

# Neoliberal Health Restructuring, Neoconservatism and the Limits of Law: Erosion of Reproductive Rights in Turkey

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## Abstract

Through focusing on the neoliberal “Health Transformation Programme” launched in 2003 in Turkey, I show how reproductive law can be modified by neoliberal mechanisms that are implemented with neoconservative policies and pressures. The paper builds on original data collected in 2014 and 2015 through focus groups and interviews with health practitioners in family health centers and women receiving reproductive care in Izmir, Diyarbakir, Van, and Gaziantep. The data analysis informed by writings on the debt economy by Maurizio Lazzarato and Bifo Berardi and transnational feminist theory demonstrate that neoliberal mechanisms of “dismantling the public” interact with pronatalist policies and pressures to erode women’s reproductive rights in Turkey. This has resulted in (1) indebtedness of women through out-of-pocket payments for contraception and abortion, (2) indebtedness of providers through performance measures, (3) reduction in the quality of reproductive care, and (4) reduction in access to reproductive care itself (contraception, counseling, and abortion). There is a need to pay attention to neoliberal mechanisms and the legal framings of reproductive rights to fully understand the limitations of law and counter the neoliberal and conservative assaults on women’s sexual and reproductive rights.

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## Introduction

Turkey is one of the two countries in the MENA (Middle East and North Africa) region, along with Tunisia, that allows abortion on demand. Abortion was decriminalized in 1983 within the framework of state demographic policies rather than as a woman's right. At the turn of the 21st century, neoliberal reforms, the restructuring of the public health sector, and the pronatalist and conservative ideology promoted by the Justice and Development Party (AKP) have made abortion access difficult for many women, although the law has not changed.

In this paper, focusing on the neoliberal restructuring of health care in Turkey through the Health Transformation Programme launched by AKP in 2003, I explore how the combination of neoconservative discourses and neoliberal mechanisms have modified reproductive law and curbed women's exercise of rights. I introduce the concept of debt economy and examine how it has affected the governance of sexual and reproductive health in the public sector by focusing on various devices, such as the semi-privatization of services, performance measures, the bureaucratization and quantification of care, and the transformation of health professionals' working conditions and status. Whereas most scholars who write on neoliberalism and gender in Turkey use Foucauldian approaches and highlight discourses rather than economic mechanisms, I utilize a political-economic lens. I contribute to the feminist literature on globalization and gender by offering a political-economic analysis of neoliberal health restructuring and reproductive rights.<sup>1</sup>

Drawing on original fieldwork in Turkey, I conclude by showing that the combination of neoliberal reforms and neoconservatism has brought about drastic reductions in contraceptive and abortion services in the public sector, with expectedly worse results for young single, poor, and rural women. The indebtedness of women through out-of-pocket payments for contraceptive and abortion care; increased workload of health care workers; exclusion of family planning counseling, contraception, and initially, voluntary abortion services from performance measures; and decrease in abor-

tions provided in public hospitals are among the results of these policies and implementations.

## History of reproductive rights in Turkey

Under the Ottoman Empire, abortion, called *iskat-ı cenin* (miscarriage of a fetus), was regulated by religious law and was allowed up to 120 days of pregnancy on demand and in cases of a threat to the pregnant woman's life. With Ottoman modernization, a rising interest in population statistics, and concern over the declining Muslim population, abortion began moving from the religious to the legal jurisdiction, marking the beginning of biopolitics.<sup>2</sup>

The Turkish Republic, established in 1923, adopted the 1889 Italian Criminal Code, with its initial Catholic and later eugenic influences. Initially defined under "crimes against individuals" (1926), abortion moved to "crimes against racial integrity and health" and against "general public morality and family order" in 1936.<sup>3</sup> During the 1930s–1950s, the country prohibited abortion, contraception, sterilization, and the provision of information on contraceptive methods, and it also explored the option of rewarding of women with six or more children with medals. These actions reflect a continuation of the Ottoman Empire's pronatalist policy, applied with nationalist and eugenic aims, this time to increase a population that had been depleted through wars. In the aftermath of the 1960 coup and the new Constitution, a range of developments—including the international shift in population policies whereby growth was viewed as a hindrance to economic development; the formation of Turkey's State Development Agency; the socialization of health care; the family planning work of public health specialists such as Nusret Fisek; and an appeal to the Ministry of Justice in 1958 by the Ministry of Health, university professors, criminal medicine experts, and the Turkish Gynecological Association to remove the ban on birth control methods—led to the passing of the Law on Population Planning in 1965. With this law, birth control and therapeutic abortions were legalized, and contraception was regulated under a "family planning" perspective, with new clinics formed to

provide free contraceptive care and counseling to women. Abortion and birth control thus moved to the medical domain, supervised by the state.

