looking for throughout my fieldwork. I was thus delighted by Ruşen's comments. Enthusiastically taking notes, I wondered whether she herself was affected by this climate of fear too. I asked a series of probes about her own practise, trying to find out whether there were certain things she had to stop doing due to this same fear over the last few years. She firmly replied:

No, not at all, for me it's the opposite. I became more... I mean, when a woman comes to get a contraceptive method, we try to push the limits as much as we can, so that she can use the method she chooses. We do everything in our power. (Ruşen, nurse at public Eastpointe family planning clinic)

This turned out to be a widespread theme across my interviews: While acknowledging the absence of any formal legal change,⁸⁷ health workers consistently described a transformation in their professional environment, both in terms of the subjective feelings of healthcare workers and in terms of the ways in which services were (or not) delivered.

⁸⁷ With the exception of Law no. 6354 that passed on July 4, 2012 concerning caesarean sections, mentioned in Chapter 2 and of which I will talk more extensively below.

They did not express any fear of government retaliation on their own part nor reported any change in their own practise. Instead, they either related stories of *other* health workers who did, or imparted that they, too, expected *other* health workers to have such fears.

[The debate about caesarean births] did not really affect me, because I work independently. I do offer [caesareans] when there is an indication. But I think it affects those who work in the public institutions negatively. (Tuna, ob/gyn at private Westpointe clinic)

They tried to pass [a law], ban it [abortion] and so forth. So many doctors, some who were afraid, or maybe some were *yandaş*,⁸⁸ I don't know, or maybe some who were very strict about the rules, they started to implement [restrictions on abortion] before even they really became rules: "Prime Minister said 'Don't', so I won't do that..." There were people who started acting that way. You know, refused to touch the patient to avoid any ramifications, even before the law changed, thinking that it was going to change anyways. (Zeliha, practitioner at public Westpointe family planning clinic)

Some also talked about a generalised sentiment of pressure from the Ministry of Health, or mentioned hospital administrators (again, always in *other* hospitals) directly or indirectly requiring their employers to not perform abortions:

Osman: When they come to inspect your office, if they find abortion-related materials, they give you harsh tickets. You say "But the law says..." They say "No. Law doesn't say so." This is an area where there is arbitrariness on the part of the inspectors.

Ayşe: How can they do that?

Osman: They just can. They say no, there is no such law. And you know, even doctors don't really know about law all that well.

Ayşe: And who is it that comes to inspect offices?

Osman: It's doctors from Public Health Directorate, or from the Provincial Health Directorate. They usually go inspect private businesses. For instance, they say that you get a ticket of three thousand Liras⁸⁹ if they find abortion-related material in your office. (Osman, ob/gyn at public

⁸⁸ *Yandaş*, connoting partisanship, came to work in contemporary Turkey as a rather derogatory way of referring to pro-government persons and groups by its critiques.

⁸⁹ Approximately \$1300 with the exchange rate at the time of interview.

Westpointe neighbourhood clinic)

Overall, while health workers did indeed experience a transformation in the general atmosphere within which they practised their profession, they nonetheless reported being capable of maintaining their professional routines. In this section, I analyse how they navigate this reported environment of fear, purportedly without changing their own practises—at least not due to fear of government retaliation. I delineate the negotiations that health workers go through with the legal limits imposed on their practise by law, and the ambiguity attached to those practises by the abortion/caesarean debate. What emerges from this analysis is that the limits imposed upon their practises have varying degrees of negotiability across different services. In order to identify those variations, this section will focus respectively on each of the four health services in which I am interested. Then, in the next section, I offer an analysis of the dynamics making certain practises negotiable and others non-negotiable.

Pregnancy Monitoring Schemes

Pregnancy monitoring schemes, as I described in detail in the previous chapter, were neither launched after the debate, nor do they constitute a legal category. They are, nonetheless, one of the areas in which health workers go through certain negotiations, which they think of as being legal. I therefore treat them as such, not the least because when asked about law and legal responsibilities, my respondents consistently brought this topic up: Time and again, these schemes were singled out as the most important legal intervention into their professional field over the recent years. Surprisingly enough, even those who knew for a fact that there was no law, administrative or criminal, about

the monitoring schemes made the same point. One possible explanation for this aura of legality around pregnancy monitoring schemes is the common belief that health workers who did not abide by these rules would be subjected to disciplinary action by the Ministry of Health. While I have not encountered any health worker who experienced such action, nor knew about someone who did, this threat seems to be interpreted by health workers as a (quasi-)legal ramification:

They want all the information to be recorded. At the end of the day, you are obligated to record those. . . . They routinely come to do GEBLİZ inspections. That is, they can actually start an administrative investigation about you. When you don't record the information. (Osman, ob/gyn at public Westpointe neighbourhood clinic)

The inclusion of mandatory follow-ups into performance-based salary system in 2012 has potentially reinforced this impression: Family physicians and their nurses strove to reach women who were identified as pregnant on the database, sometimes so desperately that they breached core principles of privacy in the process. As the timing of this arrangement chronologically coincided with the debate, those instances came to be perceived by many as the proof that the government was on a “hunt for pregnant women.” My respondents bought into that conspiracy theory to varying degrees, but even those who fully did concurred that the schemes were nonetheless helpful in ensuring free follow-ups for poor women and women living in rural areas. Yet, every respondent also admitted that there were problems with their implementation. For instance, it was widely accepted that talking to members of a pregnant woman's family instead of herself about her exams was both unethical and inappropriate.

There is that problem with the system, of course. For instance, when the family physician gets notified through the system, she calls the number that she sees on her screen, without knowing whose number that is. She calls, [the pregnant woman's] father answers, she says, “Your daughter is pregnant.”

This opens a path that can even end in an honour killing. (Şeyhmus, Eastpointe family physician)

In contrast to the consensus regarding those more abstract questions, the practises that each health worker adopted with regard to the schemes varied widely. Some abided strictly by the Ministry's mandate:

GEBLİZ is mandatory. Here, every patient, when she's pregnant, is recorded to GEBİZ. (Remziye, nurse at family planning unit of public Westpointe hospital)

Here, recording every pregnant woman who applied to us is a legal obligation. Because this is how family physicians get involved. Apart from that, we are required to record to the system every intervention that we perform during a pregnancy. (Kemal, ob/gyn at Westpointe public hospital)

This strict adherence most often comes together with an apprehension of the difficulty of the situation. Health workers are usually sympathetic when it comes to young and/or single pregnant women who go through the difficult process of seeking to secure an abortion secretly. These feelings of sympathy are also reflected onto other women, thus compelling health workers to question the practise of reporting pregnancies on the database:

Generally speaking, reporting pregnancies to the state is mandatory. That is, you need to record pregnancies into the system, which we do. But if we think about it in terms of individuals' rights and freedoms, we may not have to report all instances of Beta-HCG positive. Or it may need to not be accessible to everyone. Now, through the system, it's open to everyone. (Nafiye, assistant ob-gyn at Westpointe public hospital)

But we see such situations that I don't even want talk about. So now . . . since we apply all methods of family planning here, including abortion, [while giving the family planning trainings] I always tell [family physicians] "Don't record the information of your pregnant patients until the tenth week of pregnancy," because, individuals have the right to have an abortion until the tenth week of pregnancy. Then, if they do so within those ten weeks they wouldn't be reported to GEBLİZ, neither the patient nor the other party will be in a difficult position. There are students, college students, there are

minors, they have families; there are all kinds of difficulties... (Remziye, nurse at family planning unit of public Westpointe hospital)

The respondents who felt the pressure of this difficult decision typically relied on the privacy option that pregnancy monitoring database offers as a solace. Even though there was a great deal of confusion about what the exact function of this option was, “clicking the privacy” was offered as a protecting mechanism that they resorted to in order to alleviate the tension:

Of course, privacy is also important. . . . There are so many unusual cases. In those cases, we still record the information, but there is a privacy part, we click the privacy and then record the information. (Remziye, nurse at family planning unit of public Westpointe hospital)

You apply privacy of information. We have a duty to do so. There is an option of privacy, you click that. (Tuna, ob/gyn at private Westpointe clinic)

Well, I click the privacy button for every pregnant woman that I report. But I don't explain it to every patient separately. I just make sure that I clicked the privacy. (Şengül, ob/gyn at private Westpointe hospital)

Indeed, the privacy button does not warrant restricted access to information. The records of these pregnancies with privacy option are still accessible to any person who signs up to the database. So it works, at the end of the day, simply as a notification mechanism, suggesting that family physicians, when contacting these women, need to be “sensitive” and not disclose this information to other members of her family/household. This is redundant, because all health workers are mandated to respect the privacy and individuality of health-related information at any rate—regardless of the privacy option. There is little reason to expect that those who do not respect the legal mandate of privacy will respect the optional privacy button. The approach of family physicians and other health workers in their clinics betrays a great deal of sympathy for their patients and respect for their professional duties, but still attests to the lack of an effective

mechanism to ensure pregnant women's privacy:

Sometimes, for example, the patient is pregnant, or has an out-of-wedlock pregnancy. She gets an abortion. Then we call her [because she is still recorded as pregnant in the database] but we are not allowed to ask anything to anyone but herself. We don't ask anything even when it's her husband over the phone. We don't say, "Your wife is pregnant." (Zennure, nurse at Westpointe family physician clinic)

In our clinic, we try to talk directly with the patient herself. We tell them when they get a test, "Come here yourself in two days to take the results." If she doesn't show up, we call her, but if [somebody else], even her husband, answers the call, we don't say [anything], we ask to speak to her. (Dilşat, nurse at Eastpointe family physician clinic)

On the other end of the spectrum were those others who saw these conflicts and did not believe that the privacy option offered in the database really ensured privacy, therefore took the initiative and refused to record pregnancies:

In practise, we still offer pregnancy tests and are required to report the pregnancies that we detect. Personally, I know I am denouncing myself right now, but I don't report. Because I don't know whom in the Ministry of Health has access to this kind of information. (Zeliha, practitioner at public Westpointe family planning clinic)

What I do myself is—in line with those [compassionate] sentiments and diverting from the regular practise—I usually don't record the patients. That is, I respect it when a patient says that she doesn't want to be recorded, and I don't record. I don't enter it into the system, because if I do, then my patient will feel uncomfortable. Thus, naturally, I don't record. (Osman, ob/gyn at public Westpointe clinic)

We never notify out-of-wedlock pregnancies, and I think they shouldn't be notified. Only the ones within marriages are routinely recorded. . . . Our clientele is made up of precisely those people who don't want it to be heard anyways. (Esma, nurse at Eastpointe private hospital)

All in all, even though reporting pregnancies to the national database was widely (mis)conceived as a legal obligation by health workers, the legitimacy of the monitoring schemes was consistently questioned, even by those who thought that they served good ends overall. Those doubts sometimes led to open acts of defiance in the form of not

reporting pregnancies, but at other times health workers abided by this perceived responsibility regardless. Some suggested that the privacy option resolved those problems, even though some others raised questions about its efficacy as well. Overall, healthcare employees took the initiative to negotiate the limits pertaining to reporting pregnancies that they were going to follow individually.

Contraception

Contraception was legalised far earlier than abortion, and in many ways, is the most entrenched reproductive right in Turkey. The Law no. 557 decriminalised the uses of contraceptives in 1965 and a General Directorate of Population Planning under the jurisdiction of Health and Social Assistance Ministry was established. Concomitantly, at the policy level, family planning through the use of modern contraceptive methods has been actively promoted by the state. To this end, not only a generation of contraceptive practitioners, who later became educators for the subsequent cohorts, was trained, but they were also appointed to healthcare institutions at various levels, in various places across the country. Statistical indexes as well as ethnographic studies suggest that contraception, and to a large extent, modern contraceptives have become common practises countrywide over the last fifty years.⁹⁰

Contraception was connected to the abortion debate only later, when the flames

⁹⁰ According to the most recent wave of a prominent and respected study on reproductive health, Hacettepe University's TNSA, 98.7% of all women in Turkey (99.7% of all married women) are informed about at least one modern contraceptive method (on average, 7.6 methods are known among all women, and 8.2 among married women). 56% of all women and 77% of currently married women report ever having used a modern method. Then again, these numbers should be taken with a grain of salt, as qualitative studies also report that conservatism as well as economic precarity can severely limit women's access to contraception (Him and Hoşgör 2011).

about the Summer 2012 debate were dying out, through conspiracy-like comments by Erdoğan⁹¹ and his counterparts, therefore has not fully become a part of the controversy at its burgeoning stages. Besides, there have never been any claims about making changes to the Law no. 557; that is, neither Erdoğan nor other government officials expressed a will to change the law concerning contraception. Yet, for my respondents, contraception was a main area that had become problematic in the aftermath of the controversy. Most felt certain hostility toward their practise on the part of the government, typically attached to the problem of insufficient contraceptive equipment. While the problem of shortages involved only (certain) public sector employees, so far as the word about the situation was out, health workers in both public and private sectors expressed similar views with regards to negative government attitude toward contraception.

But this particular conundrum set aside, when it came to the question of legal limits about contraception, my interviewees did not express much concern. That is, despite it being conceived as a problem area, closely associated with the abortion/caesarean debate, contraception was not seen as a legal matter in and of itself. For one thing, when inquired about the limits of offering contraceptives to applicants, my respondents spoke exclusively of medical conditions as limits, and did not refer to any legal framework:

Ayşe: You mean, anybody can get an IUD if they want so?

Tuna: Of course. Of course. . . . Well, the only thing can come out is medical reasons. It may not be suitable for that person, in which case you wouldn't

⁹¹ Erdoğan, having moved to the seat of presidency by summer 2014, commented during a wedding ceremony that he attended on December 22, 2014, that “In this country, the betrayal of contraception was committed for years, and they tried to finish our race under its guise.” <http://t24.com.tr/haber/erdogan-dogum-kontrolu-ihanetiyle-yillarca-neslimizi-kurutma-yoluna-gittiler,281273>. On May 30, 2016, as I am writing this chapter, now president Erdoğan repeated this stance and stated that family planning should have no place in a real Muslim family's life. <http://t24.com.tr/haber/cumhurbaskani-erdogan-turgev-genel-kurulunda-konusuyor,342781>

recommend it.

Ayşe: I understand. So there are no legal limits?

Tuna: No, there cannot be any legal limits [to contraception]. (Tuna, ob/gyn at private Westpointe clinic)

Interestingly, though, the laxity toward the legal framework regarding contraception did not necessarily imply a willingness to deliver the services everywhere. While health workers at neighbourhood clinics and family planning units of hospitals perceived contraception as their primary professional duty and offered services devotedly, and private providers did not shy away from the practise, family physicians were not nearly as enthusiastic for offering these services, especially IUD insertions.

Kamile, a nurse-midwife, had practised birth control counselling and provision for years and she started to work for a family physician's clinic after 2009, when the neighbourhood clinic she was working at was transformed into a family physician's clinic. She had imagined it would be a mere name change for her, and that she would continue her practise under the new name the way she always had. She soon discovered with dismay, however, that her new "bosses"⁹² were not really interested in offering family planning services. She ended up resigning from the family physician's clinic; after a waiting period, she finally got herself a position at the Public Health Centre's division of reproductive health, where she can continue her job that she expresses so much devotion for. She remembers the situation in the family physician's clinic:

⁹² Kamile was very vocal about her dissatisfaction with the kind of relationships between family physicians and their personnel that the TiH established: "...[the family physician I work with] told me 'I pay the rent here, I decide what will be done under this roof.' In reality, he doesn't pay the rent, the state gives him the money to pay the rent. But because the money first goes into his pocket, he feels like he pays the rent out of his own salary. He considers himself as my boss." This kind of power struggle among employees placed at different levels of the medical hierarchy (for instance, practitioners and nurses, assistant doctors and experts...) was, to judge from my encounters, widespread—but this is the topic of another dissertation.

Ayşe: I heard that most family physicians in Istanbul have the certificate to insert IUDs, but...

Kamile: But they don't practise it. . . . I would offer it, and to me... I mean, our physicians didn't want me to. They would do things like, "Why are you inserting [IUDs], don't lose your time with it..." This is partially why I quit the family physician's clinic. (Kamile, nurse-midwife at Westpointe Public Health Centre's division of reproductive health)

At first this account, albeit typical, does not seem to be related to issues of legality.

Indeed, across all types of institutions, in response to probes about the legal limits, apart from the strict ban on imposing a contraceptive method on a woman that she does not want to employ, the only legal issue that came out pertaining to contraception was the situation of the minors. My respondents referred to the situation of minors as "special case"—whereas all out-of-wedlock sexuality was presented by my informants as a special case in some capacity, the situation of minors was singled out as particularly remarkable, although not uncommon. Significantly, there was a high degree of confusion about what the legal framework really set with regards to this specific situation. But both within individual accounts and across my interviews, a willingness to navigate the legal framework as they understood it and patient demands with a relatively high degree of initiative emerged:

I never saw such a thing. Legally, minors can receive consultancy, but you can't get contraceptives below the age of 18. (Ferzat, practitioner at Eastpointe neighbourhood family planning clinic)

They can use [contraception], actually. I mean they can't get tubal ligation or an IUD. But they can use the pill or condoms. (Zeynep, nurse at Westpointe neighbourhood family planning clinic)

We can give them contraceptives. I can give pills. But I wouldn't insert an IUD. (Şirin, nurse at Westpointe neighbourhood family planning clinic)

There is no legal limit for contraception. I mean, the legal age limit [of 18] applies, of course. ...[But] there are so many who get married at the age

of 15, some have already two children at the age of 18. You can't say no to such a person. (Zelal, nurse at Eastpointe neighbourhood family planning clinic)

You know, here marriages at early age are very common. Thus, if she already has a child and applies for contraception, we provide it. ...The legal limit is 18. But as I said, marriages at early age... I mean, she's below 18, but she's married, already has children, will have even more if she doesn't use contraception. There is a practical situation there. As a result of it, we provide [contraception to this group of applicants] (Fatma, ob/gyn at Eastpointe public hospital)

Overall, despite being regulated by law and considered a controversial practise, contraception was not necessarily perceived as a legal matter, with the exception of the situation of minors. Then again, even this particular legal matter seemed to be highly negotiable: All respondents expressed sensitivity toward the real life situations of minors—even though for some, the limits of this sensitivity were to a large degree determined by marital status. That is, most health workers were willing to turn a blind eye to (perceived) legal requirements and offer contraceptives to minors, but some claimed that they would do so only in case the minor in question was married. That said, this negotiability does not readily translate into liberal service provision: In addition to the constraints of equipment that spring from central planning deficiencies, some health workers also impose certain (extra-legal) limits to their own practise—as in the case of family physicians who categorically refuse to offer IUD insertions. Consequently, those self-imposed limits seem to be more staunchly observed than those that were seen as limits imposed by the law.

