‘No More than Two with Caesarean’
The C-section at the Intersection of Pronatalism and Ethnicity in Turkey

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ABSTRACT: In this article, I investigate the politicisation of the Caesarean-section (C-section) in Turkey as an anti-natalist procedure. In 2012, the Turkish state began to implement a series of interventions to lower the high rates of birth by C-section, which culminated in an attempted ban on elective C-section. In a previously unseen way, I argue that this intervention was based on the logic that because women are not medically recommended to undergo several C-sections, this surgical procedure limits the number of children a woman can give birth to, causing a concomitant decrease in population growth rates. This article traces the ways in which pronatalist discourses and interventions become meaningful in the medical setting by addressing the politicisation of C-sections. It examines how the C-section reflects a particular population discourse, which is marked by a moral language that stigmatises the fertility of Kurdish women.

KEYWORDS: biomedicine, Caesarean section, C-section, ethnicity, pronatalism, Turkey

Introduction

The ‘Turkish summer’ of 2013 witnessed a proliferation of chants, slogans and banners in which people flooded the streets and filled Taksim Square. ‘Are you sure you want three more children like us?’ people wrote on banners. This became one of the main slogans used to protest against the government, pointing to the deep-rooted unrest in parts of the population with the AKP (Justice and Development Party) administration. What they were doing was a mockery of the motto ‘at least three children’, which has been exhorted regularly by Prime Minister Erdogan and ministers in his government. ‘Donate your three children to the homeland’, Erdogan stated in his speech to his party members a month later. ‘This nation needs to be strong’, he continued, ‘and to achieve this, we need the support of women, the support of mothers. I trust women of this nation in this struggle. We do not make this obligatory, we just propose it. If it is okay for Putin to say this in Russia, why is it not okay for me?’ (‘Donate Your Three Children to the Homeland’, 2013). Two weeks after this speech, I interviewed an Obstetrics and Gynaecology specialist working at a public hospital. Towards the end of our interview, he said sternly ‘in the final analysis, what I have just given you is the X-ray of the situation in Turkey’. As he waited for me hastily to take down the notes, he continued, ‘You might hear other explanations as well, but my diagnosis is the right one’. The ‘situation’ in his narrative referred to the AKP government’s recent interventions into reproductive matters in Turkey that targeted abortion, Caesarean section and birth control. And his ‘diagnosis’ was that the ‘at least three children’ mantra of the Turkish government was to be understood in relation to a ‘political arithmetic’ (Kanaaneh 2002). This arithmetic, in turn, operated as technology of the state in monitoring and controlling the demographic differentials, namely different rates of fertility between Kurdish and Turkish populations in Turkey.

The above ‘diagnosis’ is an example of the population discourses that have been circulating in Turkey.
These population discourses are multiple, intertwined and sometimes contradictory, yet they have one thing in common: the revival of pronatalism. Pronatalism, which may be defined as a set of discourses and policies that are designed to encourage childbearing in a given context (Sun 2012), has been playing out as an increasingly powerful discursive, legislative and biomedical intervention into reproductive practices under the AKP administration and it is best known by the public as the ‘at least three children’ policy (politikası). However, no one has taken the pronatalist state policy at its face value, it seems, as the population discourses abound on the ground among people. Although Turkish Prime Minister Erdogan hailed Turkish women in general and invited all women in Turkey to have an increased number of children, the interviews with medical professionals pointed at other population discourses in which gender, ethnicity, religion and politics intersect. Some have argued that the main purpose behind the emergence of pronatalism in Turkey was the aim to increase the number of conservative voters. Others have employed another population discourse portraying the higher fertility rates of Kurdish women as a threat. They argue that the ‘at least three children’ discourse and pronatalist interventions aim to ‘balance’ this high fertility by encouraging Turkish women to have more babies.