When the global abortion debate reached Turkey in the 1970s, the Turkish Medical Association, Turkish Family Planning Association, and Turkish Gynecological Association started advocating for the legalization of abortion on demand. After the introduction of multiple bills (in 1971, 1972, and 1979) to legalize abortion, and the results of public health research showing the widespread provision and use of abortion by doctors and women, and its link to maternal deaths in cases of unsafe abortions, in 1983 abortion on demand was legalized through a revision of the 1965 Law on Population Planning. The revised law states:

*Population policy is defined as individuals having as many children as they wish to, when they want to. The state takes the necessary steps to provide education and implementation of population planning. Population planning is enabled by the methods preventing pregnancy. The termination of pregnancy and sterilization are done under the supervision of the state. Pregnancy terminations and sterilizations beyond those provided for under this law may not be performed.*

Even though the bill proposed a 12-week cut-off for abortion, objections by the Health and Social Work Commission led to it being passed with a 10-week cut-off instead, after which point abortion can be obtained only in cases of medical necessity. The law requires a husband's written consent for married women seeking an abortion, and parental consent from minors. According to regulations, in addition to obstetrician-gynecologists (ob/gyns), general practitioners who receive training can also perform abortions under the supervision of an ob/gyn.

In recent years, there has been a reignition of the abortion debate and the promotion of a pro-natalist policy by the AKP, the party in power in Turkey since 2002. Initially calling itself moderate Islamic, the AKP today can be best described as representing “an amalgam of neoliberalism with social conservatism.”<sup>3</sup> The social policies of AKP have at their center anti-women and at times misogynist discourses, policies, and implementations that

reposition women in familial roles, overturning decades of gains by feminist movements in Turkey toward the recognition of women as individuals and citizens in their own right.<sup>5</sup> During the March celebrations in 2008, then-prime minister Erdogan announced the government's plan to introduce financial incentives for births, which from 2009 onward quickly turned into a formulation of a “three children per family” (that is, per woman) policy. The initial sign of this shift of policy—from an antinatalist stance upheld since the 1960s to a pro-natalist one—can be seen in 2003, when the government attempted to redraft the Law on the Rights of the Disabled to restrict therapeutic abortions (done after 10 weeks), even in the cases of fetal disability.<sup>6</sup> Due to objections by women's organizations, medical associations, and media, the proposed article was removed from the draft. Yet Erdogan made a statement in May 2012, during the closing session of the International Parliamentarians' Conference on the Implementation of the ICPD Programme of Action in Istanbul, saying that abortion was mass murder (referencing the killing of 34 Kurdish citizens in Uludere for which his government had been critiqued). He also condemned Caesarean sections, declaring both abortion and Caesarean sections to be “secret plots designed to stall Turkey's economic growth and a conspiracy to wipe the Turkish nation from the world stage.”<sup>7</sup>

Erdogan's remarks on abortion were met with criticism from opposition parties and his own minister of family and social policy, but more importantly with a strong reaction from the feminist movement in Turkey, which organized nationwide sit-ins and protests under the slogan “abortion is a right and a woman's decision.” As a result of this activism—together with studies by Mor Cati (Purple Roof Women's Shelter), and Kadir Has University, among others, monitoring the status of abortion care in Turkey—the government's attempts to change the abortion law have been unsuccessful.<sup>8</sup> However, as discussed in this paper, the neoconservative discourse and pressure from state officials, applied alongside neoliberal mechanisms such as performance measures, have led to a serious decrease in abortion in Turkey.

As can be seen from this history, reproductive law in Turkey has been shaped in the context of population policies instrumentalizing women's bodies and sexuality. While the population control agenda and the restrictions on abortion it brings persist as the governing legal framework, the years 1965–2009 saw more of a family planning approach—despite population control approaches applied to poor women and minorities—which evolved (at least in reproductive policies) in 1990s to include a “women's rights” approach. This was due to Turkey's support for international documents emphasizing women's sexual and reproductive rights as human rights, including the International Conference on Population and Development (ICPD) Programme of Action, UN Sustainable Development Goals (SDGs), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which it ratified in 1985.

Recent steps toward a pronatalist policy and attempts to change the abortion law are in contradiction with these commitments. How reproductive services and rights can be eroded while still adhering to these commitment and without any change in laws reflects a need to focus on the political economic dimension of neoliberalism, as allied with neoconservatism.

### The debt economy

Lazzarato calls the latest stage of neoliberalism (starting in the late 1990s) the “debt economy.”<sup>9</sup> In the debt economy, finance dominates every sector of the economy and society—from housing, education, and health to public services.<sup>10</sup> Individuals, public entities, municipalities, and entire governments are controlled through debt. The debt accumulates when colossal sums of public money are transferred into private hands through privatization and the imposition (by banks, rating agencies, and investment agencies) of interest rates and determination of “appropriate rates” of unemployment wages, pensions, public services, and public debt of governments and municipalities. Through these actions, the public sector (including the welfare state) is completely dismantled and

privatized, public debt is created, and the state is turned into a regulator of services, itself bound to credit and debt mechanisms.<sup>11</sup> Berardi adds to this phenomenon the “mathematization of life and language,” whereby neoliberal ideology submits production and social life to the most ferocious regulation, as seen in increasing uses of “efficiency,” “performance measures,” and the quantification of welfare and health services and of education.<sup>12</sup>

### Neoliberal health restructuring in Turkey

The neoliberal assault on welfare systems includes health care restructuring, as seen in the emergence of a “health reform epidemic,” or, in World Bank discourse, “health sector reforms.”<sup>13</sup> These reforms were largely undertaken in the late 1980s and early 1990s in “developing” countries such as Brazil, Mexico, South Korea, and Taiwan, whose public sectors were denigrated as corrupt and inefficient and where markets were seen as a panacea to their “health care crises” and other problems.<sup>14</sup> In Turkey, the AKP's Health Transformation Program (launched in 2003) also outlined an agenda to “improve governance, efficiency, user and provider satisfaction, and the long-term fiscal sustainability of the health care system” and is part of this global neoliberal trend.