Abortion

On the last days of February, I went back to the neighbourhood family planning clinic in

the working-class neighbourhood in Westpointe. It was, in a way, a return visit, but I had not yet formally interviewed any of the personnel working there. I was welcomed in the clinic by the head nurse with some tea and biscuits. My formal interview with her lasted about an hour and a half, but I lingered, continuing to chitchat with whoever showed up in the kitchen for a few minutes' break. I was waiting for the lunch break, so that I could have, if not another formal interview, at least some informal conversations that would give me a better sense of the way things worked at the clinic and around the neighbourhood. In fact, after a while Nezihe, one of the practitioners at the clinic, walked into the kitchen as I was sitting with the head nurse, and started to talk casually when the nurse introduced me and told her about my research topic. On top of her comments pertaining to the uncertainty looming over her field, similar to those that I had heard before from other respondents, Nezihe set to relay to me rumours that I had not heard health workers speak explicitly about until then:

Look, my neighbour has had nine abortions. You see? She wears the headscarf, but she's had nine abortions. And how do they do that? Do you know what they do? In some hospitals, [doctors] give [women] some drugs secretly. They tell them to insert it into the vagina or into the rectum at night, so that she goes to the hospital the next morning, bleeding. Hence, instead of performing abortion on request, the doctor appears to have operated on a spontaneous abortion. That is, due to reasons beyond their control. Nowadays all the private hospitals, clinics do it like that. And women hear it from one another, that's how they find these doctors. I mean they do the advertisement among themselves. But if you go there to ask questions, no one will tell you anything. (Nezihe, practitioner at Westpointe neighbourhood family planning clinic)

It is not surprising to hear such rumours⁹³ about abortion—indeed, abortion had been

⁹³ In fact, this may well be more than just a rumour—not only in private, but in public hospitals as well. According to TNSA 2013 (released in 2014), during the period between 2008-2013, spontaneous abortion rate was 14.0 per 100 pregnancies, and 4.7% of all pregnancies were terminated on request. Compared to TNSA 2008, according to which the

under the brightest spotlight during and after the 2012 debate: As I discussed at length in previous chapters, not only had Erdoğan specifically targeted abortions, but the reaction against his statements also revolved mostly around abortion, and more specifically, the right to abortion. Perhaps not so surprisingly, then, different versions of such rumours about private hospitals that also discontinued the provision of abortion on request over the past years had been circulating. With the exception of one particular chain of hospitals, which is connected to Emine Erdoğan, the president's wife, I did not come across any such institution during my research. I nonetheless do not rule out the possibility that private enterprises that principally refuse to offer abortion exist, not the least because those rumours constituted an important cornerstone in my respondents' frame of reference:

Apparently there are problems in private hospitals too. I know it from what patients tell me. When I will refer someone to another hospital, I suggest the public hospital even though it's far. Because I don't know the private hospitals around here, I don't know who does [perform abortions] and who doesn't. And patients themselves tell me, they say "We asked around, doctor, none of them does." (Çiçek, practitioner at Westpointe public hospital)

After the news about abortion ban came out, demand for abortions hit the roof at our clinic. Probably because they went to a hospital, [health personnel there] didn't do [offer an abortion, told them that] it was banned. (Zeliha, practitioner at public Westpointe family planning clinic)

Even though no legal change had ever been made to the Law no. 2827, such rumours, combined with the belief that many doctors changed their abortion policies, effectively

rate was at 10.5 and 10 for spontaneous and requested abortions respectively during the period between 2003-2008, this finding is suggestive. Unfortunately, TNSA does not break spontaneous abortions down in terms of where they were conducted. Yet, an interesting finding is that the ratio of abortion on request acquired in public institutions fell from 70.2 to 61.9 from 2008 to 2014. Keeping in mind the surmounting obstacles in the public health sector, and the decrease in raw numbers (rather than ratios) one can infer that the number of abortions recorded as "on request" fell dramatically in the private sector—in line with Nezihe's account.

created an atmosphere in which there was a sense that, as one respondent put it, “as if [abortion] was something illegal” (Osman, ob/gyn at public Westpointe neighbourhood clinic). This atmosphere afflicted not only health professionals but also society at large: A recurrent theme in my interviews with health workers concerns the “false perceptions” of abortion being “banned” among their clientele.

For one thing, I still come across the question “Can we still end [a pregnancy legally]?” despite the two years that have passed since [the controversy]. Hence there still is uneasiness about it. (Damla, ob/gyn at Westpointe private hospital)

Patients sometimes believe that abortion is banned. There are those who ask “Is it legal? Is it banned? Do you offer them, doctor?” In fact most people [*vatan*daş] know it as banned. (Macit, ob/gyn at private Westpointe clinic)

According to my respondents, this false perception was based not only on media reports, but also on false information that other health workers, knowingly or unknowingly, circulated:

I know because many [patients] came to us during that period. We don’t offer [abortions]. But [they would still come to ask] “I went to the hospital but they didn’t do it there, the nurse said it was banned.” (Zeliha, practitioner at public Westpointe family planning clinic)

Osman: When they go to the hospital with a request... they don’t do it. For instance, they say it’s banned. It is not banned, in effect.

Ayşe: How can they say that?

Osman: They just say so. That it was banned. (Osman, ob/gyn at public Westpointe neighbourhood clinic)

Realistically, one can also reason that these “false” perceptions have something to do with the practical inaccessibility of abortion that was discussed in the last chapter. To reiterate, at the time of research there were three and one public institutions where abortion was offered in Westpointe and Eastpointe respectively; far below what most health workers considered an adequate number. But I will suggest that there is more to

this situation besides these problems that are introduced by the TiH. Below, I show that rather than being based on the sheer question of access, this “as if” illegality of abortion has to do with the ways in which “laws” are envisaged and implemented in healthcare institutions.

As I related at the beginning of this chapter, health workers time and again reported not having changed their own practise pertaining to abortion despite the environment of fear and misinformation. That is, they continued providing services after the debate the way they used to do before. One condition for being able to continue the practise that was singled out was sticking squarely to legal limits; among the few public, and a larger number of private sector healthcare workers who did provide abortions regularly, the legal limits were staunchly observed. In fact, while only medical limitations came up in conversations about birth control and caesareans, all respondents pointed at legal limits first and foremost when it came to abortions:

[The requirements are] that the pregnancy is under ten weeks, her spouse’s consent if the patient is married, and whether she is coerced to abortion or not. ...I don’t care about non-legal limits. A patient should have already made her decision on the basis of her own conditions when she shows up [in my office]. If there is no legal impediment, I perform her abortion. (Kemal, ob/gyn at Westpointe public hospital)

The legal limit in abortion is ten weeks; there are no other legal limitations apart from that. ...Yes, you can perform an abortion on nine weeks and six days, but you can’t if it’s one day after the end of week 10. (Fatma, ob/gyn at Eastpointe public hospital)

There is a legal limit of ten weeks, I definitely don’t [offer abortion on request] after the tenth week. I definitely take spousal consent, because it’s required by law. But if she’s single, she doesn’t need to get consent from anyone, her own signature is all that’s needed. (Şengül, ob/gyn at private Westpointe hospital)

In this hospital we offer the services, all of the services, that are sanctioned by law. (Bumin, perinatologist at Westpointe public hospital)

Not only were the legal limits duly followed, but many among my respondents also reported additional restrictions that they adopted and observed when providing abortion on request. Those additional restrictions most often pertained to time:

[Abortion on request after the 8th week] is not [offered]. For instance, we cannot provide [an abortion] for a woman on the 8th week and second day of her pregnancy. I mean we make sure that she's not over 8 weeks. (Seher, nurse at family planning unit of public Westpointe hospital)

Ayşe: Do you perform abortions until the tenth week?

Kemal: No, we do it until the eighth week.

Ayşe: Why is that?

Kemal: Because what we have here is a family planning unit, not a centre. I might be wrong about the terminology, but there is a distinction between those, and here we don't have the capacity to do emergency intervention in case a complication comes up during pregnancy termination.

Ayşe: Is this a legal provision?

Kemal: Yes. There is an ordinance about it. I don't remember which ordinance on top of my head. (Kemal, ob/gyn at Westpointe public hospital)⁹⁴

Personally, I don't provide abortions after the 8th week; I prefer not to do that. (Şengül, ob/gyn at private Westpointe hospital)

But some informants also enacted self-styled restrictions based on age, spousal consent, or marital status:

I don't offer abortions to minors. In actual fact the law says that minors can have abortions with parental consent, but I don't do it out of principle, I don't like doing it. (Sibel, ob/gyn at private Westpointe hospital)

We absolutely do not perform abortions for extra-marital pregnancies. We take the consent, the signature, of both spouses [before carrying out a married

⁹⁴ *Ana Çocuk Sağlığı ve Aile Planlaması Merkezleri Yönetmeliği* (Regulations for the Centres for Mother and Child's Health / Family Planning) (published in 1997; rescinded with the publishing of *Toplum Sağlığı Merkezi ve Bağlı Birimler Yönetmeliği*, Code of Public Health Centres and Affiliated Facilities in 2015) reduced the time limit for abortion on request to the first eight weeks pregnancy *performed in AÇSAPs*; precisely because they are free standing clinics, as opposed to hospitals' family planning clinics, they have no access to emergency treatment. I have not been able to locate any official document introducing a similar limit for this latter type of facility.

woman's abortion]. (Esma, nurse at Eastpointe private hospital)

Esma's account hinted, on top of this professed restriction, another self-appointed practise—namely, pressuring women patients to forgo abortions that they request:

Of course [abortion] can be performed until the end of week 10. Doctors will still try to persuade them [to change their mind]. We try to persuade them in all circumstances. Not for out-of-wedlock pregnancies, naturally. Those are a whole different matter, the social situation... We try to persuade in case of within-wedlock pregnancies. (Esma, nurse at Eastpointe private hospital)

Indeed, in the immediate aftermath of the onset of the abortion debate, the Ministry of Health announced its plans to implement programmes involving waiting periods, mandatory counselling geared towards discouraging abortion, and the like. While these programmes were never officially put in effect, it appears that some health personnel and institutions took it upon themselves to apply them.

To this gruesome picture is added those health workers who simply do not perform abortions, even though they are aware that it is legal, and in some cases the institution where they work at also offers abortions on request:

Fatma: There is one person who performs abortion here.

Ayşe: Are you talking about rotation?

Fatma: No, one of our friends here, only he performs abortions. I don't, neither do others. ...He takes five or six patients a day. (Fatma, ob/gyn at Eastpointe public hospital)

As one of the two practises that were central to the controversy at its initial stages, abortion seems to have never lost this dubious fame—if anything, the debate generated confusion about its legal status as well as reducing its access in practise. Those who were still capable of continuing to provide abortion on request⁹⁵ reported being able to do so

⁹⁵ While these self-imposed additional restrictions contribute to inaccessibility of abortion for many women (most importantly women with modest means and those who get pregnant as a result of extra-marital intercourse, most notably minors), it is important to reiterate that in

by strictly adhering to the limits imposed by the law, and some even went further and established their own additional limits. In other words, when it comes to abortion, not only was room for negotiation about the legal limits close to non-existent, but even the extra-legal ones were considered to be impassable and were thus staunchly observed.

Caesarean

Caesarean stands as an interesting oddity in the midst of all the debates and practical concerns. As I discussed above, together with abortion, caesarean was one of the main axes of discussion since the very onset of the debate. It also is the only area pertaining to which some actual legal change was made. The Law no. 6354 that passed on July 4th, 2012, ruling that caesarean sections shall be performed only upon medical indication and not on request. Additionally, the Ministry of Health also adopted a policy of sending ob/gyns working in public institutions to professional training when their caesarean rates were found to be high (a practise that was never systematically implemented and was later discontinued). There were also rumours that the salaries of this group of ob/gyns were going to be reduced through the performance points system (which I was not able to confirm).

All of these suggest a serious pressure on ob/gyns to not perform caesareans, an idea that is also corroborated by the mediatised caesarean scandals of summer 2012. Between

many public hospitals, even that level of service is not in question so far as many do not offer abortion on request at all—as the previous chapter documented. As the “rumours” that opened this subsection suggest, this situation may not be limited to public hospitals, and there may well be private institutions that refuse to provide this service. It is thus important to stress that while the strict adherence to legal limits and imposition of further restrictions, while noteworthy, make up only one factor adding to the inaccessibility of abortion and not the root cause.

June and August 2012, there have been at least six cases of infant death at birth⁹⁶ alongside with two women who died during labour—all reportedly due to unwillingness to perform caesareans on the part of the ob/gyns. Yet, at the time of research, the general climate among my respondents was far from being one filled with fear, and caesarean posed an exception among the healthcare practises considered here in terms of the ways that it was discussed among my interviewees. On the one hand, there was no single healthcare worker who did not agree that the caesarean rates in Turkey were excessively high, and that they needed to be diminished—therefore, agreeing with the government stance about the issue. On the other hand, they were also very critical of the government’s initiative to reduce caesarean rates, on several counts. First of all, they found the on-the-job trainings unacceptable:

Procedures of that kind were implemented, such as that absurd practise of sending doctors with high caesarean rates to training. (Damla, ob/gyn at Westpointe private hospital)

That is partly because the Ministry of Health came up with such procedures back then, like sending you to on-the-job training if your caesarean rate was high. By sending people to on-the-job trainings, at a certain level, they were trying to create the idea that you were insufficient as a doctor, and that they needed to re-educate you. Physicians went through a lot of troubles because of that. (Samet, ob/gyn at Westpointe public hospital)

Secondly, they found the new law ineffective and unnecessary:

Such things don’t affect doctors. No one was performing arbitrary caesareans before this [legal change] anyways. (Şengül, ob/gyn at Westpointe private hospital)

They passed this new law, stating that there will be no caesareans without indication; well it’s how it was before anyways. (Şeyhmus, Eastpointe

⁹⁶ According to the media review conducted by the Abortion Is Right Platform. Therefore, the numbers represent only the cases that were brought to the attention of national news media.

family physician)

And finally, they perceived a certain contradiction between the discourse about decreasing the caesarean rates and the government's actual healthcare policies, which undermined the efficacy of the measures: Indeed, as the TiH disincentivised time spent with the patient through the performance points scheme, there was little reason to expect that ob/gyns would be enthusiastic about assisting vaginal births, which often take a long time, are impossible to schedule in advance, and require extensive experience (Block 2007). Many, building off of this idea, offered a systemic reading of high caesarean rates:

You can't hope to decrease caesarean rates by leaving it to doctors' initiative. You have to structure the system accordingly if you really want to reduce it. ...[But] the system does not encourage normal [sic] births, because it doesn't make money out of normal births. (Damla, ob/gyn at Westpointe private hospital)

If something will be done, it is through actions, not words. There won't be fewer caesareans when you say "Let there be fewer caesareans." So it is not by saying "Let there be fewer caesareans," but by preparing the conditions for it that you can achieve [lower caesarean rates]. (Şengül, ob/gyn at Westpointe private hospital)

To put otherwise, the topic is a complicated one because unlike in the case of other reproductive health practises, such as abortion and contraception, caesarean is a topic about which health workers by and large share the government stance. That is, they all admit that caesarean rates are higher in Turkey than they ought to be (many cite WHO's recommendations on this count), but it is the strategies of the government for reducing it that they find problematic. Consequently, they do not only criticise the new law, but they also do not feel bound by it:

It is absurd that there is a [legal] decision about caesareans. Because at any rate there needs to be an indication [for a doctor to perform a caesarean

section]. But if you think, even the mother's wish can be an indication. You inform the patient. ... The patient makes the decision. ... Because the method of birth can be a patient's choice. (Nafiye, assistant ob/gyn at public Westpointe hospital)

Well since we're a private [clinic] ... If the patient says, "I won't give normal [sic] birth, I want a caesarean," it's absurd to force her to normal birth. At the end of the day, a patient has patient's rights. (Macit, ob/gyn at private Westpointe clinic)

Interestingly, the caesarean scandals of summer 2012 were not even recalled among my respondents. With one exception, none of my respondents has brought these incidents up themselves during the interviews; when prompted, most were completely dismissive about those:

Doctors would not withhold from caesareans. I am in the maternal mortality commission [of Eastpointe Medical Chamber]. We never encountered a case of maternal death during labour because caesarean was not performed. (Bumin, ob/gyn at public Westpointe hospital)

"The doctor is afraid to perform a caesarean." There is no such thing. A doctor wouldn't be afraid of offering a caesarean. ... Doctors are comfortable in making the decision to proceed into a caesarean. (Necla, ob/gyn at public Westpointe hospital)

These comments suggest that in the case of caesarean sections, law is not only negotiable, but also openly challengeable (if not defiable) despite all indices to the contrary.

Overall, a complex picture emerges from health workers' negotiations with legal limits: While the obligation of reporting pregnancies in the MoH's centralised database, which is known to be not based on law, is still counted among the legal regulations surrounding reproductive healthcare. Then again, despite certain (mostly economic) risks the failure to report entails, health workers see a certain room to fiddle with this requirement. Some refuse to report pregnancies outright, whereas some others, while

abiding by the rule, nonetheless question the practise and contemplate breaching it under at least certain circumstances. Contraception, which is regulated by law, is not thought of as a legal matter. Yet this does not mean that there are no problems of access associated with contraception: some health workers, especially family physicians and their personnel are unwilling to perform IUD insertions and are unenthusiastic about providing contraceptive counselling and methods in general. At the same time, while the vague laws pertaining to offering contraceptive services to minors create a large degree of confusion among health workers who provide contraception, they report willingness to stretch the limits under what they consider special circumstances. Legal limits to abortion, in contrast, are not only staunchly observed under all circumstances, but some healthcare employees go even beyond and set extra (and extra-legal) limits to their own practise. Finally, the freshly passed caesarean law provokes derision and outrage on the part of health personnel, and is not considered as setting up a legal limit in so far as it is not considered legitimate at all.

In the next section, I start unpacking this complexity. Why and how caesarean has smoothed away its controversial place amidst the entire controversy, while abortion never did and remained a uniquely contested practise? Why did contraception become problematic not during the initial stages of the controversy but only subsequently? To grasp the dynamics here, I offer an account of health workers' more general approach to the regulation of their professional practise by law. The following chapter brings the analysis one step further by delving into the ways that healthcare employees describe the broader climate surrounding their practise and their own responses to the transformations that their professional domain undergoes.

Negotiating Legality

The previous section presented a descriptive account of how health workers negotiate legal restrictions when practising their profession. This descriptive picture raises more questions than it answers. That is, it identifies the “legal” boundaries that health workers observe, but falls short of explaining how those boundaries are drawn in the first place. Indeed, not all of these boundaries are aligned completely with what is specified in law and other regulatory texts, but they are nonetheless consistent across different institutions. For instance, while abortion is legal until the tenth week of pregnancy, and the text of the law is well known by healthcare practitioners, the practise of further restricting this limit (typically to eight weeks into pregnancy) was widespread among abortion providers. How to understand this intra-institutional consistency, which is neither defined by law nor necessarily in conformity with the government stance about reproductive health practises?

One well-established thread in socio-legal studies answers such questions by focussing on the “legal consciousness” of interested actors. The concept of legal consciousness was originally developed in the 1980s and 1990s as a neo-Gramscian theoretical tool for studying issues of legal hegemony. Its path-breaking aspect was to establish “the ways law is experienced and understood by ordinary citizens” (Merry 1985) as a valid research area as opposed to court-centred approaches that were common in law and society scholarship. The key insight here was that even though ordinary people did not go to courts or get involved with legal institutions most of the time, law nonetheless did affect their views and lives, principally on the basis of how they understood and responded to law. This meant a huge shift in conceptualization of law;

scholars moved away from the instrumentalist approaches that considered law as autonomous from the social domain and limited the study of law to measurable behaviour. Instead, law and society scholars adopted a constitutive perspective that drew on the ways that law gained its form and power on the basis of everyday categories, routines and interactions among ordinary citizens. As Ewick and Silbey (1992: 737) note, “[t]he ways in which the law is experienced and understood by ordinary citizens as they choose to invoke the law, to avoid it, or to resist it, is an essential part of the life of the law.”

Whereas I find the literature on legal consciousness inspiring and insightful, I also seek to avoid merely replicating the latest trends in this body of work, which Susan Silbey (2005: 324) criticises for merely “track[ing] what particular individuals think and do,” “[r]ather than explaining how the different experiences of law become synthesized into a set of circulating, often taken-for-granted understandings and habits.” In this vein, I do not mean to suggest that health workers constitute a particular social group with a distinctive way of relating to law, which determines healthcare practises by itself. Instead, I seek to understand how law, as “a complex repertoire of discursive strategies and symbolic frameworks that structure on going social intercourse and meaning-making activity among citizens,” (McCann 1994: 282) frames and shapes the everyday interactions between health workers and their patients. On the other hand, unlike what has become commonplace in legal consciousness studies, I also do not claim to be capable of capturing “the ways in which largely *un*conscious ideas about the law can affect decisions [that people] make” (Nielsen 2000: 1058, emphasis in the original), not least because I do not know how to track the unconscious with the tools that I have at

my disposal. My interest lies elsewhere: I seek to understand how a particular professional climate, within which laws governing reproduction and the legality of reproductive healthcare practises becomes contested, is politically constructed at the interface between the state, law and daily routines within the healthcare system.