Where should we locate the C-section in this matrix of discourses, practices and policies concerning pronatalism? Further, how might we make sense of it as a surgical procedure that requires intervention in order for the pronatalist demographic goals to be achieved? In asking this question, it should be emphasised that this article does not aim to investigate the reasons behind the high rate of C-section births, which is 50.4 per cent in Turkey (Ministry of Health 2013). In other words, it is not about the C-section as such but a particular way of speaking about the C-section. Thus, it aims to explore the ways in which medical professionals themselves interpret the reconfiguration of the C-section as an antinatalist procedure. It traces how particular population discourses emerge and operate through the discussions concerning the C-section. To address these questions, this article draws on data collected from six months of research between 2013 and 2014 in Istanbul during which I conducted interviews with fifteen OBGYN specialists. Four of these were physicians working at a private hospital, whereas eleven worked at various public hospitals in Istanbul. To maintain confidentiality all names mentioned in this article are pseudonyms. Regarding ethnicity, none of the physicians I interviewed identified themselves as Kurdish, although this does not rule out the possibility that any of them might have been Kurdish. In the following sections, I first delve into the history of the population as an object of state governance and intervention in Turkey by demonstrating the different phases of pronatalism. After addressing the revival of pronatalism under the AKP rule, I continue with the specific case of the C-section by demonstrating its reconfiguration as an antinatalist procedure. I then continue with a particular example, which focuses on the ‘high fertility of Kurds’ in relation to the C-section as raised by the physicians. The conclusion highlights the need to complicate these population discourses and points in future research.

Background: From Pronatalism to Antinatalism

Turkey has been one of the very first among the Middle Eastern countries to attain a low, near replacement level of fertility (Angin and Shorter 1998; Courbage 1995). Although this low rate has been linked with the secularisation and modernisation process brought by the ‘founding father’ Mustafa Kemal Ataturk (and hence the expectation of ‘low-fertility’ as it would be the case in a ‘secular’ and ‘modern’ context), the secularist Republic was pronatalist in its population policies and strove for decades to increase its population (Angin and Shorter 1998).

In Turkey, the first pronatalist phase began with the establishment of the Turkish Republic in 1923 and lasted until the emergence of Population Planning Law in 1965 (Ergocmen 2012). In the early years of the Turkish Republic, the state had to confront the problem of underpopulation caused by the three consecutive major wars (the Balkan Wars, the First World War and the War of Independence) as well as mass deportations and exterminations (Angin and Shorter 1998; Ergocmen 2012). In that context, pronatalism was employed by the state as a tool for nation building, based on the assumption that a larger population was essential to rebuild social and economic life and to attain national prosperity (Franz 1994). To this end, the pronatalist population policies put strict legal prohibitions on the importation, production, sale and advertisement of contraceptives, banned abortion and promoted large families (Benezra 2014).

During this first phase of pronatalism in Turkey, which lasted almost four decades, the population doubled (Eryurt and Koç 2012) and the Total Fertility Rate (TFR) rose to almost seven in the 1950s (Angin and Shorter 1998). Beginning with the 1960s, however, the pronatalist policy was replaced by an antinatalist
policy that defined ‘over-fertility’ as a problem to be fixed (Ergocmen 2012; Özbay and Shorter 1970). This was a part of the global trend in the 1960s of identifying the problem of a ‘too rapid’ population growth and the resulting overpopulation as an ill to be addressed through the emergent sector of development (Connelly 2008; Maternowska 2006). In that context, following The First Five Year Development Plan in 1963, the Turkish state adopted a ‘family planning’ policy and passed the Population Planning Law in 1965 (Gürsoy 1996). The restrictions on the sale and use of contraceptives were lifted through this new law. However, it took another eighteen years until 1983 for abortion to be legalised in Turkey. Three years after the military coup d’état, which occurred in 1980, abortion was legalised through the second Population Planning Law (Toksoz 2011). Under this law, elective abortions up to ten weeks of gestation and voluntary sterilisation were legalised.

The decline of fertility in Turkey has been the case since the 1970s and the Turkish case has been much faster than many other Middle Eastern countries (Ergocmen 2012). It has been demonstrated that although Turkey had a similar fertility level to Egypt, Morocco, Iran and Sudan in the 1960s, the fertility level of Turkey was 20 per cent lower than that of Egypt and 40 per cent lower than that of Iran by the 1990s (Behar 1995; Ergocmen 2012). The fertility rate was around 2.6 in the 1990s. However, it has been declining since and reached a historic low of 2.02 in 2011, which is below the replacement level (Turkish Statistical Institute 2012). It is in this historical moment that a novel discourse emerged which has drawn attention to the dangers of below-replacement-level fertility.

At Least Three Children and The Revival of Pronatalism

Since PM Erdoğan’s first utterance in 2008 of the urgent ‘need’ to have at least three children in each family, pronatalism has revived in Turkey. This pronatalist ‘at least three children’ discourse has been employed by the Justice and Development Party (AKP) government that came into power in 2002. The AKP’s roots go back to mobilisation of Islamist politics beginning in the 1970s (Tugal 2009; White 2002). However, after coming to power in 2002, AKP distanced itself from its former Islamist politics and has since framed itself as ‘conservative rather than Islamist and presented a pro-Western, pro-Europe, and pro-private sector position while simultaneously deploying religious idioms’ (Yazıcı 2012: 113).