As in these other geographies, the Turkish health reform also originated in the late 1980s, when certain neoliberal economic and health policies were proposed (for example, the 1987 Health Services Law) and others (such as TRIPS) were applied. The reform took shape within the Ministry of Health through reports prepared by public health academics of Harvard and Johns Hopkins Universities, in consultation with World Bank advisers.<sup>15</sup>

The Turkish health reform shares many characteristics of the neoliberal global health reforms, such as financial reform, managerial reform, changes in service provision, decentralization, and the quantification of services over quality of care in the name of “cost reduction” and “efficiency.” Changes in health care provision include the closing down of the AÇSAP (Mother-Child and Family Planning) Directory, which had specialized in

reproductive health provision in primary care, and the introduction of the “family physicians system.” In this system, health centers (sağlık ocağı) and AÇSAP centers were replaced with family health centers (FHCs) and “community health centers” (toplum sağlık merkezleri) at the primary care level. Family physicians, the intended “gatekeepers” of the system, would provide preventative care and refer patients to secondary level for specialized care.<sup>16</sup> Unlike the previous system, the family physician system involved a form of semi-privatized care, which added to the ongoing privatization of care. Family physicians work as contract workers who contract midwives and nurses for a period of two years, and their wages are based on capitation set by the socioeconomic development of their region. Their salaries—as well as those of midwives and nurses—are subject to performance criteria and can be cut by up to 20% when they fail to reach their targets. Furthermore, FHCs, instead of serving a particular geographic area (as was previously the case), serve the population that registers under them. Physicians compete with one another to keep their patient populations and to maintain patients with less chronic problems.

### A multisite feminist research-advocacy project

The data used in this paper comes from a larger multisite feminist research and advocacy project that my co-researchers and I designed to investigate the effects of neoliberal health restructuring on sexual and reproductive rights in Turkey, France, and the United States. A previous article with Eylem Karakaya includes findings from FHC health care workers in Turkey.<sup>17</sup> In the current paper, adding women’s voices to those of providers, I focus on the relationship between neoliberal health restructuring, neoconservatism, and reproductive law and population policy. Although the focus of this special section is on abortion, I discuss contraception and abortion together, since these are intricately linked rights and practices in the lives of women. When the right to one is affected, the other inevitably suffers.

### Methodology

The overall study includes data collected in 2014 and 2015 from seven cities: İstanbul, İzmir, Antalya, Van, Eskişehir, Diyarbakır, and Gaziantep. These cities reflect the geographical variations in reproductive health care access as found in the Turkish Population and Health Survey, conducted every five years.<sup>18</sup> Within a geographical diversity, we chose cities where we had connections to women’s organizations and medical associations that would help us recruit participants. This paper includes an analysis of four of these cities: İzmir, Diyarbakır, Van, and Gaziantep. We completed 313 surveys with women (aged 18–45) in all four of these cities; 103 surveys in Diyarbakır and Antep with reproductive health personnel who worked in the public sector at the primary and secondary levels; and 14 focus groups with women (aged 18–45) and 8 focus groups and 3 individual interviews with FHC personnel in all cities except Van. Personnel came from 11 FHCs and one AÇSAP center. All interviews were transcribed verbatim and analyzed using the grounded theory approach.

The mean age in our focus groups was 35.5 for women and 36.6 for health personnel. In terms of marital status, there were more single women (53.6%) than married women in our focus groups. The health personnel who participated in surveys and focus groups were mainly female health workers (77.7% for surveys and 85.7% for focus groups), with the majority being nurses or midwives (75.7% of health workers in surveys and 81.8% of health workers in focus groups). Thus, the results from health providers reflect the viewpoints of the feminine labor force on health care restructuring. In this paper, I utilize focus groups with health providers and women receiving public and private reproductive care.