Such an enterprise requires both paying attention toward individual actions of health workers, as well as an understanding of how these actions are informed by exogenous processes. At one end of the spectrum lies a consideration that law and policy cannot be translated into practise without the mediation of individual health workers. As Michael Lipsky suggests in his seminal book *Street Level Bureaucracy* (2010), low-level officials like teachers, social workers, and policemen who enter into contact with policy targets on a daily basis act as policy-makers through their use of discretion. While this is crucial insight for my research, I take Didier Fassin's (2015: 5) warning against the pitfalls of both the top-down and bottom-up approaches to this construction seriously, and his call for of a dialectical approach: "...Indeed, [state] agents are confronted with explicit and implicit expectations formulated in discourses, laws and rules, while keeping sizeable space to manoeuvre in the concrete management of situations and individuals. ... [Which does not mean that they] extricate themselves entirely from the symbolic and practical authority emanating from the state's directives and legislation."⁹⁷ In this vein,

⁹⁷ Of course this raises the question: Who counts as a state actor? Can state ethnography account for the actions of health workers, working in private as well as public sector? On the one hand, it is difficult to envision a doctor or a nurse as a bureaucrat, even when they work in public institutions. On the other hand, though, health workers *are* the agents who implement state law and policy with regards to abortion, contraception, caesarean and pregnancy monitoring in so far as they act as the safeguards of the legal limits imposed on these practises – sometimes improvising, neglecting, or hyper-emulating these limits. Besides, from the perspective of their patients, health workers *embody* the law as they are the ones to tell what is legal and what is not.

keeping an eye for these top-bottom and bottom-up dynamics simultaneously can offer a better grasp of the ways in which law, broadly conceived, regulates everyday practises of healthcare workers.

Below, in the vein of legal consciousness studies, I offer an overview of what healthcare employees said about state law, how they perceived the intervention of law into their professional domain, and how they envisioned the “good law”—that is, the explicit comments healthcare employees made with regards to the intervention of law into their legal domains. Indeed, law regulates practises of reproductive health to a degree unmatched by its regulation of other healthcare services. But in an effort to combine insights from legal consciousness literature and state ethnography tradition, instead of trying to fit those accounts into ready-made categories of the literature, I seek to explain how those ways of conceptualising law, that are influenced by the broader political and professional climate surrounding health institutions, in turn feed into certain practises that effectively transform the reproductive healthcare policy on the ground.

The comments that health workers made about the intervention of law into their professional domain suggest strong opinions they held about the issue. Many, to varying degrees, highlighted the overarching authority of medical practise itself time and again during the interviews:

If you ask me, in actual fact, medical practises are above the law. . . . Laws should never be above medical realities, which are based on scientific evidence. (Osman, ob/gyn at public Westpointe neighbourhood clinic)

For us, rather than laws... Because laws can do anything. When fingers are raised in the Parliament, some random law is passed. . . . For us, what matters are medical realities. (Şeyhmus, Eastpointe family physician)

Some got so fired up about the primacy of what they called “medical realities” that they

went so far as if to suggest that law could have no word over medical practise at all:

Can law say something like that, for example, “You cannot cut more than 10 centimetres for an appendicitis surgery”? It cannot. Because, as we say in medicine, there is no such thing as an illness, there are only patients. (Zafer, Westpointe family physician)

Medical ethics is always above the law. And even if law can judge us, if what we do is in accordance with the international medical rules, courts cannot do anything to you. . . . Because the first rule in medicine is *primum non nocere*. That is, first of all, don’t hurt. First, don’t do things that will hurt your patient even if they are legal. Or, if it is for the good of the patient, do it even if it’s illegal. (Zeliha, practitioner at public Westpointe family planning clinic)

I mean, parliamentarians should not supervise my decisions about what I will be doing from some faraway place. It should be doctors supervising me. What is my professional organisation? TJOD. When there is an indication, I should take it to TJOD, and they should guide me, I should discuss my case with TJOD. (Sibel, ob/gyn at private Westpointe hospital)

Yet, even those who expressed such strong opinions retracted when asked whether they were advocating a complete independence of their profession from the law. For instance, Osman, right after declaring that medical reality was always above the law, added:

But the issues like abortion and so forth, because they are part of national politics [need to be regulated]. . . . Besides, those who offer abortions, let’s say at week 15, do it for money. That is something outside of the medical reality as well. . . . When it comes to those very basic issues, such as the time limit in abortion, or a fifteen-year old coming to me with a pregnancy... Laws need to regulate these things. (Osman, ob/gyn at public Westpointe neighbourhood clinic)

Murat, similarly, softened his previous remarks against legal intervention by saying:

Of course I think that there needs to be law. What I meant was [that laws couldn’t regulate] medical indications. There can’t be law about that. But I also think that the laws we have now are not problematic. For instance, ten weeks is a reasonable limit for abortion on request. (Kemal, assistant ob-gyn at Westpointe public hospital)

Another widespread view among health workers was that there needed to be some kind of collaboration among experts, in this case lawyers, politicians, and health workers

(some even included sociologists and theologians to this list) when deciding what laws should be like and where they were needed. Again, such need was expressed mostly with regards to abortion, seldom with regards to minors' use of contraception, and never about caesarean sections.

I think that there needs to be a legal perspective in these issues. But if you're asking, how should these standards be set in the first place, I think lawyers, legal consultants need to sit down with competent [medical] professors, and standards would come out of such processes. (Nafiye, assistant ob-gyn at Westpointe public hospital)

There are world standards for those things. There is the World Health Organisation, there are medical authorities... And of course there are sociological circumstances, they need to be taken into account. The social circumstances people live in, the world standards... these all need to be considered together [when laws are made]. (Sibel, ob/gyn at private Westpointe hospital)

While delivering valuable insight into health workers' ways of envisioning state law, these statements offer little guidance for understanding how the lines were drawn between, this time, what should be legally regulated, and what should be left to the decisions by medical authorities. For instance, why was there need for legal intervention, with or without consulting health workers, to regulate abortion but not birth control pills? Why did the caesarean law garner so much anger and even derision, while an absence of abortion law was neither conceivable nor desirable for health workers? As I show below, law had everything to do with this boundary-drawing effort, but not, as one would have expected, in its legislative dimension. Rather, and in a surprising twist, civil litigation turned out to be the most significant trope in health worker accounts. The next section seeks to explain this puzzle, paying attention simultaneously to the narratives and practises of health workers, the street level bureaucrats of reproductive health on the one hand, and the more general climate within which reproductive healthcare is sought and

offered on the other. This analysis does not only help understanding the Turkish context better, but it also offers important insights for more general questions about law and legal mobilisation, which will be the topic of the next chapter.

Rights in Conflict

I met Remziye purely by merit of persistence. After interviewing one public hospital doctor whom I had met through the Medical Chamber, I had been referred from one person to the next for new interviews in the same public hospital in Westpointe. It was during my third interview there in the massive hospital building that had recently been relocated into an outskirt of the city that finally, a respondent thought that Remziye, a nurse who had worked in the family planning unit for almost two decades would be the best person for me to interview. In effect, I had tried to walk into the family planning unit of that hospital on my own previously, but could not get too far, stopped by a private security guard. This practise of having private security *inside* the hospital is highly unusual in public hospitals; so far as I was able to see, the family planning unit was the only place with its own security force inside that hospital as well. Any person who did not have an appointment, or was not the single approved companion of one of the clinics' patients, was strictly banned from that area. I therefore was very grateful when Samet, a young obstetrician, introduced me to Remziye.

Remziye and I connected quickly, not only during the interview, which excited me a great deal at that point, but during my two subsequent follow-up visits as well. An immigrant from Bulgaria who came to Turkey with the migration wave in 1989, she was in her early middle ages. She strongly believed in Atatürk's reforms, and proudly talked

about the right to abortion having been “granted to our women by our elders” back in 1983. She took great pride in the quality of services that were offered in the unit she worked at; she blithely compared her unit to private clinics.

Remziye was also among the group of practitioners who offered family planning trainings. Upon her invitation, I joined a group of nurses and practitioners in one of their vocational training sessions. While the trainers and trainees, all of them women, welcomed me warmly to their teatime break between sessions, they greeted the idea of my presence in the seminar room with reluctance. I hence refrained from joining them during their sessions, but instead spent the day in the AÇSAP building where the training was held. Apart from interviewing two people with whom I had checked in beforehand, I spent most of the day sitting in the kitchen, chatting over tea with whoever was not in seminar room, as at least one or two people were free at any given moment.

Remziye and I were alone in the kitchen in late afternoon, the training session about to come to an end. While sipping tea from our cups, she confided that everything was changing for worse in the area of family planning, as far as she could see. I had heard similar comments so many times before, from her as well as from other health workers, but I was thrilled to hear her talking about the pressures coming from the hospital administration so openheartedly:

We are the last to make it. And we are making it only by resisting. If they only see a single mistake of ours, they will shut us down as well. The new administrative cadre is better than the previous one, because there is an ob-gyn in the new team. But for how long [is it going to go like this]? It all has to do with the performance scheme, of course. (Remziye, nurse at family planning unit of public Westpointe hospital)

And then, “Everybody is afraid,” she said. I eagerly asked what they were afraid of, awaiting to finally hear some off-the-record instructions from the hospital administration

or the Ministry of Health itself, pressuring health workers to refrain from performing abortions, or the like. Her response came as a surprise to me, but it proved immensely helpful later on in focussing my attention on the emergent theme of conflicting rights in my interviews, and eventually to putting together fragmented comments that I heard from many others:

Well, everybody is afraid of being sued. Nowadays doctors are afraid of even touching the patient, for fear that something will go wrong with the patient, the patient won't be satisfied, and will go sue them. In this manner, doctors are discredited [through these court cases]. Everybody's anxious, no one has the motivation to work anymore. I mean, it's such a thing—we became a society where everyone sues everyone for any reason. . . . It affects us too, of course, we're all afraid. (Remziye, nurse at family planning unit of public Westpointe hospital)

Perhaps one reason why I failed to attribute the importance that it deserved to this statement at the moment of the interview was the fact that I had prepared myself to hear about the government pressure, or about criminal cases prosecuting health workers—that is, a priming error on my behalf. But even more importantly, in Turkey, civil law has never been nearly as symbolically charged as it has been in the United States, nor have “tort tales” been nearly as popular. Talking to practitioners in obstetrics about caesarean sections, I had heard a great deal of clamour about how among all specialists, obstetricians and gynaecologists constituted the group that was sued the most frequently in civil cases. Considering the malpractice narratives that circulate on the web, perhaps this is not surprising. Acquiring reliable statistical information about the numbers and trends of malpractice litigation in Turkey is almost impossible: Neither the Ministry of Health or the State Agency for Statistics, nor the Turkish Medical Association or local branches of medical chambers keep systematic data that is available on their website on the issue. While there are a number of articles on malpractice that appear in non-indexed

medical journals each year, most refrain from giving numbers about overall trends or showing their sources when they do. On the other hand, medical insurance companies that mushroomed after the adoption of the mandatory medical insurance scheme for providers in 2010 group obstetrician/gynaecologists as the highest risk group and set their premium at the top level. Furthermore, judging from the articles that appear on online medical magazines, which were popular among my respondents, malpractice litigation trends pointed upwards from 2010 on, and obstetricians and gynaecologists were particularly threatened by this rising trend. For instance, an oft-quoted statistic, with an unknown source, indicates that 25% of malpractice cases were against obstetrician/gynaecologists, and in two out of three cases, doctors were found liable—an understandably frightening percentage from the perspective of my respondents, even though the same account sets the number of cases that reach the courts as low as 416 “in the past five years” (the year not indicated).⁹⁸

Nafiye’s account illustrates this theme quite well. Nafiye was a young woman, an assistant ob-gyn in one of the most prominent public hospitals in Westpointe, and she was close to obtaining her title as an expert in her area at the time of my fieldwork. During our interview, she expressed sympathy for feminist views about reproductive freedom—she resolutely emphasised her opinion that abortion should be a woman’s own decision—and voiced a great deal of concern about the abortion debate. Yet, when during the interview we started talking about her own situation as a practitioner, the principles she was cherishing gave way to more immediate and self-centred concerns:

I got my professional insurance as soon as I started working here. Because malpractice litigation is very common in obstetrics... And also, I really don’t

⁹⁸ Retrieved from <http://www.malpraktissigortasi.net/istatistikler.html> on August 11, 2017.

trust the patients. In general, I don't trust them. I may have good relations or bad relations with them, but I don't trust anyone by any means. . . . As a practitioner, now I have to think through my diagnostic decisions, decisions that are for the good of the patient, in multiple dimensions: What are the possible legal [implications] of this? What can I add to my diagnostics to cover myself? . . . I try not to interfere with anything, not to do anything to patient. I mean not to do anything bad, I want to quickly finish my job and go to the next patient. . . . We used to examine a patient in all respects, we would try to do whatever we could to serve her best interests, would resort to surgery, if necessary. Now, we try to do our best without touching the patient at all if possible. (Nafiye, assistant ob-gyn at Westpointe public hospital)

Echoing Remziye's comments about doctors' "fear of touching the patient," Nafiye vividly illustrated the dynamics afflicting the entire area of reproductive healthcare.

But this fear, perhaps understandable among obstetricians who assist deliveries, was to be expected, the way it made its way into other health professionals' frame of reference is interesting. Indeed, civil cases against practitioners mostly pertained to doctor errors and accidents during delivery,⁹⁹ leaving either the mother unable to look after the new-born or crippled the new-born in a way to increase the life expenses beyond the family's ability.¹⁰⁰ A recent research, the results of which not yet published, report that 97% of malpractice litigation against obstetricians are such cases. In fact, only 3% target gynaecologists, abortion or IUD insertion are not among the top five reasons why

⁹⁹ A prominent gynaecologist explains that in medical discourse, complications can be thought of as accidents, which are by definition unforeseeable and do not imply a given party's fault; whereas malpractice implicates that there is an error on the part of the doctor involved. Retrieved from http://www.tjodistanbul.org/index.php?option=com_k2&view=item&id=375:kadin-dogum-hekimliginde-dava-edilmeyi-onleyici-yaklasimlar&Itemid=830 on November 20, 2016.

¹⁰⁰ Michael McCann and William Haltom (2004) make a similar point in *Distorting Law*. Although this is not the primary focus of their study, and their research is based in the USA where the theme of civil litigation touches on an especially sensitive chord, anecdotal evidence suggests that there is a similar dynamic in Turkey.

gynaecologists are sued.¹⁰¹ One of my respondents, a doctor who was also doing research about malpractice cases as a member of the Turkish Medical Association, claimed that in the past, cases pertaining to malpractice during an abortion were more common but had all but disappeared in recent years.¹⁰² It was not self-evident, therefore, that civil litigation would be such a significant trope regarding abortion beyond obstetrics practise.

Nonetheless, this fear was expressed repeatedly throughout my interviews with non-obstetrician respondents as well. For instance, insofar as they performed neither abortions nor caesarean sections, there was little reason to expect that family-planning practitioners would be as affected by the trend of “defensive medicine,” which was sweeping the area of obstetrics-gynaecology. Yet, it was not only abortion and caesareans that provoked the fear of civil litigation, but a practise that one would presume simpler and less sensitive, namely, IUD insertions, was also tainted by this litigation malaise. Kamile’s story that I recounted earlier in this chapter illustrated the inaccessibility of IUDs in family physicians’ clinics: A nurse-midwife with extensive experience in the area of birth control, she was disappointed with the practitioners she worked with at the family physician’s clinic, because they did not want her to offer IUD

¹⁰¹ Retrieved from <https://www.medimagazin.com.tr/ozel-saglik//tr-kadin-dogumcular-neden-dava-ediliyor-9-681-54997.html> on August 11, 2017.

¹⁰² Over the past four years (2012-2016), there were only two malpractice cases brought to court pertaining to abortion and got reported in newspapers. Both cases involved women who had to have an abortion in advanced stages of their pregnancy due to medical reasons, and not on request. In the first case, the abortion was incomplete, and an infant with heart issues was born. Retrieved from <http://www.haberturk.com/gundem/haber/1094089-bebegi-alamamisim-diyen-doktora-300-bin-tlik-dava> on November 26, 2016. In the second case, a large piece of gauze was forgotten inside the woman’s uterus, which ended up causing infection. Retrieved from <http://www.hurriyet.com.tr/karninda-gazli-bez-unutulan-kadin-dava-acti-40051345> on November 26, 2016.

insertions. When I inquired about why they were unwilling to offer the service in their clinic, she explained:

They don't prefer to do [IUD] insertions, because they are afraid. It's also a question of whether there is monetary gain. At the end of the day, it's an invasive operation, you need to clean up the material, sterilise and so forth. Then you have to properly follow the insertion procedure. I mean, it's not very easy to do, the insertion, it involves all these risks. And they don't want to deal with it. (Kamile, nurse-midwife at Westpointe Public Health Centre's division of reproductive health)

Şeyhmus, a family physician in Eastpointe, made a similar point. Even though he encouraged the practise of IUD insertions in the clinic he worked at, he nonetheless was straightforward about his unease:

...there is the malpractice legislation now. It puts the doctors in a troublesome situation. We have to think three times before we do anything. (Şeyhmus, Eastpointe family physician)

Çiçek has been a practitioner in reproductive health for over thirty years, and she works for one of the large public hospitals alongside with being one of the prominent trainers in the area. After expressing her disappointment with all the family physicians who come to her to take the training in IUD insertions but who do not continue the practise after receiving their promotion, she explained:

Well, if something happens to the patient during the operation, it's a nuisance for both the patient and the doctor. That's why they shy away from practising; they don't want to deal with such things. So they don't practise [out of fear]. Because they don't practise, they can't improve their skills in IUD insertions. In turn, they become even more wary of the practise. (Çiçek, practitioner at Westpointe public hospital)

But civil litigation threats did not pertain solely to unforeseeable medical complications.

To complicate the matters even further, questions of paternity, which can be subject to litigation, also contributed to health workers' fear of being sued. A respondent who has

worked in family planning for over 25 years claimed that many practitioners had been sued for having neglected to collect the consent for abortion from would-be fathers. I have not been able to corroborate this claim; indeed, Turkish Medical Association's lawyers did not only report not having come across such a case, they did not even know whether that would be considered as a criminal offense or a civil case. Yet, many of my respondents maintained that the risk of being sued by would-be fathers was great, and they therefore wanted hard proof that a woman applying to them was either single or really brought the "father" with her—meaning more (and potentially time consuming) visits to local authorities to acquire that evidence on the part of the women who seek abortions.

The analysis so far, focussing on abortion and contraception, indicates that the fear of civil litigation compelled health workers to either refrain from offering certain services altogether or to become more selective about whom to offer these services. Then again, at the end of the day, most healthcare employees ended up shaping their practise in a way that parallels government preference—then why take the theme of civil litigation seriously, and not consider it just as another frame legitimising their refusal to offer certain services or offering them in a more restrictive fashion? Below I turn to the topic of caesarean sections, which present a counter-case in this research. Doing so helps further unpacking health workers' discourse about civil litigation, which in turn offers more refined insights into the ways that rights and rights talk come to produce decisive effects on health workers' routine practises.

As a matter of fact, in the case of caesarean sections, things seemed to work in the exact opposite way than abortion and contraception. To reiterate: Erdoğan, at the initial

stage of the debate, had declared that he considered caesareans as murder, just like abortion. Mayhem erupted in hospitals in response to these statements: During the months of July and August 2012 alone, several tragic cases were brought to the national media's attention. Those incidents shared the same blueprint with small variations: During the labour process, some unforeseen complication would come up; yet the obstetrician would refrain from performing a C-section, leading to the deaths of at least six infants and two women. Other cases with less dramatic consequences were brought to the attention of feminist organisations and medical associations, whereby obstetricians would explicitly mention the former prime minister's statements to deter women from C-section births.¹⁰³ But this immediate upshot of Erdoğan's statements was short lived. By the time I started my fieldwork two years after the debate, all of these were almost erased from memories. Ob/gyns whom I interviewed, when asked questions about caesareans, would immediately point at high caesarean rates—not to doctor unwillingness to perform them. Whereas the issue of civil litigation came up consistently—and almost inevitably—when talking about caesareans, these comments sought to offer an explanation for high caesarean rates:

Caesarean is a method with which doctors feel more comfortable with, with regards to avoiding possible legal ramifications that would cause trouble. For instance, shoulder dystocia during natural birth is a complication; it is unforeseeable. We have a professional definition of complication. But because penalties come up even in case of complications, doctors now practise defensive medicine. That is, they protect themselves first and foremost. This is why caesarean [rates are so high]. (Samet, ob/gyn at Westpointe public hospital)

Obstetricians are always sued because of failure to perform caesareans, not

¹⁰³ One example that came into national media's attention can be found on <http://direnisteyiz5.org/berkin-bebek-irkci-doktora-ragmen-dogdu/> Last accessed on May 28, 2017.

because they performed caesareans—it's never the other way around. Obstetricians are, in any case, the most often sued group among doctors. This is why they tend to practise defensive medicine more often, and why caesarean rates go up... But doctors wouldn't withhold caesareans. (Bumin, ob/gyn at public Westpointe hospital)

Go look at the cases that are brought up about this. No one sues a doctor because they performed a caesarean, they are always sued because they did not perform a caesarean. (Şengül, ob/gyn at private Westpointe hospital)

I will argue that what the counter example of caesareans suggests is that the primary concern that affects the everyday decisions that health workers make is not a fear of government retaliation. Instead, it reveals a deeper tension that has become the character of the healthcare sector over the last years. Indeed, if abiding by the preferences voiced by the former prime minister were the primary factor in health workers' decisions, then they would refrain from performing caesareans as well, which seemed to happen for a brief period back in 2012. The question is, then, what has happened to alleviate the fears of obstetricians about performing caesareans in the meantime, that did not happen in the case of abortions and IUD insertions?