Of particular concern has been the decline in the fertility rate, and the increazingising rate of the elderly compared to the younger population, which has been seen as a danger to the nation (Carkoglu et al. 2012; Dedeoglu 2012). PM Erdoğan, himself a father of four, has fervently argued for the urgent need to increase the fertility rates. When the latest report by the Turkish Statistical Institution (TUIK) in January 2013 revealed that the fertility rate has continued to decline, the Deputy PM Babacan announced that finding a solution to the declining population problem is now a priority of the government (Bila 2013). One year later in 2013, the total fertility rate in Turkey had increased for the first time since 1955, reaching from a below-replacement level of 2.02 to 2.08 in 2013 (Eryurt and Koç 2012).

Here, I would like to emphasise that the revival of pronatalism has not remained solely at the level of discourse (which does not mean that if it had this would not have produced ‘real effects’, as Foucault long ago argued that discourse is by definition ‘productive’). Rather, it has been accompanied by multiple changes on the level of policy. In that sense, the revival of pronatalism in Turkey has been closely linked with reproductive health matters. Contraception, pregnancy, birth-giving and abortion have emerged as matters to be addressed by the state for the sake of the nation, a par excellence illustration of the politicisation of reproduction under a pronatalist regime. The reconfiguration of the C-section in Turkey should be situated in the historical context mentioned above. This certainly is not the first time pronatalism has emerged as a population policy in Turkey, yet the ways in which it emerges and operates are embedded in articulation of social, political and economic complexities of the present day. In this context, the C-section has been reconfigured in previously unseen ways.

The C-section as an Antinatalist Procedure

On 19 June 2012 PM Erdoğan gave a speech at the conference titled ‘Being a Family’, which was organised by the Ministry of Family and Social Policy. He stated:

They utilised the birth control mechanisms in this country for years. By using family planning, they almost sterilised our people, our nation. They did everything to this end, including using medical procedures. This is what the Caesarean is, this is what abortion is … And while they were doing these, they virtually committed murder, they tricked our people. They said ‘your life is in danger, we will save you with Caesarean’ whereas they had other purposes.
Their purpose was to make more money and also they started campaigns such as ‘you cannot have more than two babies with Caesarean’ … Well, what is the truth behind all these? Their purpose was to make our population smaller and make our nation stay behind the other nations in the competition of civilisations (‘They Sterilised Our People’, 2012).

The statement above should be situated within Turkey’s biomedical culture. The doctors and nurses I interviewed pointed that one of the main indications for having a C-section is a previous C-section. That is, once a woman has a C-section, her following delivery will likely be a C-section as well. In addition, the doctors I interviewed informed me that Vaginal Birth after Caesarean (VBAC) is not commonly practiced due to the risk of complications such as uterine rupture. Hence, they argue that while the statement ‘you cannot have more than two babies with Caesarean’ is not entirely true, it is not recommended for women to have more than three C-sections. Following the same logic, if a woman’s first delivery is by C-section, this potentially might decrease the number of children she can give birth to. However, these interviewees were extremely uncomfortable that they were being accused of tricking their patients, given that their position on the issue was ‘medically’ warranted.

Whereas the AKP administration at times presented the C-section as a part of an ‘insidious plan’ to hinder population growth (‘Erdogan: Caesarean Is an Insidious Plan’, 2012) or a result of doctors’ obsession with ‘money, money, money’ (‘All They Care about Is Money’, 2012), their stance on this issue has consistently emphasised one crucial point: PM Erdogan, the Minister of Health, and the Minister of Family and Social Policies have repeatedly argued that one cannot have more than two babies with Caesarean (‘Erdogan: ‘No More than Two with Caesarean’, 2012). The argument is that C-sections limit the number of children a woman can give birth to, causing a concomitant decrease in population growth rates. In that context, perhaps it is not surprising that in 2012 the Turkish state implemented policies to collect medical records from hospitals to check whether the Caesarean sections were ‘necessary’. Turkey thus became the first country to attempt to ban elective C-sections; however, the attempt was not realised. It remains to be seen what regulations will emerge pertaining to the C-section in Turkey; however, as of 2014 there is no official ban on C-sections and the possibility of ‘electing’ to undergo it continues to be an option.