### Findings and discussion

#### *Dismantling public health care via neoliberal mechanisms and the bureaucratization of care*

In Turkey, we found that the dismantling of the public sector in health care is accomplished via

mechanisms of privatization, the introduction of hidden and explicit user fees, the introduction of market concepts such as (the illusion of) “choice” of provider and “customer satisfaction,” and the introduction of market mechanisms such as performance measures. In terms of sexual and reproductive health care, the closing down of the directory for AÇSAP and most of its centers—which had specialized in providing sexual and reproductive care, including contraception, abortion, and counseling and education on sexual and reproductive health—and their replacement by FHCs and community health centers (TSMs) affected women’s access to contraception, family planning counseling, and abortion.<sup>19</sup>

Under the new system, FHCs are divided into four categories (A, B, C, and D), with only A and B types having an additional room with an ob/gyn table. Having a general practitioner trained in intrauterine device (IUD) insertion can move a center from C or D status to B status. According to a report by UNFPA Turkey on access to family planning services and contraception, this differentiation has led to inequality in access to care.<sup>20</sup> The FHC system had replaced the previous teamwork between physicians, nurses and nurse-midwives, to a physician-based scheme, where the physician is transformed into an “entrepreneur” who contracts personnel and pays rent and any material costs that arise. Nurses and midwives, in turn, have become contractual workers whose professional titles are now “family health worker” instead of “nurse” or “nurse-midwife,” causing them to lose both professional status and the job security granted previously by their public worker status. This semi-private functioning of the centers and the transformation of the doctor-nurse relationship into an employer-employee one was not appreciated by the health workers we interviewed:

*The community health centers had to be updated and adapted to the years 2016s and 2017s and it wasn't done. That wonderful system is gone now and in its place we have a commercial- (pause). Like the commercial agencies, but we are not that. In between. We pay the electricity, water, internet, heating, cooling, everything. Hired five personnel. If*

*something happens to this place, we pay for it. From our own thing. We get a tax number and spend 70% of our time with this nonsense [another health worker in the room interjected “management”] work.*

—Mehmet (male), age 52, physician,  
A-type FHC, Antep

*There are problems both in terms of the money we receive, and status ... and it's like a boss-employee relationship. Intentionally or unintentionally. Even though they [doctors] don't pay you, we are in that position.*

—Gul (female), age 35, midwife,  
A-type FHC, Antep

Under the new system, performance measures apply to both hospital and FHC work. Under Turkey’s Healthcare Application Communiqué (Sağlık Uygulama Tebliği), which defines performance points for various health services, a performance code was initially given only to “therapeutic abortions” (beyond the 10-week legal period), leaving abortions on demand undefined and thus excluded from social security coverage. It was only in 2014 that the code was changed to “dilation and curettage services.”<sup>21</sup> In terms of sexual and contraceptive care, in the FHCs, physicians, nurses, and nurse-midwives are subject to performance measures in areas such as the rate of referrals, child vaccinations, and prenatal and infant follow-ups and can lose up to 20% of their salary if they do not meet their targets. Nonetheless, they are not evaluated for sexual and reproductive health counseling (called “family planning counseling”) or contraception supply, including IUD insertions. Such performance measures are a neoliberal market mechanism (used alongside conservative pronatalist aims) applied through bureaucratic means, since they are introduced with the aim of increasing “efficiency” by standardizing measures of accountability. To better understand the workings of performance measures and their effect on reproductive rights, I will proceed to the second arm of the dismantling of the public health care sector: the bureaucratization of care via digitalization and performance measures.

Lazzarato describes the debt economy’s use of evaluation as a technique to govern the behavior

of individuals, populations, agencies, and governments. Berardi discusses in additional depth the effects of this mathematization of language, discourse, and life.<sup>22</sup> In our research, we observed the bureaucratization and resultant quantification of care through performance measures and increased paper and computer work, which has had direct consequences on women's rights to contraception. Despite the reform's aims to improve "efficiency," providers in our research mentioned an increased workload and lack of efficiency. Indeed, 86.4% of health providers stated that their workload had grown since the health reform. This increase was due to the performance measurement system and the newly computerized system, which did not work efficiently:

*Ayse: Sometimes I think that they make us do too much drudgery ... for example, we print out the monthly work and transfer it from the computer into paper work, then you scan and enter it back into the computer, correct it within the EBES system, send it ... Remove the monthly work. If you already have a system, why is it this way? Why do you waste so much paper? If the system goes down, everything is affected. You can't send something for hours.*

*Fatma: yes, this is extra work for us*

—Ayse (female), age 37, midwife; Fatma, age 29, nurse, A-type FHC, Diyarbakir

The performance measures, together with the increased workload (caused by digitalization and the extra work required by performance measures), affect sexual and reproductive care by decreasing the quality of care provided and decreasing care itself that is excluded from performance measures. For example, the nurses and midwives we interviewed stated that they were unable to find time to offer sexual and reproductive counseling and that, due to a lack of training and work overload, they were not willing to insert IUDs:

*As the workload increases, as one does polyclinic, and needs to follow the women aged 15–49 [meaning prenatal follow-ups for reproductive-age women] and checks on obesity, you can't catch up. If you do one, the other is definitely left out.*

Malin (female), age 42, physician, B-type FHC, Izmir

In their research on family health center and community health center providers, Zeliha Asli Ocek et al. documented problems even with the services that are under performance criteria (for example, in identifying pregnant women and infants among individuals who did not register with the family physician) and problems with the quality of prenatal and infant care.<sup>23</sup> They also found, as we did, instances of fraud in prenatal follow-ups and child immunizations. The ratio of pregnant women and infants not covered by the new system, as well as problems in the quality of care, reveal that the quantification of care does not guarantee its quality or "efficiency." Indeed, the World Bank admits that "the performance-based contracting scheme in Turkey started out mostly as a 'pay for quantity' approach and does not incentivise the clinical process dimension in quality of care."<sup>24</sup>