To answer this question, we need to turn our attention to law and legislation once more. The hostile stance that the government adopted toward abortion and contraception has never been translated into actual change in laws regulating these areas. As opposed to abortion and contraception, however, legislative action about caesareans was taken curtly as the Law no. 6354, to my knowledge the first caesarean law in the world, was passed on July 12, 2012. What the law did, rather than bringing in new directives that would significantly alter the practise, was to ratify the commonly accepted professional standard that caesareans would not be performed except in the presence of

health indications—which are broadly defined, and include anxiety and distress on the part of the pregnant woman.

In this vein, I will argue that the controversy of 2012, more than anything else, generated ambiguity with regards to the legal status of fertility-related healthcare practises. Here, I divert from the more common uses of the concept of legal ambiguity, which is defined by scholars as inherent in certain laws (Kuyucu 2014; Fassi 2014) and denotes a given law’s emphasis on procedures counterweighed by inattentiveness to outcomes, vagueness of prescriptive language, and a lack of enforcement mechanisms (Edelman 1992: 6). Instead, following the sociological literature on organisations, I consider ambiguity as a characteristic of the broader environment within which laws are interpreted and implemented by interested actors. As Edelman (1991: 5) argues, “law creates a ‘legal environment’ that consists not only of law and the sanctions that are built into law, but also societal norms and culture associated with the law.” I therefore propose to think of ambiguity not simply as a quality that inheres in the written rules, but also as a reflection of the changes taking place within the normative environment onto the on-the-ground implementation of the laws.

While Lauren Edelman and others (Edelman et al. 1991; Bybee 2000; Lageson, Vuolo and Uggen 2015) discuss ambiguity as an element of legal change and the incapacity of interested actors to foresee what the limits of implementation are going to be, I suggest that the very absence of legal change, combined with controversies that take place in legal language, can also lead to legal ambiguity. Hence, the disjunction between official discourse on a given issue and the law can generate ambiguity and prompt implementers to question and redraw the boundaries of the “legal.” Accordingly, whereas the

abortion/caesarean controversy of 2012 was not immediately followed by an actual amendment to extant laws, its language heavily imbued in legal rhetoric generated anticipation of imminent legal change. The anticipation of a change in abortion law dwindled as time passed by without any official attempts in that direction; but as high-ranking government officials attacked the legitimacy of abortion and contraception, the taken-for-granted legal status of those practises became ambiguous. Health workers were not convinced that these practises were unlawful or illegitimate, but the rift between the hostile government discourse and the (unchanging) laws that lie at the heart of this legal ambiguity, compelled them to rethink and redefine the limits of the doable in their professional field. Consequently, they did not only become vigilant about the extant legal limits, but they also started to implement a series of self-styled, impromptu limits to their abortion and contraception practise. In contrast, with regards to caesareans, about which the government stance was equally negative, the passing of the Law no. 6354 brought about enough clarity for practitioners to continue their business as usual—indeed, caesarean rates were unchanged and my interviewees expressed no concern about performing them. In a nutshell, legal ambiguity and the anxiety that it provoked, which came to be expressed through the language of litigation crisis, lead health workers to align their practises of abortion and contraception with the government preference, whereas the lack thereof in the case of caesareans produced the exact opposite consequence.

Conclusion

A grounded analysis of health workers' accounts of their everyday professional practises suggests that they were working under intense tensions, fostered by the legal ambiguity that the abortion/caesarean controversy of 2012 generated. In the first place, these tensions pushed healthcare employees to redraw the limits to their routine practises—in terms of which practises to offer, to whom to offer them, and under what circumstances. Interestingly, the degree to which these re-drawn boundaries were restrictive (with respect to the language of the concerning law or with respect to previous ways of offering the same service) as well as the extent to which they were considered flexible varied from one health practise to the next—not so much from provider to provider or institution to institution. Finally, in order to explain the restrictiveness of their approach or why certain limits were seen as more strict than others, health workers made repeated references to the possibility of being sued.

This chapter made the case that the fear of civil litigation was the language into which legal ambiguity was translated in my respondents' accounts. Consequently, civil litigation became the main consideration that healthcare professionals took into account while drawing the limits to their practises; and fear of government retaliation. It will be the next chapter's task to further scrutinise the theme of civil litigation, in order to understand why this particular discourse has become so prominent in the area of reproductive health specifically. Indeed, there is no direct causal link between legal ambiguity and the prominence of the discourse of patients' rights as a source of tension for providers. In order to achieve a rich insight into the contextual nature of rights, the next chapter delineates the dynamics that come to affix these two to one another.

At the same time, this analysis brings forth noteworthy implications for feminist and professional organisations, whose mobilisation, bearing heavily on rights language, effectively halted formal legal change but fell short of creating significant impact on everyday practises in healthcare institutions. If most practitioners did not debate the status of abortion and contraception as rights and even voiced support for women's rights to reproductive healthcare, but this support was not reflected onto their daily practises, what is the value of organising around rights claiming? I raise this question in Chapter 8, as I seek to reach a better understanding of the dynamics underlying the findings presented in this chapter by delineating to what health workers' narratives correspond within the broader political context in Turkey.

CHAPTER 7

OF COMPENSATION AND COMPASSION

The previous chapter made the case that rather than having sent “orders” to health professionals about which practises to carry on and which ones to shun, the abortion/caesarean debate of Summer 2012 fostered legal ambiguity around those practises. The ambiguity around caesarean sections quickly diminished when the Law no. 6354 passed, which simply reaffirmed professional guidelines regulating C-sections. As ambiguity gave way to clarity that it was legally safe for ob/gyns to continue their practises as usual, caesarean rates remained unaffected by the controversy following the debate. In contrast, as no legal change was made to the abortion law despite the entire legal skirmish surrounding it, ambiguity only intensified around it. I contended that the anxiety that legal ambiguity generated came to be expressed through the trope of fear of civil litigation, which providers resorted to when explaining in their decisions to not perform abortions or to be more selective about when to offer them. Furthermore, contraception and pregnancy monitoring schemes also became attached to the debate: the former because of subsequent statements by Erdoğan, and the latter because of their perceived relation to abortion. Yet, health workers displayed more flexibility toward these two than toward abortion, about which they observed very strict limits.

This argument, albeit straightforward, still needs to be more solidly substantiated, as certain points remain puzzling. Indeed, ambiguity by its very definition leads to open-endedness rather than a predetermined course of action; while it led health workers to rethink the “legal” boundaries to their practises, it was not preordained that providers

were going to shy consistently away from abortion in the public sector while carrying it on as usual in the private. Equally unforeseeable was how crucial a place was the perceived tension between patients' rights and women's rights to hold in providers' boundary-drawing effort. In a country in which patients' rights have been a legal entitlement for decades, and have as a rule been very weakly enforced, it is unclear why healthcare providers would turn into this discourse—and turn into it only when it came to reproductive healthcare practises.

This chapter scrutinises the factors that enabled the patterns of health service delivery that were presented in the previous chapter within their particular context. Toward this aim, I start with a few simple questions: Why were abortion and IUD insertion shunned in the public sector but not in private practises? Why was the theme of patients' rights so prominent in my respondents' accounts? And why did public healthcare employees who voiced strong support for women's right to access all reproductive health services they desired, especially abortion either refrain from offering the service altogether or impose further requirements for performing one? In other words, what explains the discrepancy between providers' commitment to women's rights in the abstract and their failure to deliver on these rights? My contention is that while ambiguity precipitated an interrogation and re-negotiation of the "legal" limits to reproductive health practises, it is only by looking at the broader context within which these negotiations took place that we can understand this reconfiguration of reproductive healthcare delivery in Turkey.

In this vein, this chapter will resort once more to the broader political trends that were laid out in depth in previous chapters, namely, neoliberalism and neoconservatism.

While I find it useful to analytically distinguish between neoliberalism and neoconservatism, other scholars, instead of making such a division, handle the trends that I delineated as characteristics of neoconservatism as direct or indirect consequences of neoliberalism itself—such as the diffusion of particular moral orders into ever more areas of social life (f.i. Muehlebach 2012). I borrow extensively from this literature that considers the increasing dominance of gendered (and racialised) moralities in social life as a dimension of neoliberalisation, all the while insisting on the analytical distinction. My point in emphasising the role of neoconservatism, as I discussed in Chapter 3, is to show how working in tandem with neoliberalism, the neoconservative current in Turkey gave rise to what I called familial citizenship—a politics based on the inclusion of individuals within the polity primarily through their status within the family. As noted earlier, the gendered dimension of this mode of citizenship is crucial in that it uniquely affects women: It promotes motherhood as the most important, if not only, way for women to be considered proper citizens—which bears tremendous implications for reproductive health practises.

Within this framework, I use neoliberalism as an analytical tool that allows me to explain the consequences of marketisation in healthcare, resulting from policy changes at the macro level that were implemented over the last decade. Neoconservatism, in turn, which refers to the legitimisation of gendered inequalities, allows me to capture the dynamics that are unique to reproductive practises and do not necessarily affect other areas of healthcare. To reiterate, I agree that these two aspects work in tandem, yet they also cannot be reduced to one another—hence the necessity to adopt different analytical tools. For purposes of clarity, I handle the two dimensions separately but seek to draw

the relations between the two. The next section, returning to the neoliberal transformations sweeping the Turkish healthcare system, seeks to shed light on how abortion and IUD insertion came to be considered “risky” endeavours that employees were not eager to carry out in public institutions. I then move on to delineate how neoconservative morality enables providers to refuse to carry out these practises, all the while cherishing women’s rights to access them.

When Two Rights Collide: Calculating the Risks in Reproductive Health

My interviewees who worked in public healthcare institutions were quick to point to the transformations in their professional environment when explaining the constraints that they felt on their practise. Specifically, the shift of the Ministry of Health’s role from a direct provider of healthcare toward a more “regulatory” agency (Ağartan 2012: 469) weighed heavily on the ways that health workers carried out their routines on a day-to-day basis. As I detailed in Chapter 5, while the MoH retained—even increased—its control over the day-to-day functioning and financing of public healthcare institutions under the new structure, its accountability dwindled as more and more responsibilities were passed on from the state to providers themselves. Many interviewees were particularly vocal about how the changing expectations from doctors under the new structure put additional strains on employees:

Right now every individual working in the health care system is anxious, and feel concerned in many ways. I mean no one has eagerness, or desire, or capability to carry out their work. The biggest problem of our health care system is the fact that they are trying to impose European standards of investigation on us before our working standards reach the European level. For instance, according to European standards, and the number of patients shouldn’t exceed 20, and one shouldn’t receive more than one patient in 20

minutes. But here, my friends working in the maternity ward receive around 200 patients a day. While I was doing my obligation period¹⁰⁴ a complaint was filed against me because I didn't see the 63rd patient before noon. The Vice Health Director came to take my testimony; he interrogated me for two hours. When you work under these conditions, of course you no longer feel eager for perform your profession. (Samet, ob/gyn at Westpointe public hospital)

Overcrowding of public health institutions has always been a sweeping problem for the Turkish healthcare system, which has been a major source of tension and conflict for both healthcare employees and their patients as well as between them. My interviewees suggested that on the one hand, the Transformation in Health aggravated the extant issues pertaining to overload by enhancing access without enhancing hospitals' capacity through the so-called universalization of healthcare (Üstündağ and Yoltar 2013). On the other hand, so far as the MoH no longer assumed responsibility for the shortcomings at the level of service delivery that resulted from overload, but instead held providers accountable for all of these, the new system also generated new and disparaging dynamics at the level of everyday encounters between providers and patients. Patients' rights to bring about complaints against healthcare workers gained salience both in the context of, as well as in response to, these mounting antagonisms:

It has always been like this. . . . Doctors have always been discriminated against. But now it has reached such a point that a patient can complain about the doctor. . . . I never worked in public sector, but the conditions of the doctors are really bad there. Whoever wants to do so can go and file a complaint. Then the doctor has to give testimony and so forth. Back in the day people used to respect doctors, today they harass them. (Macit, ob/gyn at private Westpointe clinic)

¹⁰⁴ Students who have completed a medical degree—after BA, expertise, and/or a minor expertise—have to serve at a location to which they are allotted to by the Ministry of Health for a period of 300 to 600 days, depending on the allotment location before earning the professional title to work at their location of choice.

Conflicts with the patients, investigations by administrators, the possibility that a patient's complaints can end in a court case, and finally, a Ministry of Health that seemed rather unresponsive towards healthcare workers' grievances were the recurrent themes of health workers' descriptions of their work environments—all of which added to a generalised sense of vulnerability among health workers. Indeed, these tensions and feelings of vulnerability regularly came up during my interviews when providers explained why they became more reluctant to perform abortions and certain contraceptive practises. For instance, Fatma, after listing a number of hypothetical scenarios through which (in her own words) “the government pitted doctors against the patients,” explained the reasons for her decision to not perform abortion on request in the family planning clinic of the hospital where she worked:

The Ministry of Health doesn't stand by the physician. In case something goes wrong, physicians find themselves in a fix. (Fatma, ob/gyn at Eastpointe public hospital)

Therefore, Fatma felt that she would be susceptible to trouble, with no institutional support to back her, if complications should arise during or after an abortion. In other words, it was not so much the risks inherent in the procedure itself (which she used to offer in the past), but the disappearance of institutional support, which led to this decision.

But why did private practitioners, who were cut off from the Ministry's support network even more decisively, not take this lack of institutional backing as a reason to retract from abortions and IUD insertions? Here, returning to the argument that I previously made about the perverse incentives instituted by the TiH and the ensuing marketization of healthcare may be helpful. To reiterate, the TiH instituted a

performance-based salary system to calculate health workers' remuneration, whereby the MoH assigns (according to many interviewees, rather arbitrarily) performance points to every practise that could be carried out in public healthcare institutions. Health workers thus earn points for each practise they perform and accumulate points throughout the month, at the end of which the employee's salary is calculated on the basis of the performance points she earned. Providers can also earn negative points for the errors that they make, which are then deducted from their monthly pay check. Thus, on the one hand, the TiH precipitated "responsibilisation" of healthcare workers, whereby the meaning of responsibility shifts from "*ex post* accountability for one's own actions into an *ex ante* virtue, which emphasises acting in the present and preventing undesirable situations and events" (Peeters 2013: 593)—true to the spirit of neoliberalism (Rose 2000). On the other hand, while it is rather difficult to convert performance points directly into monetary value,¹⁰⁵ this payment scheme incentivised healthcare employees to take into account the comparative benefits (compensation) and potential disadvantages (losing time, effort, negative performance points) that any action could bring before carrying it out. In the process, the provider-patient relationship is effectively reduced into a market transaction in the public sector.

While there are risks inherent in every invasive operation—such as haemorrhage, infection, or damage to organs and tissues—it is important to remember that risk is always calculated comparatively. Within the Turkish healthcare context, health workers

¹⁰⁵ Each health worker, according to their position within the healthcare structure, have a base-salary, to which the performance points earned during a given month are added. Social security expanses are then deducted from this sum, and so are negative points, if any. Consequently, health workers do not know exactly how much money they earn for any given practise, but can make comparisons across different types of practises to judge which practises are "worthy" and which ones are not.

considered the risks associated with abortion and IUD insertions not to be serious in and of themselves, but only relative to the compensation that it would bring them. Indeed, providers working in the private sector hardly ever mentioned the “risks” that abortion and IUD insertion involved; rather, they described these practises as “simple” and “safe.” In contrast, my respondents in the public sector—who reported that abortion and IUD insertion did not bring them a substantial amount of points—persistently brought up the risks that these procedures entailed.

A quick glance at the list of performance points assigned to medical practises explains why health workers put so much emphasis on this point, as well as giving an idea about the incentive structure at place. In 2014, inserting an IUD brought 40 performance points, removing one brought 50 points, while draining an abscess on the vaginal entrance brought 60. Among vaginal operations, with the exception of anamnestic practices like taking a pap smear, abortion on request was assigned the lowest performance score together with cyst and caruncle removal: 177, whereas, for instance, draining an abscess in the pelvis through the vagina brought 294 points.

Aside from not feeling compensated adequately for offering abortions and IUD insertions, health workers were also left to carry the burden of those risks themselves, so far as the MoH no longer assumed responsibility for potential hazards but punished its employees when faced with one. In other words, providers did not perceive invasive practises as inherently risky, but they assessed the risks by comparing the potential losses to the compensation that a practise would bring: Risks were thus seen as negligible if one was well compensated, but as too large to take if one would be hardly paid for performing it.

By the same token, the very same circumstances reinforced health professionals' tendency to prefer caesareans over natural births, as vaginal births were considered more prone to entail complications:

I think that the Ministry of Health puts a lot of pressure on physicians. I mean, physicians are all alone when complaints are brought against them. There are a lot of malpractice cases in our area; for instance when there are complications at birth, [we are sued] for not having performed a C-section. (Kemal, ob/gyn at Westpointe public hospital)

The neoliberalisation of healthcare, therefore, constitutes the professional background against which health workers had to navigate the (newly) legally ambiguous professional area following the abortion/caesarean debate. At the same time, as I sought to show above, the new structure itself came to shape how limits were drawn and acted upon. In this context, patients' rights became a deterrent for practitioners working in the public sector with respect to invasive operations, such as abortion and the insertion of an IUD, while it promoted caesarean sections over vaginal births: While the government voiced a preference for vaginal births over caesarean sections, ob/gyns nonetheless felt vulnerable to civil litigation cases in so far as the risks associated with vaginal births were higher and the anxiety about patients' rights loomed over their practise.¹⁰⁶ In contrast, when it comes to abortions and IUD insertions, the fear of patients' rights led practitioners to follow government preferences because simply offering those services were read as

¹⁰⁶ The absence of a centralised structure across Turkish courts makes it difficult to determine with certainty the numbers involved. According to one article published in an online medical news magazine, there were over 1200 cases filed against doctors in Turkey by early 2015. The article further states that 22% of the cases involve complaints about wrongful management of delivery—the second most common grievance in malpractice cases after wrongful management of surgery. Such news and articles in medical websites, magazines and bulletins appear often, which undoubtedly adds to the currency of the trope of civil litigation among health workers. Retrieved from <https://www.medikalakademi.com.tr/hekime-1-200-dava-6-5-tl-tazminat/> on May 14, 2017.

undue risks: Carrying out these procedures in public institutions did not bring substantial compensation, but it brought the “risk” that a complaint could be pushed against a provider, which would result in negative performance points. Looking at the issue from the reverse side, abortion and IUD insertions were easily available and ob/gyns were more likely to assist vaginal births in the private sector precisely because the compensation that private providers receive rendered the risks associated with it negligible. In a nutshell, unlike the private sector, in public institutions patients’ right to litigation, while incentivising caesarean sections, became an obstacle to the right to access to abortion and contraception.

To summarise, the sense of vulnerability, stemming from a lack of institutional support in their professional area and the threat of monetary sanctions that the TiH instituted among health workers, was decisive in shaping their in the legally ambiguous environment. Within this new professional climate, public health employees perceived a conflict between women’s right to reproductive health and patients’ rights to hold practitioners accountable for malpractice and errors. Accountability, now shouldered not by the MoH but providers themselves, implied the risk of monetary sanctions, and the compensation that they received for abortions and IUD insertions was not enough to entice providers to take that risk. They consequently shaped their practises in a way to minimise risks to themselves, rather than to abide by the government preferences or to deliver their rights to their patients.