Nevertheless, the revival of pronatalism has brought new regulations and intervention in reproductive rights and practices. In order to gain a better understanding of this intervention, this article argues that we need to locate pronatalism in wider social, political and economic processes. In so doing, we can develop an analysis of reproduction as a domain in which competing ideas and discourses, as well as antagonistic class, ethnic and regional interests have come together and apart. Pronatalism, after all, manifests the ‘uneven and contested nature of the social terrain on which the politics of reproduction are played out’ (Ginsburg and Rapp 1995: 15). Paying attention to that ‘uneven and contested terrain’ is of utmost importance when the language of pronatalism is ‘seemingly’ universal and hails every woman yet no one believes this on everyday level. In Turkey, the government’s pronatalist discourse universally encourages every woman to have more children, without targeting any specific group. However, what we witness is that different actors in medical settings plurally and selectively interpret it. No matter what the ‘secret agenda’ of the state is, the revival of pronatalism has mostly been taken to signify a ‘demographic war’ (Inhorn 2006; Kanaaneh 2002; Yuval-Davis 1996), either targeting to ‘balance’ the perceived hyper-fertility of Kurdish people or increasing the number of conservative and Islamist voters. In the next section, drawing on the ways in which the government framed the problem of C-section rates, I delve into the particular case of problematisation of C-sections, elucidating how OBGYN specialists made sense of this intervention.

An ‘Anxious’ State: Ethnicisation of Pronatalism through C-section

‘The Turkish state got anxious [tedirgin],’ said Dr Ali, when I raised the question of the ‘at least three children’ mantra. According to him, ‘the state’ was aware of the danger of a ‘mushrooming’ Kurdish population, and what we have been witnessing is a politics that clearly aims to increase the number of ethnically Turkish people. This narrative surfaced during other interviews, underscoring the issue of differential fertility between Turkish women and Kurdish women. To make sense of this demographic concern, I would like to describe the ‘Kurdish problem’ in Turkey that has long been a constitutive tenet of Turkey’s societal and political dynamics.

Kurdistan, the homeland of Kurds, includes the southeastern and eastern parts of Turkey. Kurds are ‘one of the world’s largest and stateless ethnic groups’ (Ergin 2014: 324). They constitute an ethnically and linguistically distinct group and, according to a sur-
vey by a private organisation, more than thirteen million Kurds live in Turkey (KONDA 2010). Understanding the ‘Kurdish problem’ requires an understanding of the construction of modern Turkey as ‘a homogenous nation-state of Turkish speakers, and of the integral elite-led policy of cancelling, negating and suppressing the Kurdish ethnic identity in any shape or form’ (Gunes and Zeydanlioglu 2013: 7). Although the history of the conflict goes further back to the establishment of the Turkish Republic, the last three decades in particular have been marked by the ‘low-intensity’ war between Kurdish guerrillas and the Turkish army, which was also accompanied by forced migration of 3.5 million Kurdish people from their villages to urban centres such as Istanbul, Izmir, Ankara and Diyarbakir (Icduygu et al. 1999). In the cities where they relocated, Kurdish migrants have often found work in the informal economy, leaving them without benefits or regular wages (Saraçoglu 2011). Recent studies of Kurdish migrants have explored, first, how migrants face poverty, social exclusion and deprivation in the cities (Ayata and Yükseker 2005; Çelik 2005) and, second, how their presence in cities has stirred anti-migration sentiments which have converged with already-existing prejudices and stereotypes (Bartu Candan and Kolluoğlu 2008; Çeliker 2009). The population discourses surrounding the Caesarean section should be considered within this history of conflict and oppression of Kurdish people in Turkey. Although the ‘peace process’ has begun under the AKP rule, Turkey has yet to attain a democratic solution, and the interviews I conducted with some doctors reflected the deep-rooted stigmatisation of this ethnic minority.

For instance, Dr Ali, who works in a public hospital in Istanbul, has repeatedly argued that the C-section discussion should be seen as a part of the ‘Kurdish problem’. Warning me not to ‘lose track of the truth’, he claimed:

Caesarean section is a reflection of a problem that is social [emphasis mine], not medical. With all these Caesarean-section debates, the government is misdirecting the public … They make it seem like what they care about is C-section, however they do not. The problem is that the Kurdish population has been increasing with a great pace. They definitely have a higher fertility rate. That is what the Turkish government has in its mind.