In terms of the decrease in sexual and reproductive care, the decrease in IUD provisions in FHCs has been detected both by researchers and by the results of Turkey's 2013 Demographic and Health Survey, which show that the use of IUD among married women fell from 18.8% in 1993 to 16.8% in 2003, with the decrease first visible in 2008 (five years after the beginning of the health restructuring).<sup>25</sup> A decrease in family planning counseling has also been reported by both Ocek et al. and Ceren Topgul et al.<sup>26</sup> As they noted, I also found that the decrease in counseling and IUD provision are due to an increased workload, exclusion of these services from performance measures, and lack of adequate training:

*The last time I placed an IUD was last year ... I don't find it appropriate to do it here [Interviewer: Why?] Because there are patients waiting and there is the time for that patient ... And when you don't do something regularly, you lose the practice. So I try to refer the patient to where IUDs are placed ... Like maternal-child health centers.*

—Zeynep (female), age 43, midwife, B-type FHC, Izmir

*If it was me, I would not have an IUD placed here. For example, I went and learned the IUD placement on a model. How can I do it on a woman, something I only performed on a model? I can neither place an*

*IUD nor do [pap] smears. [Interviewer: Didn't you practice before receiving the certificate?] We did not receive a certificate. A training for 20 minutes only.*

—Cicek (female), age 40, nurse,  
A-type FHC, Diyarbakir

In addition to performance measures, digitalization, and inadequate staff training, another bureaucratic mechanism that impedes women's access to contraception are periodic problems in the supply of contraceptive methods to FHCs by the city health ministries. In all of the cities where we conducted our research, women and providers mentioned these periodic irregularities in supply. In Topgul et al.'s study, family physicians in FHCs also reported such irregularities, which they interpreted as reflecting the anti-contraception attitude of the state and a lack of coordination between the ministry, community health centers and family health centers after the reform. In our study, some health providers attributed the problems to the Ministry of Health's incorrect calculation of their needs or to not being properly informed when supplies had arrived. Moreover, Topgul et al. point out the links between changes in the financing of contraceptive methods and the lack in supplies. They state that the supply of contraception in Turkey from 1965 to 2000 was financed mainly by international funds, with USAID being the largest funder.<sup>27</sup> When USAID started to decrease its financial support between 1995 and 1999, the Turkish Ministry of Health had to finance the methods, which led to decreases in supply in 2000 and 2001.<sup>28</sup> The Ministry of Health decentralized the method acquisition. However, when this created a standardization problem, the Ministry recentralized the acquisition. The problem remains, as public bids in contraception acquisition involve long processes and include cancellations. According to UNFPA, no purchases were made by the Ministry of Health in 2012.<sup>29</sup>

While the reasons for these constant irregularities need to be further investigated and monitored, the result is the violation of women's right to free contraception at the primary level, which leaves women with the options of paying out of pocket (becoming indebted), changing to another contra-

ceptive method available at the FHC, or continuing an unwanted pregnancy. As our interviewees noted:

*Fatma: Last year, we had nothing for four months except for the injection.*

*Anonymous: Most of the time the ministry buys it but it doesn't come to us, waits there. The municipality doesn't inform us. There is a waiting. It's a two-way problem. Problem emanates 80–90% from the ministry.*

*Interviewer: Okay, so when there is nothing and the woman comes and asks for a method, what do you do?*

*Ayşe: They become pregnant. Because you know the pill in the pharmacy is 18 lira. They can't buy it. They can buy as much as they can from the pharmacy, otherwise they become pregnant.*

—Fatma (female), age 29, nurse; Ayşe (female), age 37, midwife; anonymous (male), age 43, physician, A-type FHC, Diyarbakir

*There are those who get pregnant. There was no pill for a while for example, and we saw many women who got pregnant and gave birth to their whateverth number child.*

—Habibe (female), age 42, physician,  
B-type FHC, Izmir

*Zehra: In 2008, there was a community health center below us and nurses from there said that women could access condoms and pills from the centers. But a bit later, there was no emergency pill or birth control pill.*

*Elif: The nurse in my family health center told me that she fits IUDs, but that her physician does not know it. Told me she can fit me one but I know they don't provide condoms anymore.*

—Focus group with women, Izmir

*Interviewer: Is the IUD placed in FHCs here?*

*Havva: In some but not all.*

*Interviewer: How about injected contraceptives or condoms?*

*Havva: That might be changing according to location of the center. Some have it but some say they have problems getting these and forced the budget and have their unit buy these ... They say at meetings that they have much difficulty when the supplies are finished.*

—Focus group with women, Antep



The exclusion of contraceptive care and family planning counseling from performance measures, low performance points given to abortion in hospitals, and periodic irregularities in contraceptive supplies are in line with the AKP's pronatalist policy. This ties in to the last part of our findings, which relates to how conservative discourse and pressure has led to a decrease in abortion and contraception access, thus violating women's reproductive rights.