Who Is the Subject of (Reproductive) Rights?

Then again, even if the tensions and anxieties inherent in the new healthcare structure can explain why the fear of civil litigation became a major trope in health workers' accounts, it does not explain how providers reconcile the tension between their stated support for women's rights and their reluctance to deliver on these rights, specifically with respect to abortion and contraception. Moreover, why is it that such extensive reluctance, to the extent of substantially thwarting healthcare delivery, arose only in reproductive health and not in other areas of healthcare, while the problems that I delineated above afflict the entire healthcare structure?

In order to answer these questions, I suggest that we need to take into consideration the moral counterpart of neoliberalism, namely, neoconservatism. To reiterate, neoconservatism seeks to impose a certain moral order on society. While the kind of morality championed by neoconservatism never goes uncontested, to the extent that some of its aspects are institutionalised by "programmes and policies [that] contain assumptions about desirable ways of being and behaving and are thus involved in the process of political subjectification" (Larner 2000: 257) its values and exclusionary logics gradually become naturalised across society. As I described in Chapter 2, the kind of moral order that the AKP's neoconservatism sought to institute defines family as the pinnacle of society, and women in particular are valued (exclusively) in terms of their role within family—most importantly, as mothers. Unlike other kinds of healthcare practises, reproductive healthcare entails some sort of intervention into the realm of motherhood, bringing it at once under the rubric of familialism. More specifically, abortion and contraception imply a woman's attempt to control her fertility and avoid motherhood,

hence defy the norms of familialism. My contention is that, consequently, the familial form of citizenship that gained currency in recent years in Turkey precipitated a transformation of women's status as citizen/subjects, and consequently has had immense implications for who is considered as the subject of (reproductive) rights in Turkey. Below, I will trace the ways in which the question of subjectivity looms over my respondent's daily routines, and how it leads to a reconfiguration of the way that the provider and the patient are positioned in their exchange in healthcare institutions. I argue that it was precisely this reconfiguration that allowed healthcare providers to ease the tension brought about by the discrepancy between an idealistic commitment to women's rights and their refusal to carry out health practises that they allege to consider as a woman's right.

Indeed, my interviews with public sector healthcare employees were replete with anecdotes illustrating health workers' experiences of not delivering on these rights, either to particular individuals or as a general rule. Remarkably, health workers shared a particular vocabulary to talk about such instances. Osman, a gynaecologist that I met through the ITO, had a strong left-wing political commitment, which for him implied a gender-egalitarian approach in his own profession. Yet, he was also explicit about facing constraints in this regard, preventing him from always fulfilling his ideals. He remembered one instance, whereby the female partner of a non-married couple¹⁰⁷ wanted an abortion, but

¹⁰⁷ Osman did not remember for certain whether it was a co-habiting couple, or they were married through a religious ceremony. In Turkey, religious weddings are not officially (fully) recognised; the husband within such a marriage hence does not have a say in her wife's decision to have an abortion, at least on paper. This could have meant relatively easy access, that is, access without spousal consent, to abortion on request for a sizable population of

[T]he man's reaction was so volatile. It was volatile both towards the woman and towards myself. So, in that case, for instance, I didn't want to do such a thing. I mean I couldn't help that woman. She had to give birth to that child. (Osman, ob/gyn at public Westpointe neighbourhood clinic)

It may be argued that as an exception to his general professional leanings, Osman's decision to not perform abortion in this particular instance can well be explained by the imminent threat of physical violence, which I do not contest. Yet his choice of words in narrating that situation is, to say the least, telling: He described his unwillingness to carry out an operation that was requested by a woman patient, who had every legal right to obtain it, as his failure to "help" the patient—not as his failure to fulfil his professional duties.

Osman was not alone in perceiving his professional relationship to his patients within the framework of helping. Indeed, this theme emerged as one big trope that my interviewees resorted to in order to reconcile the inconsistency between a stated commitment to women's rights and their refusal to offer certain services. Many of my respondents, while narrating how they carried out their duties, as well as the ways that they failed to do so, resorted to this framework. "We help [our patients] out to the extent that we can," [*elimizden geldiğince yardımcı oluyoruz*] said Remziye, insisting that service delivery in the clinic that she worked at was exceptionally well functioning. What she meant by helping her patients was to refer a patient immediately to the hospital's laboratory and request the colleagues in the lab to send the test results to the family planning unit before the legal time is up. Or, asking a single/divorced/widowed woman to bring her population register records instead of turning her away instantly also counts

women. Yet, precisely because of reasons that come out of Osman's story, we can expect this not to be the case.

as helping her out—even though under the law, this corresponds to nothing more than what is considered a woman’s right.

It is no coincidence that this framework was pervasive only in public institutions but not in the private practises, because the question in private institutions typically is not whether one has a right to get an abortion or not, but whether one has the ability to pay for it or not.¹⁰⁸ In contrast, as detailed in the previous section, public sector employees did not make significant monetary gains by performing abortions and inserting IUDs. Furthermore, so far as patients in the public sector received healthcare for free—a context within which the right to access healthcare becomes more salient than private sector—practitioners were easily capable of imagining their actions as acts of goodwill rather than as service (see also Newman and Clarke 2009).

In this vein, by “helping,” rather than serving, their patients, health workers construed themselves as compassionate subjects, who were not obliged to act in certain ways but did so out of benevolence when they deemed necessary. By the same token, women patients were positioned as subjects of compassion rather than of rights. Indeed, such reconfiguration was possible only under a neoconservative logic. According to institutionalised familial norms of citizenship, the refusal to become a mother entailed norm violation, which relinquished a woman’s rights-bearing status. Consequently, it was up to a provider to decide whether or not a patient (or all patients) “deserved” their benevolence or not. In contrast, precisely because caesarean sections did not defy the

¹⁰⁸ This, of course, goes for the cases that fall under the legal limits—although it is a well-known secret in Turkish medical circles that so far as one has the economic means, it is not difficult to find private practitioners who would willingly step outside of legal limits.

expectation that a woman will become a mother, performing a C-section was never conceptualised in terms of helping out.

This is precisely why I contend that this “helping patients out” framework is dangerous: Within its confines, practitioners could easily and with a clear conscience waive their duty to and refuse carrying out the requests of a patient. When for one reason or another, patients, either as individuals or as a group, failed to evoke health workers’ compassion, thus failed to compel them to “help,” they found themselves without remedies. Fatma’s account perhaps illustrates this dynamic the best. Fatma was an ob-gyn working at the largest public hospital in Eastpointe. Whereas early on during the interview she asserted that “...abortion should be legal. 10 weeks is a good time [limit], it shouldn’t be pushed down;” she conceded that neither herself, nor other doctors in her department, with the exception of one person, performed abortions—despite reporting a very high demand for the service in her city. In other words, the hospital met all the requirements for offering abortion procedure, yet all but one of the doctors working there refused to carry it out. When inquired about her reasons for this, she said:

One doesn’t want to shoulder that burden, that responsibility. As a doctor, as an individual, you don’t. Plus you don’t know what will come out of that later on. Besides, when you don’t perform it, it doesn’t mean that it will not be performed. Most [of the patients] go to private hospitals—there are so many patients in private hospitals. (Fatma, ob/gyn at Eastpointe public hospital)

Later in the interview, Fatma clarified that she was referring to the issue of civil litigation when she said “you don’t know what will come out of that later on,” explaining her and her colleagues’ decision to not perform abortions. But what is significant here is how little discomfort she felt, as a public employee, for denying abortions to her women

patients. Indeed, for sheer monetary reasons, obtaining an abortion may not be an option for all women—which is the very reason why the extant law mandates abortion to be made available in public institutions. Her refusal to offer abortions could thus mean not being able to procure one at least for some of her patients.

In so far as women patients who sought abortions and IUDs were not recognised by health workers in their daily encounters as the subjects of the rights that were cherished in the abstract, their access to health services remained dependent on providers' compassion. Yet, as Judith Butler (2009: 50) suggests, "affect depends on social supports for feeling." In the Turkish context, the neoconservative morality did not only disqualify women from having the right to abortion and contraception, but it also constrained their chances of eliciting health workers' compassion. Fatma's case illustrates the farthest point in the spectrum of diminished compassion toward women: Patients evoked her suspicion—that they could sue her in case anything went wrong during or after a procedure—rather than her compassion, leading her to refusing to perform requested abortions completely.

In addition to such blanket refusal of a given service to all patients, this dynamic can also play out in a more selective fashion: "Deservingness" can be threatened not only by a woman's refusal to carry a pregnancy to term, but by the particular ways in which she relates to providers as well. As Boltanski (1999) underlines, the compassionate subject expects the object of this sentiment to remain passive in her suffering, submissively await help and not actively seek it. Certainly, women patients' attempts to reclaim rights-bearing status and to assert their rights to access services typically backfired on them.

For instance, one day where things were out of hand at the hospital she was working at, whereby the building of the polyclinics was evacuated and the schedules were messed up, Nafiye had a confrontation with a woman patient who sought an abortion on request. The patient had gone through all the required steps and had received appointment for the procedure on the said day, and was in obvious distress when she found out that there might be a chance the operation would not be carried out that day. Considering the strict time limits—the family planning unit in Nafiye’s hospital offered abortions until the 8th week of pregnancy—hers was an understandable concern. But Nafiye was so irritated by the altercation she had with the patient that when I asked her what was going to happen to her, she replied: “I don’t know, and I don’t care what will happen. I am not giving her abortion. Some other doctor can, if they want to. It won’t be me.” As she was the supervising obstetrician in charge of the family planning unit the said day, there was close to no chance that any other doctor, with no obligation to attend to family planning patients, would carry out the operation. What happened to the woman afterwards, whether or not she was able to terminate her unwanted pregnancy, in that hospital or elsewhere, is unknown to me; what I do know is that Nafiye did not perform her abortion. As far as her argumentativeness had disqualified her from deserving Nafiye’s help, Nafiye had no qualms about denying her the service.

Critical scholars of poverty time and again highlighted how “deservingness” has served, over the last decades, as a pervasive discourse to exclude certain people from public service networks, even though the qualities that enable a particular individual to deserve access to any given assistance changes from context to context (O’Connor 2001; Gilliom 2001; Goode and Maskowsky 2001). Similarly, public reproductive healthcare

employees in the Turkish context engage in similar assessments of deservingness to decide whom to extend their “benevolence.” Berna Ekal (2011: 9) identifies a similar propensity among the employees of municipal shelters for women victims of violence, whereby accepting a client is coded as “helping” her, and applicants are subjected to merit-based test “to prove [their] ‘womanhood’ in certain domains like housework and motherhood so as to be among those inhabitants who are deemed by workers as those that deserve to be in the shelter.” In a similar vein, many among my interviewees made repeated claims that (some) women were being irresponsible with regards to contraception, and were relying on (state-funded) abortions as a birth control method:

Now there are all those contraceptive methods, and everybody is informed about them, they are very widely propagated. Yes, there can be accidents, but... After seeing [the same woman’s] ninth abortion, I find it difficult to [sympathise]. (Nafiye, assistant ob/gyn at public Westpointe hospital)

For instance, sometimes a patient comes. You inquire about her pregnancy history, it’s her fifteenth. How many of those were aborted? Eight. This shouldn’t be allowed. This is wrong. This is perhaps the one aspect of the [existing] law that needs improvement. As it is, there is no limit to stat-funded abortion on paper. You can get pregnant every year and get an abortion every year within the first ten weeks; no one can say anything. [There should be] something to prevent this. (Samet, ob/gyn at Westpointe public hospital)

I don’t think there is anything wrong about abortion. What is wrong is to get an abortion, another abortion next month, and then another one three months later. There are people who use abortion as birth control. [There are those who] have had five abortions at the age of twenty two-twenty three. (Şengül, ob/gyn at private Westpointe hospital)

Taking into account all the barriers to access to abortion on request that I detailed above, especially in the public sector, the scenario seems unlikely—if possible at all.

Furthermore, considering TNSA data that I referenced in previous chapters, such cases cannot be representative of larger trends among the general population. The pervasiveness of this theme among my respondents, therefore, hints not necessarily at a

widespread public health problem, but rather, to the dynamics of the gendered moral economy at healthcare institutions: In addition to being obedient and grateful, women need to prove being “responsible” in their sexual lives in order to “deserve” abortions.

Thus, neoconservatism “narrows the category of rights bearers by excluding certain groups who do not comply with the dominant images [of womanhood] —such as ... women who willingly step outside the normative family institution” (Babül 2015: 118). In the context of reproductive health specifically, women lose their rights-bearing status either because of their refusal to get pregnant (contraception) or their refusal to carry a pregnancy to term (abortion). In contrast, it is unlikely that a woman’s status as a rights-bearing citizen will be questioned at all when she is choosing a method of delivery. Consequently, and in an ironic twist, offering women caesarean sections was regularly referred to through the framework of rights rather than helping out:

If the patient says she will not give a vaginal birth and want to have caesarean instead, it’s not rational to force her to do otherwise. At the end of the day, she has rights. (Macit, ob/gyn at private Westpointe clinic)

Practises geared towards controlling fertility therefore become available to women only as acts of benevolence—to the extent that healthcare providers are willing to “help their patients out.” Yet, not all providers are eager to display such benevolence, as Fatma’s account illustrates. Furthermore, compassion is not easy to secure: One needs to prove that she “deserves” it. In a way, the framework of “helping patients out” is symptomatic of neoliberal moral economies, which keenly distinguish the “deserving” citizens/subjects from the “non-deserving” (Wacquant 2009). So far as patrons of reproductive healthcare in Turkey are female as a rule, the criteria for assessing deservingness in this area rely heavily on gender norms—which are currently being

redrawn in familial terms. Accordingly, this gendered moral economy facilitates refusing to serve those who are, for one reason or another, deemed as undeserving this benevolence—either because of their assertiveness or because of their sexual irresponsibility.

On the flip side of the coin, while this moral economy produces and entrenches a gendered hierarchy between state officials (in my case, public healthcare employees) and those to whom they gracefully extend their “help”, it also leaves the refusal to do so off the hook by not holding the “benefactors” accountable—indeed, compassion is, albeit a desirable quality, not a duty. At the end of the day, the erasure of women’s rights-bearing status eases the tension between health workers’ expressed respect for women’s rights and their unwillingness to deliver on these rights, precisely because such erasure also veils the political issues at stake in the exam rooms by reducing the matter into one of individual good will.

In sum, my argument in this chapter comes close to what Miriam Ticktin (2011) calls the “new regimes of care,” which she maintains are becoming an increasingly dominant form of governmental power across the globe. Ticktin contends that these regimes represent a form of anti-politics, in that within their framework “those who act in the name of the moral imperative generally claim to be apolitical—beyond or outside politics; second, rather than remaining outside the system in their desire to not engage with politics, they work to reinforce the status quo, the established order” (Ticktin 2011: 19). In a similar vein, I argue that in their refusal to acknowledge the rights-bearing status of their patients, healthcare workers—unintentionally, and compassionately—act upon and reinforce the neoconservative morality.

Conclusion

This chapter delineated the dynamics underlying the counter-intuitive prevalence of the theme of civil litigation among reproductive health professionals, and the reasons that while this discourse was prevalent across the board, it led to a retraction from abortion and certain contraceptive practises only in the public sector. It argued that the dual processes of neoliberalism and neoconservatism helped explain the puzzle: the former by reducing patient-provider in the public sector to a market transaction, and the latter by taking the status of rights-bearing subject away from women who defied the gendered norms of familial citizenship—namely, by refusing motherhood. Accordingly, on the one hand, public healthcare employees began assessing the risks that practises that they offered brought on them, since their livelihoods depend on it under the new healthcare structure. Ironically, the already-marketised private sector remained immune to the transformations that saddled the public sector in so far as the compensation that private providers received were high enough to compel to take them such risks. On the other hand, public healthcare employees were capable of overcoming the tension between their refusal to offer certain services when risks were deemed too high and their celebration of women's rights, precisely because they were enabled to *not* recognise their patients as the subjects of these rights.

I will tentatively suggest, reflecting on Nafiye's account, that there is a deeper connection between these two tendencies. So far as women were not considered as subjects of rights but as (potential) subjects of compassion, requesting an abortion or an IUD—hence, defying gender norms—situated a woman as a subject of questionable legitimacy. The patient-provider relationship was therefore replete with suspicion to

begin with; suspicion lasted until a healthcare employee made a decision as to whether in front of her was a legitimate subject of compassion or an undeserving claimant. The relationship was therefore considered as potentially antagonistic from the outset, which further exacerbated the fear of civil litigation. Therefore, the processes of neoliberalisation and neoconservatisation, working in tandem and reinforcing each other constrained the concrete remedies that rights—more specifically, the right to access abortion and contraception—could deliver in real-life practise.

This chapter highlighted the notion that we need to adopt a context-sensitive perspective in order to understand how rights work in real-life contexts. What emerges from such an approach is a complicated picture, which does not allow simplistic conclusions—or enthusiastic hopes in the promises of rights necessarily. Indeed, the narrative presented in the last three chapters leaves us with a rather bleak picture: In a nutshell, I suggested that only service delivery was circumscribed because of structural reasons through the sheer fact that there were fewer providers and units to offer abortion and contraception (Chapter 5), but those who still could did so under more restricted terms (Chapter 6). This chapter argued that they did so, once again, due to the influence of neoliberalism and neoconservatism, which do not play out only at the macro level but also at the level of individual encounters between patients and providers. All together, these suggest that even if women's right to access to reproductive healthcare services is not futile, it is heavily circumscribed. In the next chapter, in an attempt to bring together these findings with the accounts of Abortion Is A Right Platform organisers, I raise the question of what, under such circumstances, the effects of claiming rights could be for the women's movement in Turkey.

CHAPTER 8

RIGHTS ON THE STREETS, RIGHTS IN THE EXAM ROOMS: OF THE “EFFECTIVENESS” OF RIGHTS CLAIMING

On February 3, 2015, Mor Çatı Women’s Shelter publicised on its website the findings of a survey that its volunteers had conducted over telephone, and circulated among journalists. The findings, albeit unsurprising, were outrageous according to shelter workers: In Istanbul, by far the largest city in the country, with an estimated real population of 20 million, abortion on request was accessible in only two of 37 state hospitals. This suggested that access to abortion in public institutions had become, if anything, more difficult than the period preceding the abortion/caesarean debate and the ensuing rights mobilisation of Abortion Is A Right Platform.

MÇ shelter’s widely circulated research provoked uproar in the press and on social media, which was nonetheless short lived and proved insufficient to reenergise the abortion rights campaign. When shelter workers reached out to the constituents of the platform to set up a meeting to discuss their next steps, only seven women turned out (one of them being this humble researcher). Organisers lost heart and did not attempt to set up any further meetings with the platform afterwards. Other women’s shelters and solidarity centres across the country conducted their own research on the issue, yielding similarly appalling results.¹⁰⁹ Each time the findings from one city were announced, media coverage and social media activity on the topic soared, yet such news was lost

¹⁰⁹ Among the 12 cities where research was conducted, public hospitals offered abortion on request only in three. Out of 184 public institutions, only 9 offered abortion on request, whereas 65 offered therapeutic abortions and 76 offered abortion under no circumstances. Retrieved from <https://www.morcati.org.tr/tr/yayinlarimiz/izleme-raporlari/371-kamu-hastaneleri-ku-rtaj-uygulamalari-arastirma-raporu> on April 22, 2017.

from headlines within days without ever escalating into rallies or other forms of organised protest. The potential for another wave of action was thus lost. Seemingly, the times that women had to fight not only for abortion rights, but also for being capable of bringing reproductive matters onto the political agenda, were back.

Considering the narrative presented in the previous chapters, the findings of MÇ's research—which temporally coincided with my fieldwork—seem hardly shocking. But at the time, these findings, as well as organisers' inability to mobilise their network anew, led them to question their campaigns' tactics and its success: Had rights claiming proven futile, considering the fact that in practical terms, access to abortion had become even harder despite their large-scale mobilisation which had spread across the country? Did the difficulty of launching a new campaign have something to do with the rights language itself?