Dr Ali here is referring to the ‘different demographic regimes’ present in Turkey (Koc et al. 2008). Because ethnicity-based national surveys are not conducted by the Turkish state, mother tongue and geography have been employed by scholars to approximate the fertility rates of different ethnic populations. Using mother tongue as a variable and based on the data from the 2003 Turkish Demographic and Health Survey, Koc et al. claim that ‘Turkish-speaking women will give birth to an average of 1.88 children during their reproductive years. The corresponding figure is 4.07 children for Kurdish women. Kurdish women will have almost 2 children more than Turkish women’ (2008: 449).

One other point that surfaced during the interviews is that the high fertility of Kurdish women is accompanied by low-rates of C-section. That is, not only are Kurdish women perceived to be ‘hyper fertile’ compared to Turkish women, but their C-section rate is lower than that of Turkish women. The available literature on the issue, although being scarce, offers a similar explanation. For instance, Seçkiner et al. and Tezcan (2010: 4) write:

Women in the West region have higher caesarean rates. On the other hand, in the East, women have been less likely to deliver their babies by Caesarean section … When mother tongue is taken into consideration, level of Caesarean section is prominently differentiated between women who speak Turkish and those speaking Kurdish. Accordingly, 45 percent of women who have reported their mother tongue as Turkish had their babies born by Caesarean section whereas this falls to 26 percent for Kurdish women regarding the results of most recent survey.

Most of the doctors I interviewed asserted that their Kurdish patients indeed resisted having a C-section, which at times put their lives and foetus’ lives in danger. For instance, Dr Derya who works in a public hospital argued that:

Those who are from the eastern and southern part of Turkey would always say that they were against the C-section. They think that we are trying to assimilate them. This even was the case before PM Erdogan started talking about this. They somehow know that with C-section the number of children they can have is limited. I mean, one can have, say six babies after a C-section, but we don’t recommend it because the risk increases with every surgery. So, to those people children mean everything and their purpose of life is to have more and more children … So they never wanted to have C-section. Even when I told them that the baby’s life was in danger, they did not want to have C-section.

On a similar note, Dr Haluk argues that:

The government cannot convince Kurdish women to have C-sections, no! They do not even want to go to hospital to insert IUDs because they think IUDs are bugs of the state to record their activities, let alone having Caesarean. The only thing the government can
According to Dr Haluk, it should not be the job of the rates, arguing, ‘These people don’t even assimilate!’ his own concerns about Kurdish women’s fertility to have. In a similar manner, Dr Haluk, raised uneducated to figure out the ‘correct’ number of chil-
alised Kurdish women by framing them as too faetà 2014), these medical professionals have margin-
parentheses 2002), further ethnographic research needs to be conducted with Kurdish women issue is to realise that if the population in the West increases, then it will balance the high rates of Kurds in the East’.7

It should be emphasised that what these medical practitioners contest is the idea of ‘convincing’ Turk-ish women to have at least three children. That is, even as they claim to ‘see what lies beneath’ the pronatalist discourse of the Turkish state, they also contend that ‘you cannot force women to have more babies’ as Dr Ali puts it. ‘They will have as many as they want’, he told me, ‘It is not Erdogan’s job to tell them to have more babies’. Although this narrative frees Turkish women from the ‘responsibility’ of ‘reproducing the nation’ and insists on their reproductive freedom, it still employs a stigmatising moral language that positions the fertility of Kurdish women as a kind of ir-responsibility.

Recent literature (Ayata 1997; Ergin 2014; Saraçoglu 2011) in Turkey draws attention to prevalent discourses that index Kurdish people with certain characteristics. For instance, Kurds are characterised as involved in illegal and informal activities, living in squatter settlements, and they are labelled ‘parasites’ (Ergin 2014). They are also accused of being uncul-
tered, uneducated and ignorant (Icduygu et al. 1999). As Saraçoglu (2011: 149–50) demonstrates, Kurds are seen as ‘separatist hate-mongers’. Ergin argues that there is an increasing overlap between notions of ethnicity and race in Turkey, and underscores that ‘Kur-
dish ethnic identity is in the process of acquiring racial characteristics’ (2014: 325). It should be noted that not all of the doctors I interviewed agreed with the dangers of a ‘mushrooming’ Kurdish fertility, yet narratives of those who did provide a clear vantage point from which to explicate formal and informal relations between biomedicine, ethnicity, gender and class in Turkey. Thus, while a small number of studies draw attention to the ethnic and gender-based discrimina-
tion in the medical settings in Turkey (Adato et al. 2011; Üstundağ and Yoltar 2007), further ethnographic research needs to be conducted with Kurdish women who receive reproductive healthcare.
Conclusion

The C-section has been theorised primarily as an example of a medicalisation process, which is intertwined with states’ medical policies and health-care systems. The literature has ample number of debates regarding the C-section’s effect on women’s health and emotional wellbeing, foetuses’ health and cost of healthcare (Davis-Floyd and Sargent 1997; Irwin and Jordan 1987; Rooks 1997; Shearer 1993; Wagner 2000; Wendland 2007). However, as this article tries to elucidate, when pronatalism has framed reproduction as an object to be regulated and intervened in by the state, a surgical procedure such as C-section might take on new meanings and significance.