### *Conservative discourse and pressure on providers*

In our focus groups, we asked providers and women about abortion and birth control access in their cities since the health reform. We were surprised to learn that not only most of the women but also most of the health providers were confused about the legal status of abortion. Some thought it was banned while others were not sure whether the legal time limit had been shortened.

*Firuze: I would not go to the public hospital. I would consult my doctor, but if I needed an abortion, I would not go to public, since I know that it's illegal. Interviewer: Do you think or know that abortion is banned in public hospitals?*

*Nuray: The government has such a policy.*

*Zehra: I mean that in practice it's not done, not easily. They make it harder.*

*Firuze: I know that if the husband consents, it can be done.*

—Focus group with women, Izmir

*For example, umm the prime minister, umm telling women to give birth, I heard that he banned ... I went to the community health center three years ago, there was no birth control pill, the president banned it. [Interviewer: Did they say that?] Mm-hmm. [Interviewer: At the community center?] Yes.*

—Azra, focus group with women, Antep

*I know that abortion on demand is banned.*

—Irem, focus group with women, Izmir

These testimonies show that the conservative discourse that started with Erdogan's remarks in 2012 that "abortion is murder" was successful in muddying the waters and creating confusion on the legal

status of abortion, as well as pressure on providers, without actually changing the law. The decrease in abortions in public hospitals throughout Turkey was documented in a recent survey of state hospitals and teaching state hospitals by Kadir Has University.<sup>30</sup> Our interviews showed that abortion has become more difficult in public hospitals in recent years due to service rejection and to requests by providers that the pregnant woman obtain her husband's or parents' consent:

*if we can collect money, we send the women [we work with] to private hospitals. When there is no husband, the public ones reject them anyway. In the private, there is resistance as well. I have been doing this job [working at a women's shelter] for seven years. For the last three years, we have had serious difficulties about this [accessing abortion]. The number of kids we give [for adoption] to protection services is too many. There are many pregnant women coming to us, ending their pregnancies and returning home. They have no other way of hiding their pregnancies. Why couldn't you abort? "I had no money." But this is a public service. But if it's recorded in her social security, anyone can access it and now they inform the husbands, parents, by text message ... So, she has no other option.*

—Elif, women's focus group, Izmir

*Meryem: In public hospitals now, they don't do it [abortions] if there is no problem [medical necessity].*

*Zeynep: I went and said I do not want this pregnancy, went to the birthing hospitals. They said go bring your husband, he signs and we do it ... And I was scared.*

—Women's focus group, Diyarbakir

Health providers also feel pressured to avoid talking about and providing abortion and birth control and noted the newly brought scrutiny on the husband's signature for abortion, which previously had not not been so strictly enforced by health providers:

*Actually, there is a change [from the community center model to the family health center model]. A change in views. How can I say this ... Abortion is legal, but there is an incentive not to provide it. You can't talk about it, talk about this different point of view. For example, the person says, "I don't want to*

*give birth, I want to use protection,” and you get the feeling that you are doing a wrong thing mentioning the methods. ... There is such a change here and it exists on abortion too. It is legal, so I still don’t understand why the husband comes. And you take the husband’s signature.*

—Ayse (female), age 39, physician,  
D-type FHC, Antep

Among our study participants, single women (most of them young) stated that they found it difficult to access contraceptive and abortion care from the public sector, out of fear or due to real experiences of being judged for being sexually active. When they can, single women utilize private care. Fusun Artiran Igde et al. point to how the legal restriction of abortion provision to ob/gyns and to general practitioners who work under the supervision of ob/gyns contributes to urban-rural inequalities in access to abortion since rural areas lack ob/gyns.<sup>31</sup> Given the climate of conservative and patriarchal care, where some providers do not feel comfortable talking to or treating single women, these new conservative pressures, together with the existing limitations of the law itself, will disproportionately affect poor women, young single women, and rural women, who will be forced to pay out of pocket for contraceptive and abortion care, to seek unsafe abortions, or to carry unwanted pregnancies to term.

## Conclusion

In this paper, drawing on the writings on the debt economy and a transnational feminist lens, I have discussed how neoliberal mechanisms, with their marketplace-oriented and bureaucratic arms, interact with conservative policies to erode women’s reproductive rights in Turkey. To summarize, the neoliberal-neoconservative restructuring of health care in Turkey has resulted in (1) the indebtedness of women through out-of-pocket payments for private contraceptive and abortion care; (2) the indebtedness of physicians, nurses, and midwives to the state through salary cuts from missed performance targets (and use of fraud to avoid these misses); (3) a reduction in the quality of existing reproductive care (such as prenatal follow-ups); and

(4) a reduction in access to reproductive care itself (namely contraception, sexual and reproductive counseling, and abortion).