This chapter seeks not to find definitive answers to these questions, but to suggest some avenues for thinking them through in light of activists' own appraisals of the campaign. Toward this aim, I begin by outlining the theoretical debate over the effectiveness of rights claiming that has been one of the driving discussions in law and society studies over the last decades. Then, I turn to activists' own evaluations of their campaign's effectiveness. During our interviews, activists pointed at various different ways to assess the successes and failures of the campaign. All respondents considered the governments' retreat from legislation banning or restricting abortion as success. Beyond this point, there were important differences. Some, judging by the on-going problems of access, adopted a critical lens towards the value of rights claiming; others pointed at more indirect ways in which they felt rights had helped them to achieve important gains.

Besides giving voice to my respondents' thoughts, this chapter also seeks to bring these activist accounts into dialogue with the findings of the previous chapters in order to elaborate the broader theoretical implications of the study.

Drawing theoretical conclusions always requires one to take a leap from the data. Even though I try to remain as close as possible to my respondents' accounts in this chapter as I did in the previous ones, here I am also compelled to depart from them, sometimes even oppose them, in my endeavour to think together with them rather than solely interpret their narratives. I am taking this leap reluctantly—but perhaps there is no other way to conclude a dissertation that sought to dismantle the anti-politics of reproductive healthcare.

How to Assess the Effectiveness of Rights Claiming?

At least since Karl Marx' *On The Jewish Question*, “[p]erhaps no topic, short of law itself, has been more central to the sociolegal legacy of scholarly inquiry than that of rights” (McCann 2014: 246). Intellectual movements of the 20th century dealing with law and its interactions with societal change, namely legal realism, the Critical Legal Studies (CLS), and law and society movements have been shaped primarily around this discussion. Legal realism established, time and again, the existence of a “gap” between the “law on the books” and “law in action;” that formal law often times did not live up to its promise of bringing equality to those who needed its equalising power the most (Pound 1910). The CLS, inspired heavily by Marx' critique of law as an insufficient means for bringing about meaningful social change, asserted that while “the gap” was very real, it was not a shortcoming but the very success of law and legal institutions, in that their “real”

intention was not to bring about equality but to protect the status quo by cloaking it with an aura of legitimacy. According to this line of criticism, certain inherent characteristics of rights precluded them from benefiting the disempowered. In the first place, because of their individualistic nature, rights could potentially bring about relief for a few, but could not have real transformative effect on a societal level. Secondly, because of their indeterminacy, not all members of a disadvantaged community could benefit from them. At a third level, so far as rights language impelled people to translate their real life experiences and injuries into legal discourse—that is, reifying human experience—it led communities to lose from sight of their real goals. Most importantly, the very idea that all members of society possess equal rights masked existing inequalities, thereby legitimising the social and legal order (Tushnet 1984; Gordon 1982). In sum, “the goal of civil rights law [was] to offer a credible measure of tangible progress without in any way disturbing the basic class structure” (Freeman 1982: 110).

The law and society movement, on the other hand, while recognising that law was not necessarily a plane of equality, still sought to explore the ways in which those who are disadvantaged by the legal order nonetheless make use of law in general and rights in particular, sometimes in unexpected and inventive ways. From this perspective, law is undoubtedly implicated in unequal social relations, but it cannot be reduced to a simple tool of the dominant classes and sectors of society: “[I]f we say that existent class relations were mediated by the law, this is not the same thing as saying that the law was no more than those relations translated into other terms, which masked or mystified the reality. This may quite often be true but it is not the whole truth. For class relations were expressed, not in any way one likes, but *through the forms of law*” (Thompson 1975: 262,

emphasis in original). Law, then, should be conceptualised also as a force in itself, which can generate complex, multidirectional, and unintended effects.

This stance most certainly does not imply unreservedly embracing rights as unqualified goods; rather, it suggests a more nuanced perspective on how law, not as a corpus of written rules but as a phenomenological reality, comes to be experienced by those who come into contact with it. Law and society studies, henceforth, instead of building off of a unified conceptualisation of law, opened new avenues for exploration and discussion. As underlined above, rights received special attention within these debates.

One question that has dominated the field for decades was whether resorting to rights claiming by progressive groups effectively brought about social change in the desired direction, or rights were coincidental to transformations. Stuart Scheingold's framework that counterposed the "myth of rights" to the "politics of rights" ([1974] 2004) and emphasized that remedies did not seamlessly follow from formal recognition of rights, set the tone for the following discussions around the contribution of rights claiming to activist goals. These debates did not only query whether law and rights could be used as effective tools to achieve social change, but also raised the question of what "meaningful social change" is.

To answer these questions, some scholars sought to isolate the effects produced by the judicial affirmation of a particular right and measured them against the explicit goals of social movements advocating that particular right. For instance, Gerald Rosenberg (1991), in a widely cited study on the Supreme Court's 1954 *Brown v. Board of Education* decision, investigated indicators of desegregation in education in the period immediately

following the ruling, and found that the extent of desegregation was negligible absent other sorts of political support. Instead, he asserted that what accelerated desegregation was the onset of the Civil Rights movement in the 1960s. In a similar vein, feminist critiques of women's rights advocacy pointed at the repeated failure of law and rights to deliver on their immediate promises, let alone bringing about broader attitudinal changes. Kristen Bumiller (1987), for example, criticised the efforts to extend race-based anti-discrimination laws toward sex-based domains, on the basis that the symbolic importance of such laws notwithstanding, systematic barriers to litigation fell short of offering real-life protection for the victims of discrimination.

While this line of reasoning was appealing to some, others heavily criticised such conceptualisations of judicial impact in that "...viewing law primarily as a tool of public policy designed to achieve pre-established purposes, whether an effective or failed tool, obscured the aggregate and cumulative contributions law made to sustaining a common culture, historical institutions, and particular structures of power and inequality" (Silbey 2005: 324). This view of law, which rejects the notion that law is a sphere separated from politics and social life, implied a more nuanced understanding of the "impact" of rights mobilisation. Developing the conceptualisation of law as a constitutive element of social life, McCann (1996: 459) suggests that a "positivist model of causation is instrumental, linear, and unidirectional: it seeks evidence regarding how discrete institutional stimuli (independent variables) [...] produce changes in the behavior of targeted persons (dependent variable)." The constitutive approach, on the other hand, focuses attention on the complex interaction between social context and constitution of subjectivities, and therefore avoids reducing complicated social phenomena into an over-simplified schema.

This shift of focus brings about the recognition that law cannot be reduced to “clear, unidirectional, one-dimensional commands issued by discrete court decisions” (467) but should be understood as “a complex repertoire of discursive strategies and symbolic frameworks that structure on going social intercourse and meaning-making activity among citizens” (McCann 1994: 282). The predominance of formal legal institutions in our depiction of law is therefore “decentred,” attuning our attention to multifaceted and indeterminate ways in which rights come to produce “effects,” which are not necessarily reducible to behavioural indicators.¹¹⁰

It is against this theoretical backdrop that I am raising the question of effectiveness with respect to the mobilisation for abortion rights in 2012, and turn into activists’ own accounts of success and failure to open up the discussion. Interestingly, in their different points of focus, my respondents seemed to be as divided in assessing the successes and failures of the campaign as scholars of law and society are in relation to the question of effectiveness of rights. Following a similar narrative to the theoretical discussion above, below I first present the criticisms that some of my respondents raised against their own campaign tactics, which echoed to large extent the socio-legal and feminist critiques of

¹¹⁰ While the examples I deploy in this brief account are U.S.-based, I think the concepts and questions derived in this literature offer fertile ground to study other contexts. Indeed, ideas about law and legal symbols have a peculiar historical importance in the US, as noted by Alexis de Tocqueville as early as the first half of the nineteenth century ([1835] 2008). Since the power of the politics of rights draws entirely upon the extent to which the myth of rights prevails in the popular imaginary, the United States can be seen as the most fertile ground for its effective exercise. Yet, Michael McCann’s work on the pay equity movement shows that the purchase of the myth of rights is not unconditional even in the United States. On the other hand, so far as the ideal of rule of law has derived strong resonance in Southern nationalist and postcolonial contexts through “diffusion by prestige” (Mattei and Nader 2008) we have enough reason to think that rights claims can be effectively used in similar ways in these contexts as well, albeit with a similar degree of cynicism. For a review of law and society scholarship in non-US contexts, see McCann 2014.

rights claiming. That section is followed by a discussion of these views on the effectiveness of rights claiming, where I think through the criticisms together with the findings of my field research. Finally, I conclude by focussing on the accounts of other campaigners who, in a more constitutive vein, pointed at some ways in which their campaign brought about, perhaps in a roundabout way, outcomes that they found were positive.

Looking Back: Critiquing Rights Claiming After Claiming Rights

Looking back at their campaign, organisers advanced several lines evaluating what they had achieved and fallen short of achieving through rights mobilisation. While official legal change and practical access to abortion and other reproductive healthcare services were not the only criteria of success that they resorted to, as I will discuss in more detail later in this chapter, these two nonetheless proved to be prominent measures in their accounts. Many respondents referred to the former as the one big success of the campaign. Indeed, from a strictly positivist standpoint, it is not possible to determine with certainty how effective women's mobilisation was in halting official legal change, and whether there were other factors thwarting the governments' attempt to ban abortion. Yet, organisers confidently counted the absence of legislation to restrict access to their own credit:

I think we really are not aware of how powerful we really are. It's thanks to our mobilisation that they dropped the idea [of banning abortion]. I really believe that. (Bade, Labour Party)

On the other hand, the problem of access to services had become even more acute over the subsequent years, as MÇ shelter's report established and as many of my informants

were also keenly aware from their own experiences. Even though it is equally difficult to establish the problem of access as a direct failure of the campaign itself as seeing the absence of legal change as its success, organisers still expressed frustration about their inability to bring in any practical remedy to this state of affairs:

There certainly came about a huge difference [after the debate] . . . Before, I had never heard things like that, neither in the feminist circles nor among my friends, that doctors didn't do abortions. Erdoğan's [comments] were a turning point. Then everything changed in practise. They tried to change the law, but they couldn't because of our mass mobilization. But it nonetheless gave a signal to everyone. . . . [MÇ?] study concretely documents this. (Sümbül, Mor Çatı Women's Shelter)

At the time of our interview, Sümbül was trying to keep her hopes high, thinking that MÇ's report could reinvigorate the platform. Not only did she hope that a new mobilisation could address the practical concerns of accessibility, but she was also proud, as one of the women behind the shelter's research, that her group had been able to break away from the exigencies of the day and to bring the issue of abortion to the table. Later, when faced with the low participation to the platform meeting after all the efforts they had put in the research, she was bitterly disappointed; she thus conceded that creating and pursuing one's own agenda had once more proven extremely difficult. Other respondents further expanded on this point:

Our problem, or rather, the government's political strategy is to divide us by attacking us on so many fronts. We are faced with the family package¹¹¹ one day, with the security package¹¹² the next. It is thus difficult to stand together

¹¹¹ "The Programme for Protecting the Family and a Dynamic Population Structure" was introduced to the Parliament in early 2015. Women's organisations heavily criticised the package for reinforcing norms about motherhood, further confining women to care-giver roles, and for discouraging women's full and equal participation to labour force. For instance, see [http://www.keig.org/content/haberler/kepbrostur_son%20\(1\).pdf](http://www.keig.org/content/haberler/kepbrostur_son%20(1).pdf)

¹¹² "The Internal Security Package" is a law that sought to broaden the powers of the police. It was proposed to the Parliament in February 2015 and passed in April. The law has been

and come up with a comprehensive response to all of these attacks on all fronts. Everybody does something about whatever is on her own group's agenda. It is thus difficult to go back and start talking about abortion again, because we are under attack on so many fronts. (Derya, Socialist Democracy Party)

Indeed, the political agenda was more than busy at the time of research: Within the few years that spanned between the controversy and my fieldwork, Turkey had witnessed a series of astounding events—political prisoners' hunger strike in late 2012; the evolution of the “Kurdish opening” into “peace process” in early 2013;¹¹³ the Gezi uprising of June 2013;¹¹⁴ a notorious corruption scandal involving many high-end government officials in December 2013;¹¹⁵ the impacts of the war in neighbouring Syria, most notably

criticised within and outside Turkey by human rights organisations for breaching several human rights conventions.

¹¹³ The “law-intensity warfare” between the Turkish army and Kurdish guerrillas that lasted over two decades gave way to the “democratic opening” in 2009 with the AKP's initiative, which soon turned into the “Kurdish opening.” The Kurdish opening involved the recognition of certain group rights of Turkey's Kurdish population, most notably greater room for the Kurdish language in the public sphere, epitomised in the establishment of the first state-sponsored TV channel in Kurdish. However, these initiatives were, as many critics noted, superficial, and clashes between the Turkish military forces and the Kurdish guerrilla as well as attacks against Kurdish politicians continued. Things took a new twist in early 2013 with the AKP government's declaration that they were ready to engage in peace negotiations with the imprisoned PKK leader Abdullah Öcalan. Öcalan's open letter to the Kurdish people, read during the Newroz celebrations in March 2013, marked the official beginning of the peace process, which entailed an immediate and unilateral cease-fire by the PKK and subsequent peace talks. See Özkahraman 2017.

¹¹⁴ The protests organised in late May 2013 by a small group opposing the demolition of Gezi Park in Istanbul as part of an urban renewal project, upon being faced with outrageous police violence, soon went viral and expanded to almost every city in Turkey during June 2013, bringing millions of people onto the streets in Istanbul alone. The revolt targeted the AKP government's neoliberal policies and morality politics. For scholarly reflections, see the Hot Spot by *Cultural Anthropology* “An Impromptu Uprising: Ethnographic Reflections on the Gezi Park Protests in Turkey.” Retrieved from <https://culanth.org/fieldsights/391-an-impromptu-uprising-ethnographic-reflections-on-the-gezi-park-protests-in-turkey> on February 26, 2017.

¹¹⁵ The tension between the two former allies in government, namely Erdoğan's close entourage and the *Hizmet* movement led by Fethullah Gülen, began in early 2013 when Erdoğan declared his intentions to ban private tutoring centres, a favourite area for recruiting new members for Gülen. The tension climaxed into a corruption scandal as two

the rise of ISIS and an influx of war refugees took place within this period, to name just a few.

While many respondents, like Derya, blamed for the most part the dim and hectic political climate in Turkey for the platform's inability to reenergise the abortion rights campaign, some also turned to self-criticism, particularly addressing the campaign's choice of language and strategies. Could it be that rights talk itself led to the current obstacles campaigners faced as they sought to organise around the issue of increasing inaccessibility?

Some feminist organisers offered an especially bitter critique of their engagement with the law. While still considering themselves successful in organising a large-scale mobilisation, they nonetheless expressed disappointment about how limited were the opportunities for achieving concrete gains that legal language provided them with. Indeed, as discussed in Chapter 4, feminists' engagement with, and their interrogation of the usefulness of law and rights claims both have a long history, and my feminist respondents' comments on the issue echoed these discussions. Meltem, who said she faced the same dilemmas in her work at the women's shelter in that she had to continually resort back to law while seeking ways to combat male violence, elaborated on this point at length, as she perceived this conundrum as an intrinsic weakness of the feminist movement:

prosecutors known for being Gülen followers launched a wave of arrests and investigations against several high-end government officials, the sons of three ministers, one mayor and a construction tycoon on December 17th, 2013. Simultaneously, documentation that many AKP officials—and potentially Erdoğan himself—were involved in bribery, corruption, fraud, and money laundering among other crimes was leaked into the press. Erdoğan stood by the accused, and the investigations did not go far.

We have a handicap with the law being such an essential part of our political field. [With the abortion campaign], it was inevitable, because it's something that is regulated by the law to begin with, and we can't lose this [right]. After all, legal rights preclude arbitrary practises; they define the minimum standards to be met. . . . But on the other hand, we are expecting too much from law in a country where law is, at best, dysfunctional. . . . Because, there are all these laws, we have all these rights, but... Can everybody access those rights? There are so many layers here... . . . This is why we need to say something that goes beyond the law. We need to go beyond the notion that state and laws are the essential elements that we should seek to change, that changing laws would transform the society. (Meltem, Mor Çatı Women's Shelter)

Meltem thus suggested that the value of having the rights on paper notwithstanding, the capacity of formal rights to incite social change was at best questionable. Indeed, even though activists had displayed a keen awareness of the fact that rights on paper were in fact not guarantees, and had sought to bring the issue of access to the forefront of their campaign, these endeavours did not prove helpful in remedying the practical problems. Meltem, and a few other respondents, interpreted this as an intrinsic limitation of rights claiming and other political struggles fought on the legal plane.

For those respondents, this critique extended well beyond the abortion rights campaign and developed into a more generalised line of criticism addressing the particular mode of doing politics that was common among feminists. In this vein, organisers commented that the confinement of the abortion rights campaign within the legal language was not accidental, but symptomatic of a more generalised problem that afflicted the movement at large in their various struggles:

Women's movement and the feminist movement are stuck within the field of law. . . . For instance, I am not sure how much we've been able to bring women's stories to the forefront [through the campaign]. . . . We are thus confined within the government's strategy. This is not doing politics. [The prime minister] does something, something on the legal plane, you say "No, this is a right," in response, and define this right with reference to the law...

This is a trap, and we're in it. This is the general situation with the entire movement. (Sümbül, Mor Çatı Women's Shelter)

As I pointed out earlier, activists were aware of these potential pitfalls of rights language from the initial stages of the campaign on. They had nonetheless thought that it would be possible to imbue abortion rights rhetoric with new meanings pertaining women's agency through a meticulously crafted and substantiated rights campaign. Yet, some campaigners were critical of the rights language as they felt that they had not been able to bring their campaign beyond a mere reaction against government officials' explicit attempts at delegitimising abortion and imposing a particular view of gender and motherhood on society. Rights did provide women with a powerful normative language through which to respond to anti-abortion rhetoric, but insofar as rights are abstract in character, their normative power did not necessarily extend into the question of concrete remedies. Perhaps unescapably, as a result, rights talk did not generate mobilisation absent an open attack toward these rights even when the problem of access became more insurmountable than ever. Campaigners focussing on this point thus advanced a staunch self-criticism for having fallen into the government's trap by crafting their campaign around their opposition to the prime minister's position, which subsequently made addressing the question of access in a sustained manner more difficult for them:

[The issue of abortion] got forgotten. Because it was merely a reaction toward the government. That is, [the prime minister] says something, and we talk back at him. Then he stops, makes people forget about it for three months, six months, and then attacks again. Only then the issue comes back on the agenda. This was true for the Platform's political practise as well. We came together only to respond [to the government's attack]. (Bade, Labour Party)

To sum up, some respondents felt that rights language had failed them in at least three regards. In the first place, the indeterminate nature of rights rendered them prone to be

easily discarded in real-life practise: The recognition of abstract rights did not raise concrete remedies. Rights mobilisation hence did little to ensure access. Secondly, despite their efforts to imbue rights language with more liberatory content, rights mobilisation did not go beyond a mere reaction, albeit powerful, against the explicit attacks by the government against reproductive practises. Hence, activists felt that rights language confined the movement within the government's playing field. Thirdly, and by extension, as rights mobilisation remained reactive, mobilising became all the more difficult once the government officials stopped their open attacks, even at the face of practical barriers to abortion. What thus resurfaces in these respondents' accounts is one of the key debates in feminist sociolegal studies, namely a persistent pursuit of legal rights despite the awareness that rights do not always deliver on their promises, which led Nandita Gandhi and Nandita Shah (1992: 267) to woefully ask “[w]hy is it that every campaign in the [feminist] movement has demanded legal reforms despite its severe criticism of the legal system, the hopelessness of achieving legal redress, and the endless squabbles with law makers and implementers?”

This question, which has been explored by many academic and non-academic feminists over the past decades, still looms large as many women's groups, just like the Abortion Is A Right Platform, are turning to rights claiming to pursue their political goals. In the context of the abortion rights campaign in Turkey, let us remember that campaigners had sought to generate alternatives at the initial stages of the platform, none of which seemed more favourable than rights language—which pushed them to stick with the rights rhetoric as the main theme of the campaign. Is it true, then, as Nivedita Menon bemoans (2004: 207) in her call for an alternative politics that will keep its

distance from law and rights language, that “[s]o powerful is the hold on our imaginations of the perception of the law as an instrument of transformation that every critique seems to land back on its terrain”?