In Turkey, it can be seen that this new meaning and significance revolves around the C-section’s emergence as an antinatalist procedure. The interviews I conducted pointed out that most doctors perceived the government’s intervention into the C-section as a manoeuvre to govern the population, addressing the ‘danger’ of declining fertility of Turks and ‘mushrooming’ Kurds. While all of them agreed that the rate of C-section is indeed high in Turkey and measures should be taken to address this issue, they stated this should be done in light of women’s well-being, not in light of implementing a population-control agenda. For instance, Dr Selin argued that the way the government portrayed C-section has had negative impacts on her medical practice and on her interactions with her patients. She said that ‘some women consider it almost as sterilisation. When I have to perform a C-section, it becomes difficult to convince those women on the necessity of the procedure’. On a similar note, Dr Tayfun said ‘I realise that I even refrain from mentioning the word C-section as much as I can. Even mentioning it harms the relationship; it eliminates their trust’.

The politicisation of the C-section as an antinatalist procedure has produced an array of discourses, truths and moral regimes that shape individuals’ subjectivities and reproductive policies. It reconfigures the C-section as an ensemble of discourses and medical practices. Investigating this ensemble enables one to see how pronatalism plays into medical practitioners’ language while at the same time revealing the language of ethnic difference that has constructed Turkish and Kurdish women in particular ways. It also needs to be underscored that there is a very fine line between choice and coercion, illegality and inaccessibility, self-monitoring and monitoring by the state. What this article indexes is that the revival of pronatalism has imbricated the C-section – whether having, performing, electing or resisting it – with relations of power and hierarchies of ethnicity, class and gender. The ethnography and discussion presented here should be understood to flag the need to explore how and with what consequences women from diverse social and political groupings, such as Kurdish, Turkish, secular, religious, lower- and upper-class experience the demographic shift and revival of pronatalism.

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Notes

1. Hereafter referred to as OBGYN.
2. This article has been written as a result of the preliminary research that I conducted in the summers of 2013–2014. While I was given permission to interview the doctors working at private and public hospitals, I did not receive approval from the ethical boards of the mentioned hospitals to conduct ethnographic research with women visiting these settings. Hence, no female patients were interviewed at the time of writing this article and their voices cannot be given space here. In my dissertation research, I hope to address this gap and bring their voices into the literature.
3. Hereafter referred to as C-section.
4. According to the Turkish constitution, any citizen of the Turkish state is by definition a ‘Turk’. This is translated into English as being ‘Turkish’. However,
the term ‘Turk’ has nationalist connotations, as it might imply ‘blood bond’ and ethnicity. Therefore critical citizens prefer to use the term ‘Türkiyeli’, which might be translated as ‘the one from Turkey’. The term ‘Türkiyeli’ does not have an English translation, causing the term ‘Turkish’ to be the only option in English to refer to citizens. It is crucial to highlight that Turkey has Kurdish, Arab, Jewish, Circassian, Armenian and other populations. In this study when the term ‘Turkish’ is employed to refer to citizens, it is meant to imply ‘Türkiyeli’, the one from Turkey.

5. A review of literature shows that Turkish OBGYN specialists publish about the safety of VBAC and advocate for it, on the condition that proper care and follow-up will be provided. See Akçay et al. (2001), Gözükar and Eroğlu (2011), Ílge (2004), Kaplanoglu (2014). However, most of the doctors I interviewed repeatedly said that one should refrain from vaginal birth after Caesarean section.

6. The Turkish state does not collect data on ethnicity; this is why the percentage of Kurdish population varies depending on the data source. See Koc et al. (2008).

7. I would like to emphasise that due to the massive forced migration, the strict distinction between the ‘east’ and ‘west’ has blurred. Although ‘the east’ refers to those cities in Kurdistan (the term ‘Kurdistan’ is not acknowledged by most Turkish people), the cities in the ‘West’ have high Kurdish populations to the extent that Istanbul, perhaps the ultimate signifier of the ‘West’, is currently the city with the biggest Kurdish population in Turkey.

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