In Turkey, women’s rights to contraception and abortion did not come about as a result of demands by the feminist movement; rather, they emerged in the context of antinatalist policies combined with public health concerns regarding maternal deaths. As Elif Aksit argues, the AKP’s pronatalist policy can, in one way, be seen as a continuation of the approach to women’s bodies, reproduction, and sexuality in Turkey that has been in place since the late Ottoman period, whereby reproductive rights are treated in the context of population policies.<sup>32</sup> The difference from previous times is the extension of the state’s biopolitics to the regulation of assisted reproductive technologies (such as infertility treatments and sperm donations) and the application of neoliberal market mechanisms together with conservative ideologies aimed at controlling women’s sexuality.<sup>33</sup>

I believe that the way in which reproductive rights in a country are gained and laws formulated affects the susceptibility of the laws (and rights) to actual or de facto modifications by market and conservative mechanisms. For example, in the United States, *Roe v. Wade*, which legalized abortion in 1973, is phrased as protecting women’s “right to privacy” in a decision made with the doctor and in which the state preserves its interests to intervene on behalf of the woman or the fetus. It is not surprising that immediately after abortion’s legalization, the Hyde Amendment (1977) preventing federal coverage of abortions was passed. Senator Hyde argued that this was a not a limitation, since women were *free to choose* another (private) provider for abortions. In the United States, we can also see how neoliberal mechanisms (such as increasing malpractice lawsuits against ob/gyns, changing zoning and operation room requirements for abortion clinics, and the defunding of Planned Parenthood) have been used alongside conservative measures (such as mandatory waiting periods, parental consent or judicial bypass for minors, and ultrasounds and fetal heart monitoring before receiving an abortion)

to make the right to abortion de facto nonexistent in many states.<sup>34</sup>

While reproductive law in Turkey lacks a feminist basis and enables the continued instrumentalization of women's bodies through pro- or antinatalist policies, Turkey's commitment to ICPD action plans, the Sustainable Development Goals, and CEDAW has marked a change at the policy level from a population control to a women's right approach, which is monitored by feminist organizations. Under the ICPD Programme of Action, states are expected to take all necessary measures to secure access to health care, including sexual and reproductive health care, and to consider gender equality and women's autonomy in decision making in sexual and reproductive health matters when developing reproductive health programs and population-related programs. The Sustainable Development Goal on gender equality (Goal 5.6) also includes stipulations for the granting of universal access to sexual and reproductive care, including abortion access, stating that governments should not limit access to abortion on cultural or religious grounds. Additionally, CEDAW requires governments to attain gender equality in health care, including family planning services (art. 12), to secure adequate access for rural women on family planning counseling and methods (art. 14(b)).<sup>35</sup> In CEDAW General Recommendation no. 35, denial or delay of safe abortions and forced continuation of pregnancy are considered gender-based violence (Item 18).<sup>36</sup> The results of this study, taken together with those of others, show that the current state of affairs on sexual and reproductive health in Turkey constitutes multiple rights violations in the areas of access to methods, access to information, and respecting and enabling women's autonomy in decision making on reproductive matters.

Feminist monitoring of ICPD, the Sustainable Development Goals, and CEDAW is important. So is the inclusion of women's sexual and reproductive rights in the agenda of the Turkish feminist movement after the 2012 mobilizations. While these provide valuable counter-forces to attempts to curb abortion and reproductive rights, as this

paper shows, the neoliberal economic context (with its conservative and increasingly authoritarian dimensions) should also be critically examined, and, ideally, a new law that recognizes reproductive rights as women's rights and not dependent on the state, men, and family, should be passed.

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## References

1. C. Mohanty, "Under Western Eyes" Revisited: Feminist Solidarity through Anticapitalist Struggles, *Signs*, Vol. 28(2) (Winter 2003), pp. 499-535.
2. Balsoy, G. E. *Kahraman Doktor İhtiyar Acuzeye Karsi: Gec Osmanli Dogum Politikalari*. (Istanbul: Can Sanat Yayinlari, 2015).
3. E. C. Ertem, "Anti-abortion Policies in Late Ottoman Empire and Early Republican Turkey: Intervention of State on Women's Body and Reproductivity," *Fe Dergi* 3/1 (2011), pp. 47-55.
4. A. Bugra, & C. Keyder, "The Turkish Welfare Regime in Transition," *Journal of European Social Policy* 16/3 (2006), pp- 211-228.
5. F. Acar, & G. Altunok, "The 'politics of intimate' at the intersection of neo-liberalism and neo-conservatism in contemporary Turkey," *Women's Studies International Forum*, 141 (2013): pp. 14-23.
6. Acar & Altunok (see note 5).
7. Hurriyet Daily News, 26 May 2012.
8. Mor Cati, "Kurtaj yapiyor musunuz? Hayir yapmiyoruz" February 3, 2015. <https://www.morcati.org.tr/tr/290-kurtaj-yapiyor-musunuz-hayir-yapmiyoruz>; Kadir Has University Gender and Women's Studies Research Center, "Legal But Not Necessarily Available: Abortion Services at State Hospitals in Turkey", 2016. <https://gender.khas.edu.tr/sites/gender.khas.edu.tr/files/inline-files/Abortion%20English.pdf>.
9. M. Lazzarato, *The making of the indebted man*. Translated by Joshua David Jordan. (Amsterdam: Semiotext(e), 2012).