Recovering Rights

I want to begin by questioning whether it is fair to present this conundrum as a mere issue of lack of (alternative) imagination on the part of activists. Indeed, we can talk about law’s hegemony—which by definition limits imagination to that which is recognisable and acceptable under a given ruling ideology, or as Comaroff and Comaroff (1991: 23) suggest, is “quite literally . . . habit forming.” Still, it should be borne in mind that hegemony originates not merely in “false” consciousness but in an acute and grounded understanding of one’s own political reality. In other words, even if law can be said to be hegemonic and imposing on our imaginations, to present this as a failure of progressive social movements would be erroneous: People are not only constrained by the extant “order of signs and practises, relations and distinctions, images and epistemologies,” (*ibid*) but as its subjects, they also know this order inside out. They are hence capable of recognising in legal talk in general and rights talk in particular a uniquely effective way of advancing “articulation[s] of claims that people use to persuade others about how they should be treated and what they should be granted” (Minow 1987: 1866-1867). As a matter of fact, what is distinctive about rights language is that it offers a vocabulary that is not only intelligible to persons, but also intelligible to institutions—most importantly, to the state.

On the flip side of the coin, the most formal way in which the state can recognise a

certain claim as valid is by affirming it as a right. Consequently, to borrow from Mindie Lazarus-Black and Susan Hirsch, (1994: 10) “[r]esisting state domination (or domination of other sorts) often entails seeking inclusion in legal institutions.” The difficulty of generating alternatives to rights claiming, therefore, is not—just—the consequence of a colonising force of law over our imagination, but—also—of the knowledge that rights claiming has a distinctive power for communicating certain grievances (to the state), and that the recognition conferred (by the state) through the affirmation of a right has an unmatched symbolic power.

Yet, as campaigners were well aware, keeping “good” laws in the books would not in any way be adequate to ensure access. To the contrary, campaigners sought to engage the state despite the full knowledge that state recognition did not amount to guaranteed access; because of the symbolic, and not practical, power that state affirmation brought about. What I am suggesting here is not that we should turn a blind eye toward the failure of rights to deliver on their promise in real life. Rather, I am drawing attention to the alignment between the campaign’s objectives and organisers’ choice of a rights framework to achieve them. Indeed, the abortion rights campaign had more than one goal: As delineated in Chapter 4, aside from ensuring access to abortion, obtaining active state recognition for women’s agency in deciding whether or not to be mothers held an even more central place in the organisers discussions during the early stages of the campaign. It would have been possible for organisers to pursue the former goal through perhaps difficult and trying, but previously tested, strategies like mobilising underground networks and organisations, such as the Women on Web. In fact, organisers had been contacted by activists from the Women on Web in Summer 2012, who offered to send

their famous “abortion vessel” to a trip to Turkish coasts. Abortion Is A Rights activists declined the offer, precisely because they wanted to give more weight to pressuring the government to recognise abortion as a right and to secure access to all women.

Ultimately, as legal sanctioning was *the* way through which state affirms its recognition on any given subject, claiming abortion as a right emerged as *the* way to pursue this latter goal.

Again, this should not come as a call to obliviousness toward how little help keeping the rights to abortion and contraception on the books brought women in Turkey in terms of practical access. Yet, the findings of the previous chapters suggest that neither the notion of women’s rights itself proved detrimental to the campaign’s goals, nor were activists “duped” to believe that formal rights would guarantee smooth access to reproductive health services. After all, organisers saw law and rights as one avenue for advancing their struggle, rather than being ends in themselves. As Sally Engle Merry (2014: 289) notes, “[d]espite activists’ awareness of the limitations of the rights framework, under current conditions of neoliberalism and privatized government in much of the developed world, they have few alternatives. Rights themselves are circumscribed.”

I sought to show, in previous chapters, the specific ways through which reproductive rights were circumscribed in the Turkish context, as a consequence of neoliberalisation of healthcare and the broader trend of rising neoconservatism. My findings suggest that in the first place, marketization of healthcare and a series of shortcomings it created at the level of service delivery accounted to a large extent for the increasing inaccessibility of abortion and contraception as family planning clinics either disappeared from

neighbourhoods and state hospitals or underwent serious personnel constraints. Yet, I also argued that there was more to this story, insofar as these practises were not readily available even in clinics where physical and personnel requirements were met. I argued that it was due to the curtailing of institutional support mechanisms backing healthcare employees in the process, which fostered feelings of vulnerability to civil litigation among providers, and the transformation of the patient-provider relationship from one based on serving to one based on helping—that is, loss of rights-bearing status on women’s part—undermined smooth service delivery.

If, as my argument goes, health workers’ failure to recognise their women patients as the subjects of the rights that they cherished in the abstract was a crucial component of why women were denied access to abortion and contraception is so crucial—indeed, if it was not for the ease with which providers could deny rights-bearing status to individual patients that they encountered in their clinics, refusing to offer them certain services would have been harder even under the threat of civil litigation—there is all the more reason for insisting on, reclaiming, and advocating for women’s rights. But my findings also suggests that this effort needs not to be geared solely towards pressing for the recognition of these rights in the abstract, but also for recognition of living and breathing women as the subjects of these rights. In other words, rather than dismantling the importance of rights as mere formalities, the findings of my research support the idea that rights are indeed, indispensable—not only in terms of their presence in the books, but also in terms of the status they may confer on people. At the end of the day, if the discourse of compassion displaces the political stakes from the patient-provider encounter, the rights discourse can serve as one means through which to reinsert politics

into these encounters—hence to defy “anti-politics,” which by definition serves to reproduce extant inequalities.

Ultimately, rights are always contextual, and that the effects they produce are indeterminate. Hence, while I share the frustration about the obstacles to access to abortion and contraception that my respondents expressed, in the light of the analysis that I presented in previous chapters, I do not agree that the campaign fell short of remedying these problems *because* the campaign focussed on rights claiming. To the contrary, my interviews with health workers suggest that rights are indeed a powerful trope, and their power goes well beyond mere reactive politics. But efforts to claim rights, as well as to study rights, need to be more context-sensitive—and in particular, take the question of subjectivity more seriously.

Rehearsing (Gender) Revolution

While the previous section addressed the more positivist side of the question of effectiveness—namely, the ways in which rights claiming may or may not be an important asset at the level of reproductive service delivery, both by pressuring the government to keep access to abortion and contraception legal and through their symbolic power from the perspective of the “gatekeepers” of reproductive health—I want to end this chapter by turning to my respondents’ remarks about more constitutive powers or rights claiming. Indeed, while every respondent addressed the shortcomings at the practical level with vehemence, some activists put more emphasis on mobilisation and struggle in their narratives. In this vein, they asserted that even if the campaign had fallen short of generating change in healthcare institutions in a way to facilitate and

increase access to reproductive health services, it nonetheless had positive impact in other regards, particularly in terms of the scale of the mobilisation that they built and its legacy for the women's movement and oppositional politics to the AKP government. In these respects, organisers felt that the campaign was a success story.

To reiterate, while campaigners counted the absence of legal change to the status of abortion and contraception as legal rights to their own credit, they were quick to note that this limited victory itself could be easily threatened. Mindful that rights language in and of itself could not deliver more than this partial success, they kept underlining that rights could at best be “ancillary weapons” to accompany mobilisation:

Will there be further changes made to laws [further restricting abortion]?
There might be. That part just depends on women's struggle and legitimacy that they will be capable of garnering. (Türkan, Istanbul Feminist Collective)

My respondents insisted that the mass base they succeeded to build for the campaign owed to the rights language to a great extent. Their organising experience, at least in this particular regard, lived up to their initial discussions that I detailed in Chapter 4: Rights indeed proved to be a trope that was acceptable to many women, thus providing the organisers with a common ground on which to build alliances.

In this vein, activists advanced a powerful counter argument against feminist critiques of rights talk, who suggest that “we should resort to the law only when the movement is strong enough to carry the law reform forward” (Haksar 2005: 149). While Türkan's words above suggest, my respondents wholeheartedly agreed with the idea that law and rights could be only part of a broader political movement, but could not be a substitute for this latter. Yet, the critical perspective that Haksar offers (shared by many feminists across the world) suggests little in terms of how to build that strong movement in the

first place. Abortion activists in Turkey felt that rights language could be mobilised precisely to this end. In that regard, for many of my respondents, the unifying and mobilising potential of the rights language even surpassed in importance its unique capacity to engage the state in its own terms to elicit its affirmation:

After all these years, I still find it amazing—it was a time when women were not organised at all, but so many people came out to the streets [to protest]. . . . It wasn't something confined to the area of law, there was a social aspect to it. But on the flip side of the coin, we didn't turn the campaign into something too radical precisely because we didn't want it to be too marginal. This was how the platform was formed in the first place, and consequently it has become the largest women's platform ever. (Zarife, Istanbul Feminist Collective)

John Berger (1968: 11), writing in the heyday of anti-systemic movements of 1968, suggested that “[i]t would seem that the true function of demonstrations is not to convince the existing State authority to any significant degree. Such an aim is only a convenient rationalisation. The truth is that mass demonstrations are rehearsals for revolution: not strategic or even tactical ones, but rehearsals of revolutionary awareness.” Indeed, should states have democratic leanings to which the numbers involved in demonstrations could speak, performances of protests would be hardly necessary in the first place. Their necessity, in contrast, lies in the very act of bringing people together, in a setting artificially separated from the everyday life, to allow demonstrators to recognise their shared fate and purpose in each other. Zarife, bringing her comments further, echoed Berger's argument and suggested that their campaign was a “rehearsal” for the Gezi Park events that erupted the following year. She reminisced:

It was the pre-Gezi period, and we organised the most massive actions up to Gezi. Nothing like that had happened before, to that scale, actions going on in multiple cities for months. . . . It is true that Gezi is something entirely different, it was a rupture in and of itself, but we prepared the ground for it to happen. (Zarife, Istanbul Feminist Collective)

Others made similar points to Zarife's about the relationship between the abortion rights campaign and the Gezi uprising. Some suggested that not only mobilisation itself, but also the rights talk that the campaign deployed was a precursor to the Gezi uprising:

I think the discourse of "This is my right, and you can't meddle with my rights," served well our purposes. It carried on to Gezi later, and it became even more crystallised then. It was this feeling that brought people out there. (İpek, Socialist Feminist Collective)

While Gezi itself eventually turned out to be another momentary "rehearsal" for the future revolution, organisers also pointed at a more sustained legacy of the abortion rights campaign. At the time of my field research, many of the constituents of the Abortion Is A Right Platform, with further newcomers, were still working in alliance in two large coalitions, one pursuing a long-term, sustained campaign against violence toward women Turkey, and the other a rather brief but energetic solidarity effort with the Kurdish town of Kobanê in Northern Syria that came under Islamic State siege in September 2014.¹¹⁶ Prior to the abortion rights campaign, although women from these different groups regularly come together for March 8 (International Women's Day) and November 25 (International Day of Struggle against Violence toward Women) demonstrations, the differences in political priorities and strategies among them had always made a sustained, issue-based alliance unlikely. The Abortion Is A Right Platform, felt my respondents, had been a place where they began to trust one another more,

¹¹⁶ Kurds' democratic experiment in Northern Syria places heavy emphasis on women's liberation, leading feminists and women's groups in Turkey to consider the Kurdish cause as an inherently women's issue. In other words, support for Kobanê did not stem solely from opposition to ISIS' violent Islamic conservatism or from a commitment to democracy, but also from a commitment to women's liberation.

learned to work out their differences, and ultimately, to collaborate more effectively.¹¹⁷ In a way, by bringing women from differing political leanings together, rights language offered a stepping stone toward a new political culture, based more on collaboration than antagonism among women's groups.

Conclusion

It is difficult to not get carried away by the romanticising tone in my respondents' comments about what they see as the legacy of Abortion Is A Rights Platform, not the least because these events already took their place in the collective memory of the left in Turkey as landmark moments. I nonetheless try to move beyond this inclination in order to conclude the chapter with my theoretical, and not emotional, points.

In the first place, I want to make clear that this chapter drew “soft,” rather than “hard,” conclusions. While it is attractive for activists and scholars alike to seek for generalised answers to big questions, like saying that “rights work,” or “rights do not work,” I think that a more productive approach is to attend more closely to the conditions under which they do or do not work, and in which specific ways. In this vein, departing from my respondents who saw in the on-going obstacles to access to abortion and contraception as a shortcoming of rights language, I argued that such a sweeping dismissal missed the intricacies that I observed in healthcare institutions. What my findings suggest is, if anything, thinking more thoroughly about rights, and not only in

¹¹⁷ The mobilisation for Kobanê lasted only a few months, but during that period hundreds of women travelled down to the border town of Suruç as part of this campaign to work as volunteers in the effort to host over 50 thousand war refugees. The Group for Emergency Precaution against Women Killings is still operating, both organising street actions and social media activism, and intervening in criminal cases of women who killed their violent partners in self-defence.

terms of their content on paper but also on the ways in which they are recognised and acted upon in real-life settings can benefit both social movements and scholarship on rights greatly. This, of course, requires one to accept the contextual nature of rights, and be more sensitive toward this context specificity.

That was the more positivist side of the question, which focussed more closely on the ways that the remedies that rights on paper were or were not accessible in real life. The second, and equally compelling point pertains to the constitutive power of rights, which in this particular case presented itself in the form of offering grounds for broad alliances among progressive movements. Indeed, organisers acknowledged that rights had proven invaluable in bringing large groups into the streets—which, perhaps had not contributed much from a positivist standpoint to campaign goals, but had strengthened the women’s movement tremendously. Perhaps this is not so surprising. To quote from Berger once more, “[d]emonstrations express political ambitions before the political means necessary to realise them have been created. . . . Demonstrations predict the realisation of their own ambitions and thus may contribute to that realisation, but they cannot themselves achieve them.” Rights turned out to be, in the case of Abortion Is A Right Platform, an indispensable means for expressing women’s ambitions to counter the neoconservative logic and reclaim their political agency. To reiterate Türkan’s words, achieving these ambitions “depends on women’s struggle and legitimacy that they will be capable of garnering;” building off of the legacy of the Summer 2012.

CHAPTER 9

CONCLUSION

In late August of 2012, Nevin's appalling story made the headlines of major newspapers, in Turkey and abroad. In a village near Isparta, south western Turkey, a young, married mother of two children, shot a relative with a shotgun, severed his head, which she then brought in a bag to the village square and tossed on the ground under the gaze of village men socialising in the coffee house. Nevin was immediately arrested and sent to prison. Once her trial began, the details of her story started to come out: In the absence of her husband who had left the village for work, Nurettin, the man whom Nevin killed, raped her under threat for months. Eventually, Nevin got pregnant and was incapable of procuring an abortion; she became a gossip topic in her village, deepening her solitude and sharpening her helplessness. After she was arrested, already five months into pregnancy, Nevin requested an abortion while in prison. It was denied. In a country where women killings, normalised as they are,¹¹⁸ no longer generate shock or uproar, Nevin's story indeed created enormous scandal. The progress of her pregnancy also became a major news item. Her decision to refuse to take care of the baby after she gave birth to it in November was condemned by commentators. The baby, after being named by the prime minister's wife, was finally given to foster care. Nevin's trial lasted almost

¹¹⁸ As mentioned in Chapter 3, violence toward women is considered to have reached the proportion of a "femicide" in Turkey, although real numbers are either not recorded or not released by the Ministry of Justice. But *bianet*, an independent news network, keeps the record of those women killings that were brought to national media's attention since 2009, which can be accessed at <https://bianet.org/kadin/bianet/133354-bianet-siddet-taciz-tecavuz-cetelesi-tutuyor>.

three years. In March 2015, she received aggravated life sentence, with no abatement applied.

Certainly, Nevin's ordeal was not so much the product of her pregnancy (or her inability to end it), but rather, of systemic male violence to which she was subjected—from the sexual violence perpetrated by Nurettin to the impassivity, and later, the hostility of the criminal justice system.¹¹⁹ But unwanted pregnancy and failure to obtain an abortion were the aspects of her story that caught the most attention. Indeed, if part of what made Nevin's case so notorious was the scandal that it involved (newspapers christened it as the “severed head murder”), the other part was its timing: Then prime minister Erdoğan's outburst against abortion and caesarean sections, which initiated a heated controversy about abortion and some other reproductive health practises, had come a mere three months prior to the event. Abortion was still the hot topic of the day when Nevin's story came under the spotlight.

It certainly is difficult not to think about the timing when thinking of her. Did the abortion/caesarean debate start right when Nevin found out that she was pregnant? Was she already looking for a place to procure an abortion when she heard that stern voice on TV, saying, “Abortion is murder”? Had she been able to end her pregnancy, would things have been any different, and would she find another way to get herself out of the violent circle in which she was trapped? How many more women felt the same desperation that she did upon Erdoğan's outburst?

¹¹⁹ For an analysis of the patriarchal character of criminal justice systems, and how they take part in and reproduce male violence against women, see, for instance, Kennedy 1992.

Many people I interviewed for this dissertation, activists and health workers alike, remembered witnessing the feelings panic and helplessness that women around them felt around the same time that Nevin was looking for a way out:

It was so terrible... I remember, for instance, a friend of mine working here [at the hospital] got her girlfriend pregnant. It was just a week or two after these debates started. And they thought abortion was banned. I really don't know how women [in similar circumstances] dealt with it during those days. (Seher, nurse at Westpointe public hospital)

I know one thing very well from my work experience at the MÇ shelter: We started receiving calls from women asking "Is abortion illegal?" after the debate. . . . Even though it was a right defined by law, which can be accessed in state hospitals, it felt as though abortion was illegal and we were showing them how to engage in this illegal action... (Meltem, Mor Çatı Women's Shelter)

And it was not just women who found themselves in similar predicaments who partook in this "as if it was illegal" sentiment. During Summer 2012, when my friends and I were organising the abortion rights campaign, we regularly heard that healthcare employees themselves were in doubt about the legal status of abortion, which led them to refuse offering certain services to many patients—most notably, abortions. Certainly, health workers' reluctance regarding abortion, and at times contraceptive methods, must have added to the ambiance of illegality that was already percolating.

It was this latter thread that I followed in this dissertation. Indeed, from the outset, what provoked my interest in this topic has been the knowledge that reproductive health practises and access to them have profound impact on women's lives. But instead of pursuing a phenomenology of women's experiences through the lens of access to reproductive practises, I analysed the structural factors that shaped those experiences—above all, law. To the extent that reproductive health practises are as a rule strictly

regulated by law, it seemed worth exploring the specific ways that law came to function as a regulatory force in—mostly—unintended ways.

One of the most striking things during the abortion/caesarean controversy of Summer 2012 was the extent to which all parties that partook in it adopted legal language, most notably rights talk, to advance their claims. But this extensive use of legal idioms and constant threats to resort to official legal channels was offset by complete formal legal inaction on the part of both the government and women's rights groups. I then started to ask, how did the turn towards law and legal language by those who opposed and advocated for reproductive rights lead such drastic changes in the area of reproductive health in the absence of any formal legal action such as legislative change or a lawsuit? In other words, how did law materialise in daily practises of healthcare workers despite legal inaction?

One of the most important theoretical findings of my research, presented in Chapter 6, is that abortion became more inaccessible after the controversy not despite, but rather, because of, legal inaction.¹²⁰ The controversy, more than anything else, rendered the legal status of abortion (and to a certain extent, contraception) ambiguous. Legal ambiguity, in return, rendered blurry the limits that providers were required to observe while offering certain practises, compelling them to rethink and redraw these boundaries in

¹²⁰ Certainly, this is not the only reason why abortion and contraception have become inaccessible to the extent that they have. As I detailed in Chapter 5, the broader transformations in the healthcare structure that were implemented over the past decade account for a significant part of their inaccessibility: Abortion was already very difficult to access in public institutions by the time the controversy started. Though its effect in terms of curtailing access was therefore limited to those few places where abortion was offered before the controversy began, I found it nonetheless important to attend to the specific ways in which it affected those institutions from a theoretical standpoint.

idiosyncratic ways. In contrast, even though caesarean sections were also one of the debated topics, the ambiguity surrounding them quickly gave way to certainty when a “caesarean law” was summarily passed in July 2012. The formal legal change, rather than bringing in new directives that would substantively alter the practise, ratified the commonly accepted professional standards for performing C-sections—signalling to health workers that they could continue their practise as usual. When it came to abortion and contraception, however, such clarity was never established, as no legal change pertaining to them was ever made over the following years. In their effort to manage ambiguity, some providers completely discontinued offering abortions and IUDs, whereas others staunchly observed the extant legal limits but also imposed additional, self-styled limitations to their own practise. For instance, while the legal time limit for abortion is the tenth week of pregnancy, providers in the public sector, with few exceptions, refused to perform abortions after the 8th week.