10. C. Lapavitsas, "The financialization of capitalism: 'Profiting without producing'", *City* 17/6 (2013), pp. 792-805.
11. Lazzarato (see note 9).
12. F. "Bifo" Berardi, *The uprising: On poetry and finance* (Los Angeles, CA: Semiotext(e), 2012).
13. Europe Solidarity Delegation, *Greece the Frontline of Austerity* (April 2013); R. Klein, "Health care reform: The global search for utopia," *British Medical Journal* V307 (1993), p. 752.
14. T. Ağartan, "Gender and Health Sector Reform: Policies, Actions, and Effects" in S. Dedeoğlu & A. Y. Elveren (eds), *Gender and Society in Turkey: The Impact of Neoliberal Policies, Political Islam and EU Accession* (I.B. Tauris, 2012), pp. 155-172.
15. Ç. Keyder, "Giriş" in Ç. Keyder, N. Üstündağ, T. Ağartan, & Ç. Yoltar (eds.), *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, (İstanbul: İletişim Yayınları, 2007), pp. 15-35.
16. T. Ağartan, "Sağlıkta reform salgını" in Ç. Keyder, N. Üstündağ, T. Ağartan, & Ç. Yoltar (eds.), *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, sorunlar, tartışmalar* (İstanbul: İletişim Yayınları, 2007), pp. 37-54.
17. A. Dayi & E. Karakaya, "Transforming the gendered regime through reproductive politics: Neoliberal health restructuring, the debt economy and reproductive rights in Turkey" in A. Kian & B. Turkmen (eds), *Les Cahiers Du Cedref: Transformations of the Gender Regime in Turkey*, n. 22 (2018), pp 158-92. Available at <https://journals.openedition.org/cedref/1150>.
18. Hacettepe University Institute of Population Studies, "TNSA: Türkiye Nüfus ve Sağlık Arastirmasi/Demographic and Health Survey" (Ankara, 2013).
19. Before the health reform, larger AÇSAP centers in Istanbul, Izmir, Ankara and Diyarbakir, provided abortions. Personal conversation with E. Karakaya, November 24, 2019.
20. UNFPA Birleşmiş Milletler Nüfus Fonu. *Aile Planlaması Hizmetleri ve Kontraseptif Yeterliliği Ulusal İstişare Çalıştayı Raporu*. Ankara, 26.12.2016.
21. C. Topgöl, T. Adalı, A. Çavlin, C. Dayan. *Sisteme değil isteğe bağlı hizmet: Sağlık Çalışanları Gözünden İstanbul'da Kürtaj ve Aile Planlaması Hizmetlerinin Durumu*. Nüfus-bilim Derneği, Türkiye Aile Sağlığı ve Planlaması Vakfı, UNFPA Türkiye Ofisi. Ankara, 2017.
22. Berardi (see note 12).
23. Z. A. Ocek, M. Ciceklioglu, U. Yucel, & R. Ozdemir, "Family medicine model in Turkey: a qualitative assessment from the perspectives of primary care workers," *BMC Family Practice*, V15/38 (2014), pp. 1-15.
24. Ibid., p. 10.
25. A. Davas Aksan, "Sağlıkta Dönüşüm ve Üreme Sağlığı" in *I. Kadın Hekimlik ve Kadın Sağlığı Sempozyumu Sağlıkta Kadın Emegi Sempozyum Kitabı* (Ankara: TTB Yayınları, 2011), pp. 31-35; TNSA, 2013 (see note 18).
26. Ocek et al. (see note 23); Topgöl et al. (see note 21).
27. A. Yavuzylmaz A, M. Topbaş, B. Orhan, N Kaymaz, U. Köse, G. Çan G., "Kontraseptif Yöntemlerin Maliyeti ve Finansmanı", *Sağlık ve Toplum* 20/2 (2010), pp. 9-13.
28. N. Etiler N and C.I. Yavuz, "Sağlık Reformlarının Ana Sağlığı Hizmetleri Üzerine Etkileri: Ülke Örnekleri", *Toplum ve Hekim* 19/4 (2004), pp. 285-292.
29. UNFPA Turkey. (see note 20).
30. Kadir Has University Gender and Women's Studies Research Center (see note 8).
31. F. Artiran Igde, R. Gul, M. Igde, and M. Yalcin. "Abortion in Turkey: Women in Rural Areas and the Law," *The British Journal of General Practice* 550/58, (2008), pp. 370-373.
32. E. E. Aksit, "Geç Osmanlı ve Cumhuriyet Dönemlerinde Nüfus Kontrolü Yaklaşımları," *Toplum ve Bilim* 117 (2010), pp. 179-197.
33. Ibid; A. Dayi & E. Karakaya (see note 17).
34. Allen Guttmacher Institute. *An Overview of Abortion Laws*, November 13, 2019. <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws>.
35. Convention on the Elimination of All Forms of Discrimination against Women, 1979. Available at <https://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx>.
36. General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19. Available at [https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1\\_Global/CE-DAW\\_C\\_GC\\_35\\_8267\\_E.pdf](https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/CE-DAW_C_GC_35_8267_E.pdf).