One major conclusion that I draw on the basis of this finding is that the very notion of rights produce certain unforeseeable effects over providers’ decisions. Remarkably, the tension that was created by legal ambiguity came to be expressed through the language of “litigation crisis” by my respondents. The discourse about high rates of litigation against health practitioners, working in the area of reproductive health specifically, was the dominant theme in my interviews. A purported conflict between women’s rights (to access reproductive health services) and patients’ rights (to bring complaints against health workers) was a key element in providers’ reluctance to provide abortion and IUDs after the controversy. Health workers made repeated references to the fear of being sued, and not to the fear of government retaliation, when explaining the

restrictiveness of their approach or why certain limits were seen as stricter than others. Many of my respondents were openly hostile toward the concept of patients' rights, complaining about how patient's rights and the "risks" that they entail, "took the joy out of their profession." Most others, who were not condemning the concept in its entirety, were critical of what they perceived to be "abuses" of (patients') rights.

This came as a surprise, because in contrast to the United States, where tort cases are symbolically charged and "tort tales" remarkably popular (Haltom and McCann 2004), in Turkey civil law is not a particularly powerful cultural idiom. There was thus no necessary link between legal ambiguity and the discourse of litigation crisis. Moreover, the private sector seemed to be immune to the fear of civil litigation, which plagued public institutions. I thus deepened my analysis by making the connections between health workers' "risk management" and the neoliberal transformation in healthcare that hit the public sector the hardest. But perhaps more importantly, I also sought to show the links between their perception of their patients as potential "abusers" of rights and the neoconservative political climate in Turkey which recognise women exclusively as mothers and consequently undermine women's status as rights bearing citizens—especially those women who seek to control and limit their fertility. This analysis reveals how rights are "circumscribed" in contemporary world (Merry 2016); furthermore, by highlighting the contextual character of rights, it underscores the notion that context-sensitivity is crucial to understanding in which specific ways rights are circumscribed. Such understanding is necessary to bring to light what potentialities rights still bear in spite of their limitations.

For sure, in addition to my theoretical interest in understanding how law gained its regulatory powers through unexpected ways (in this case, through legal ambiguity), my research was guided by my own political investment in the issue. As the abortion rights mobilisation of Summer 2012—which was, from the perspective of those of us who took part in it, formidable and electrifying as long as it lasted—started to lose momentum within months, I became increasingly suspicious of what potentials rights could bring. Was rights mobilisation nothing but a flash in the pan, bound to die away without realizing its goals? And why was it still such a popular strategy for social movements across the world, despite a wide recognition that rights were, at best, limited in their capacity to deliver on their promises?

Parts of my dissertation thus centred on organisers of Abortion Is A Right campaign. Chapter 4, focussing on the initial stages of mobilisation, asked whether the choice of the campaign framework was a product of the “myth of rights.” Analysing the considerations that shaped the final decision of the organisers about campaign language and strategies, I argued that a deliberate and thoughtful process led them to adopt the rights framework, as organisers thought it had strong advantages over other possible frames. Moreover, keenly aware of the possible limitations of rights mobilisation, organisers sought to substantiate rights claiming in innovative and liberatory ways. Chapter 8, bringing the focus back to the organisers, inquired into the “effectiveness” of rights claiming through the perspective of those who partook in it. As access had become even more problematic during the years that followed the controversy (and the campaign), did organisers believe that their efforts had proved futile? Indeed, while some of my respondents, witnessing the conditions at healthcare institutions becoming

incrementally worse, had grown critical of their past strategies over the years. Yet, looking at the concrete remedies (or the lack thereof) was not the only criterion that organisers used while assessing the success of their campaign. Activists made a passionate case for their campaign and the place the notion of rights held within it: Rights language, they argued, facilitated building an unprecedentedly large coalition among women organisers coming from different political groups and backgrounds; it also helped them to reach out to large numbers of women from all sectors of society. Consequently, not only did the abortion rights campaign turn into the largest women's mobilisation in Turkey's history, but its effects also proved long lasting. The coalition among different groups continued organising together for various goals, and the movement at large had more legitimacy in the eyes of many women who were not politicised prior to the campaign. The slogans, banners, and graffiti referencing the abortion controversy in particular and the AKP's gender politics in general that were pervasive inside and outside of the park during the Gezi revolt brace activists' claim that the rights rhetoric that they deployed during the campaign resonated with the formerly non-politicised crowds of Gezi.

Anybody familiar with the current state of affairs in Turkey at the time of writing of this dissertation would be surprised by the hope with which my dissertation imbues rights mobilisation. Indeed, after the Gezi revolt and the corruption scandal of 2013, which turned into a feud between Gülenists and AKP cadres, Erdoğan and his entourage only tightened their oppressive grip over society. On the one hand, street protests have become all but impossible countrywide due to both extreme police violence and unwarranted detentions and arrests of protestors. On the other hand, the government's

abrupt termination of the peace process with the PKK culminated in months-long curfews over numerous Kurdish towns and cities, devastating some villages and neighbourhoods to the point of razing them. Academics have been fired and detained for speaking up against human rights abuses in the Kurdish cities. Erdoğan and his counterparts used the failed coup attempt of July 2016 as a pretext for establishing a state of exception that is still in place at the time of writing, not only banning most forms of public protests but also sending thousands behind the bars—most notably, Kurdish politicians including over a dozen MPs and mayors, journalists, and human rights advocates. The political regime in Turkey has thus added the adjective “authoritarian” among its already not-too-flattering epithets. How realistic it is to emphasise the promises and potentials of rights claiming, at this particular historical moment, then?

The literature on law in authoritarian regimes suggests the same degree of indeterminacy that my dissertation did. Studies in this field suggest that the tension between the ideals of rule of law and the use of law by authoritarian governments as a tool of governance can indeed enhance state power (Rajah 2012; Ginsburg and Moustafa 2008). Yet, these studies also maintain that law cannot be conceptually reduced into a mere instrument of state power insofar as it still bears the capacity to become a site of political contention. Considering that this has been the case in Turkey through the abortion/caesarean controversy of 2012, I can only speculate that law and rights can continue fulfilling the same function in the future. It is, of course, true that rights proved of little concrete help as things have become increasingly bleak in Turkey over the last few years, in healthcare institutions, courtrooms, and beyond. Moreover, they seem to have produced similarly ambiguous and unexpected consequences, not always to the

advantage of those who need their help the most. Still, under such oppressive conditions, I think anything, no matter how small it is, that provide people from different backgrounds with a common ground for coming together to fight back could be of value and has the potential to serve as a site of resistance. *Abortion Is A Right Platform* attests, if anything, that rights carry this potential at the very least. At the end of the day, rights still do hold one great promise—in terms of establishing and maintaining solidarity, if not in terms of effectually liberating ourselves from oppressive structures. And what, if not solidarity, could help us in this latter regard?

I therefore want to end in a positive note, as I sit looking at the poor quality picture, sent to me over e-mail, of Nevin's last letter from prison to Istanbul feminists. She writes that, despite all the things that have gone wrong in her life—from harsh prison conditions to her concerns about the appeal process—she is comforted by the knowledge that we think of her all the time. Certainly, we do.

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baskentkadin.org

benimkararim.org

keig.org

kurtajhaktir.org

morcati.org.tr

sosyalistfeministkolektif.org

Online news resources

aksam.com.tr

bbc.com/turkce

bianet.org

cnnturk.com

direnisteyiz5.org

gazetearsivi.milliyet.com.tr

gazetevatan.com

haber7.com

haberturk.com

hurriyet.com

istanbul.indymedia.org

milliyet.com.tr

ntv.com.tr

radikal.com.tr

star.com.tr

t24.com.tr

Professional resources

ailehekimleri.net

hips.hacettepe.edu.tr

ito.org.tr

psikiyatri.org.tr

tjod.org

tjodistanbul.org

ttb.org

turkiyeaileplatformu.com

Official sources

saglik.gov.tr

resmigazete.gov.tr

tbmm.gov.tr

Miscellaneous

asistanhekim.org

culanth.org

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APPENDIX I – INTERVIEW GUIDES

I. Interview guide for practitioners

a. Descriptive questions

* *Everyday activities*

{Can you begin by talking about your professional background? Eg., your formation, your expertise... What is your role in this hospital/clinic? For how long have you been fulfilling this role? Are there any other tasks that you carry out in addition to that role? *Probes:* Can you describe a typical day of yours working in the hospital? What did you do yesterday/so far today? When was the last time you did x?..}

* *Medical practises*

{Which procedures do you carry out yourself or know that are carried out by other practitioners in the institution you work in? *Probe:* When was the last time you did x?.. I want to know about the limits you observe about the practises you offer... *Probe:* *Ask about each practise that they report offering.* How do you determine these limits? How would you compare these to the limits that were implemented, say, ten years ago?}

* *The effects of the abortion debate on the routine*

{How would you compare these to the limits that were implemented, say, ten years ago? (*In case they point at substantive differences*) How do these changes relate to the controversy of Summer 2012? *Probes:* Which practises did you stop performing? Which new ones you started to perform more often? What compelled you to change your practises in this way (i.e., a particular ordinance from the Ministry, feeling of insecurity, administrative policy change...)? How have the demands by your patients changed?}

b. Knowledge questions

* *Knowledge about regulatory legal texts*

{What are the most up to date laws and ordinances regulating your practise? *Probe:* How did you learn about this particular law/ordinance/regulation/policy?}

* *Knowledge about legal interpretations*

{In light of these regulations, what are the furthest limits for the legality of your practise? *Probe* about the specifics about particular practises, for instance: “What is the time limit for abortion on request? For therapeutic abortion? In case of rape or incest?}

* *Knowledge about penal law*

{What would be the repercussions (legal or otherwise) of trespassing these limits, if a hypothetical practitioner had trespassed? *Probe* by providing hypothetical scenarios if necessary, for instance: “What would be the consequences of performing abortions after the 10th week of pregnancy?”}

* *Anecdotal knowledge*

{Do you personally know anybody who has trespassed the legal limits? Do you know anybody who has had to bear negative repercussions for doing so? Have you ever heard of someone having done so? Who had to bear repercussions for having done so? *Probe* about the details of any events that the respondent claims to have heard. Have you ever been, or do you know anyone who has ever been, sued in a civil case by a patient? What did the case pertain to?}

c. Perception questions

* *Perceptions about the institution’s mission*

{What do you think the hospital should prioritise (patients’ wishes, the law, general political climate, profitability...?)}

* *Perceptions about own role and duty*

{What do you think your role within the institution is?}

* *Perceptions about new regulations*

{What do you think about the new regulations and surveillance measures?}

* *Perceptions about legal/political intervention into own professional practises*

{What do you think about the legal debate about abortion and other fertility-related practises? To what extent do you think medical practises should be regulated by law?}

d. Comparison questions

* *Comparing actual law to what is considered as ideal*

{To your mind, how would “ideal” laws on fertility-related practises look like?}

* *Comparing pre-2004 period to post-2004 period*

{How has the implementation of the Transformation of Health affected your practise?}

* *Comparing the period before the abortion debate to thereafter*

{How has doctors’ practise change since the onset of the abortion debate? Has it become more difficult/stressful?}

II. Interview guide for medical professional advocates

a. Descriptive questions

** Role within the association/ advocacy group*

{What kind of work are you doing for the association? *Probes:* How many days/hours a week do you work for the association? What happens in a typical day you work for the association? What are the routine tasks? What are the highlight activities?}

** Association's/ advocacy group's role within the abortion debate*

{How does the association define its organizational mission vis-à-vis the issue of abortion/fertility-related health practises? *Probes:* Did the association take a public stance regarding the issue after the onset of the debate? If yes, how is this stance propagated to the larger public? Who constitutes the association's targeted audience? What kind of activities/publicities are used to reach these audiences?}

**Use of legal language/ strategies for own advocacy*

{How do you articulate the association's stance regarding abortion/fertility-related practises toward the public? *Probe* about the use of legal idioms: Has your association ever resorted to formal legal channels? Of which kind?}

b. Knowledge questions

** Knowledge about regulatory legal texts*

{What are the most up to date laws and ordinances regulating to fertility-related practises, most importantly abortion? *Probe:* How did you learn about this particular law/ordinance/regulation/policy?}

** Knowledge about legal interpretations*

{In light of these regulations, what are the furthest limits for the legality of these practises? *Probe:* about the specifics about particular practises, for instance: "What is the time limit for abortion on request? For therapeutic abortion? In case of rape or incest?}

** Knowledge about penal law*

{What would be the repercussions (legal or otherwise) of trespassing these limits, if a hypothetical practitioner had trespassed? *Probe* by providing hypothetical scenarios if necessary, for instance: "What would be the consequences of performing abortions after the 10th week of pregnancy?"}

** Anecdotal knowledge*

{Do you personally know anybody who has trespassed the legal limits? Do you know anybody who has had to bear negative repercussions for doing so? Have you ever

heard of someone having done so? Who had to bear repercussions for having done so? *Probe* about the details of any events that the respondent claims to have heard}

c. Perception questions

* *Perceptions about medical institutions' mission*

{What do you think a hospital should prioritise (patients' wishes, the law, general political climate, profitability...?)}

* *Perceptions about professionals' role and duty*

{What do you think a doctor/practitioner working in a hospital should prioritise?}

* *Perceptions about new regulations*

{What do you think about the new regulations and surveillance measures?}

* *Perceptions about legal/political intervention into professional practises*

{What do you think about the legal debate about abortion and other fertility-related practises? To what extent do you think medical practises should be regulated by law?}

* *(If any) perceptions about own use of legal language/strategies*

{How do you think using legal language/strategies helpful for achieving the professional goals that you described? How successful do you think your association's use has been when it used legal language/strategies?}

d. Comparison questions

* *Comparing use of legal language/strategies for bringing about change to other possible strategies*

{Do you think these strategies/language have/has been more successful than any other possible strategy? In which ways have they been successful, in which ways not so successful/unsuccessful? What would have been an alternative to legal language/strategies? What would its upsides and downsides be?}

* *Comparing actual law to what is considered as ideal*

{To your mind, how would "ideal" laws on fertility-related practises look like?}

* *Comparing pre-2004 period to post-2004 period*

{How has the implementation of the Transformation of Health affected doctors' practise?}

* *Comparing the period before the abortion debate to thereafter*

{How has doctors' practise change since the onset of the abortion debate? Has it become more difficult/stressful?}

III. Interview guide for feminist/women's groups activists

a. Descriptive questions

** Role within organisation/group*

{What kind of work is your organisation doing in general? What is your role within the organisation/group? *Probes:* How much time do you spend for the association? What are the most typical things that you do while working for the organisation/group? Highlight activities?}

** Association's/advocacy group's role within the abortion debate*

{How does your organisation/group define its stance vis-à-vis the issue of abortion/fertility-related health practises? *Probes:* How is this stance propagated to the larger public? Who constitutes the organisation's/group's targeted audience? What kind of activities/publicities are used to reach these audiences?}

** Organisation's/advocacy group's role within the abortion campaign*

{How did the campaign start? How has your organisation/group took part in the campaign? Can you describe the initial stages of the campaign? How did you decide to organise under a platform? How did you decide the name and the frameworks that the platform used? What function did/does the campaign fulfil? What is your organisation's/group's role within the campaign? How much commitment does your organisation/group has for the campaign?}

** Use of legal language/strategies for own advocacy*

{How do you articulate the organisation's/group's/the campaign's stance regarding abortion/fertility-related practises toward the public? *Probe* about the use of legal idioms, and whether they have ever considered resorting to formal legal action}

b. Knowledge questions

** Knowledge about regulatory legal texts*

{What are the most up to date laws and ordinances regulating to fertility-related practises, most importantly abortion? *Probe:* How did you learn about this particular law/ordinance/regulation/policy?}

** Knowledge about legal interpretations*

{In light of these regulations, what are the furthest limits for the legality of these practises? *Probe:* about the specifics about particular practises, for instance: "What is the time limit for abortion on request? For therapeutic abortion? In case of rape or incest?}

* *Anecdotal knowledge*

{What do you know about the current situation in healthcare institutions with regards to reproductive health? Where did you hear these from? What are your own experiences with reproductive health workers?}

c. Perception questions

* *Perceptions about the new regulations*

{What do you think about the new regulations and surveillance measures?}

* *Perceptions about legal/political intervention into women's lives/bodies/decisions*

{What do you think about the legal debate about abortion and other fertility-related practises? To what extent do you think can law regulate individual fertility decisions?}

* *Perceptions about organisation's/group's/the campaign's use of legal language/strategies*

{How do you think using legal language/strategies helpful for achieving the professional goals that you described? How successful do you think your association's use has been when it used legal language/strategies?}

d. Comparison questions

* *Comparing use of legal language/strategies for bringing about change to other possible strategies*

{Do you think these strategies/language have/has been more successful than any other possible strategy? In which ways have they been successful, in which ways not so successful/unsuccessful? What would have been an alternative to legal language/strategies? What would its upsides and downsides be?}

* *Comparing actual law to what is considered as ideal*

{To your mind, how would "ideal" laws on fertility-related practises look like?}

* *Comparing the period before the abortion debate to thereafter*

{Does your organisation/group receive complaints about the situation in hospitals? If yes, how has the frequency of such complaints changed since the onset of the debate?}

APPENDIX II – INTERVIEW SCHEDULE

Interviews with health workers		
Fatih	Westpointe family physician's clinic	August 2014
Şebnem	Westpointe neighbourhood clinic	August 2014
Damla	Private Westpointe hospital	September 2014
Seher	Public Westpointe hospital	September 2014
Bumin	Public Westpointe hospital	September 2014
Zafer	Westpointe family physician's clinic	September 2014
Neslihan	Westpointe family physician's clinic	September 2014
Kamile	Westpointe Public Health Centre's division of reproductive health	September 2014
Esmâ	Private Eastpointe clinic	October 2014
Sibel	Private Westpointe hospital	October 2014
Fatma	Public Eastpointe clinic	October 2014
Zelal	Public Eastpointe family planning clinic	October 2014
Zeliha	Public Westpointe family planning clinic	October 2014
Zeynep	Public Westpointe family planning clinic	October 2014
Osman	Westpointe neighbourhood clinic	October 2014
Rüya	Eastpointe private hospital	November 2014
Dilşat	Eastpointe family physician's clinic	November 2014
Leyla	Eastpointe municipality clinic	November 2014
Ruşen	Public Eastpointe family planning clinic	November 2014
Ferzat	Public Eastpointe family planning clinic	November 2014
Nefiye	public Westpointe hospital	January 2015
Necla	Public Westpointe hospital	January 2015
Kemal	Public Westpointe hospital	January 2015
Gönül	Public Westpointe hospital	January 2015
Samet	Westpointe public hospital	January 2015
Remziye	Westpointe public hospital	January 2015
Şengül	Private Westpointe hospital	February 2015
Jale	Public Westpointe hospital	February 2015
Çiçek	Public Westpointe hospital	February 2015
Şirin	Westpointe neighbourhood family planning clinic	February 2015
Emine	Private Westpointe hospital	February 2015
Semra	Private Westpointe clinic	February 2015
Ekrem	Private Westpointe hospital	February 2016
Tuna	Private Westpointe clinic	March 2015
Macit	Private Westpointe clinic	March 2015
Ömer	Public Westpointe hospital	March 2015

Interviews with activists and members of professional organisations		
Zarife	Istanbul Feminist Collective	August 2014
Özgür	Reproductive health NGO	August 2014
Çiğdem	Istanbul Medical Chamber	August 2014
İpek	Socialist Feminist Collective	September 2014
Nadire	Women's Initiative for Peace	September 2014
Sümbül	Mor Çatı Women's Shelter	October 2014
Merve	Socialist Feminist Collective	October 2014
Merve	Socialist Feminist Collective	October 2014
Derya	Socialist Democracy Party	January 2015
Muazzez	Istanbul Medical Chamber	January 2015
Meltem	Mor Çatı Women's Shelter	January 2014
Bade	Labour Party	January 2015
Ümit	Istanbul Bar Association and Foundation for Patient's Rights	February 2015
Belgin	Centre for Legal Support for Women	February 2015