SINGLE WOMEN'S EXPERIENCES OF SEXUAL HEALTH SERVICES IN TURKEY: IDEOLOGY, POLICY PRACTICES AND RECOMMENDATIONS

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ABSTRACT

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The virginity of single women is a valued construct in Turkish society. The current authoritarian and conservative political environment can contribute to the notion that women are allowed to experience sexuality only within the institution of marriage. This study aims to analyze the connection between educated and middle-class single women's experiences in sexual and reproductive health services with the construction of women's sexuality and current sexual health politics in Turkey. For this reason, semi-structured in-depth interviews are conducted with 11 married and 11 single women, along with 5 experts that work in sexual health. This research indicates that single women cannot effectively benefit from sexual and reproductive health services due to disapproval of their sexual activity as single women. Their needs can be neglected, and they can be discriminated against by health staff. Moreover, structural problems in state hospitals can negatively impact their experiences in sexual and reproductive health services. In response to those obstacles, single women provide their own strategies, such as forming information networks and increasing their sexual health knowledge in order to improve their sexual and reproductive health. According to these findings of the study, policy recommendations and new services were suggested in order to improve the sexual and reproductive health of single women.

Keywords: Sexual and reproductive health, single women, virginity, healthcare system

ÖZ

TÜRKIYE'DE BEKAR KADINLARIN CİNSEL SAĞLIK HİZMETLERİ İLE İLGİLİ DENEYİMLERİ: İDEOLOJİ, POLİTİKA UYGULAMALARI VE ÖNERİLER

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Bekar kadınların bekareti Türkiye'de değer verilen bir yapıdır. Mevcut otoriter ve muhafazakar politik ortam kadınların cinselliği yalnızca evlilik kurumu içinde deneyimlemesine izin veren kavrayışa katkıda bulunabilmektedir. Bu çalışma eğitimli, orta sınıf bekar kadınların cinsel sağlık ve üreme sağlığı hizmetlerindeki deneyimleriyle Türkiye'de kadınların cinselliğinin inşa edilişi ve mevcut cinsel sağlık politikaları arasındaki bağlantıyı analiz etmeyi amaçlar. Bu amaçla 11 evli ve 11 bekar kadın ile cinsel sağlık alanında çalışan 5 uzman ile yarı yapılandırılmış derinlemesine görüşmeler gerçekleştirilmiştir. Bu araştırma, bekar kadınların, bekar kadın olarak cinsel aktivitelerinin onaylanmaması nedeniyle cinsel sağlık ve üreme sağlığı hizmetlerinden etkin bir şekilde yararlanamadıklarını göstermektedir. İhtiyaçları ihmal edilebilir ve sağlık personeli tarafından ayrımcılığa maruz kalabilirler. Ayrıca devlet hastanelerindeki yapısal sorunlar, onların cinsel sağlık ve üreme sağlığı hizmetlerindeki deneyimlerini olumsuz etkileyebilmektedir. Bu engellere karşılık olarak, bekar kadınlar cinsel ve üreme sağlıklarını iyileştirmek için bilgi ağları oluşturmak ve cinsel sağlık bilgilerini artırmak gibi kendi stratejilerini oluşturmaktadırlar. Çalışmanın bu bulgularına göre, bekar kadınların cinsel ve üreme sağlığının iyileştirilmesine yönelik politika önerileri ve yeni hizmetler önerilmiştir.

Anahtar Kelimeler: Cinsel sağlık ve üreme sağlığı, bekar kadınlar, bekaret, sağlık sistemi

To all neurodivergent researchers in academia

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LIST OF ABBREVIATIONS

AKP	Justice and Development Party
EU	European Union
ICPD	International Conference on Population and Development
IUD	Intrauterine device
LGBTI+	Lesbian, gay, bisexual, transgender, intersex and plus
KETEM	Caner Early Diagnosis Screening and Training Centers
MDG	Millenium Development Goals
MERNIS	Central Population Management System
METU	Middle East Technical University
NGO	Non-governmental organization
SDG	Sustainable Development Goals
STI	Sexually Transmitted Infections
WHO	World Health Organization
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
US	United States

CHAPTER 1

INTRODUCTION

Are you married or single? That is a question that women are familiar with if they ever consulted to sexual and reproductive health services in Turkey. Indeed sexuality, especially the sexuality of single women is taboo in Turkey. Sexuality is taboo, and moral codes and the concept of honor dictate the norms of sexuality (İlkkaracan, 2008). These codes and concepts are the product of culture, religion, conservatism and modernization in Turkey. In this interlink of constructs, the norm around sexuality also depends on who experiences it. For example, heterosexism and discrimination towards LGBTI+ people are very common in the world. However, in the specific case of Turkey, sexually active single women also belong to the group of the ones that are oppressed the most through those social norms since the chastity and purity of women are seen as the determiner of the honor of the family directly.

The norms on sexuality in Turkey have been reproduced and fueled by government policies and discourses to ensure the regulation of sexual behavior. The government has been encouraging motherhood for women through investment in fertility clinics and discourses like "at least three children", "strong family, strong society", "children are blessings" and that "each abortion is Uludere" (Cindoglu & Unal, 2013, 2017). On the other hand, the sexual activity outside of marriage as something degrading for women and as a danger to order has been emphasized many times by politicians (Cindoglu & Unal, 2013). When the sexuality of women is denounced this much, not by only the public but also the state, how do women, especially single women, who are sexually active reach to necessary services when they need them?

The regulation of female sexuality and women's bodies in Turkey may lead to shaming the women for being sexually active and limiting the services that are available to them. In this case, there is a need to investigate how much this regulation and control of female sexuality reflects on the services state or private market provides. Among these services, reproductive and sexual health care is the one that can be directly related to the way women's sexuality is constructed in Turkey. Thus, exploring the regulation and realization of these services for

sexually active single women can explain the state's position on female sexuality and its impact on women.

The goal of this research is to analyze how the conceptualization of women's sexuality in Turkey that is shaped by the culture of honor and current policies and discourses affect educated middle-class single women's experiences of sexual and reproductive health experiences and the obstacles that they encounter while benefitting from these services. Twenty-two educated, middle-class women between the ages of 25 to 30 and who had accessed sexual and reproductive services in Ankara were interviewed. Additionally, 2 family physicians, 2 gynecologists, and 1 Non-governmental organization (NGO) worker who worked related to sexual and reproductive health in Ankara were interviewed to get an expert view. Interview structures were designed as semi-structured in-depth interviews.

1.1. Research Questions

In the light of the concerns that I have mentioned, the main aim of the research is to find answers to the listed questions.

1. How do policies, regulations, and discourses related to sexual health care affect the educated, middle-class single women's experiences of gynecology services in Turkey?

2. How do the meanings are given to virginity and female sexuality in Turkey affect the experiences of educated, middle-class single women in sexual and reproductive health services?

3. What is the impact of the current healthcare system on sexual and reproductive health services?

4. How do educated, middle class women create their own strategies and solutions to get the services they need in sexual and reproductive health?

1.2. Assumptions of the Research

In the design process of this research, few assumptions are employed to be studied. The first assumption is that physicians and other health staff could be socialized to disapprove of single women's sexual experiences in Turkey and that they might reflect their approach onto their patients in service interactions.

The second assumption is that sexuality and sexual health are taboo in Turkey, especially for single women. I considered that women might struggle to talk with physicians and other health staff regarding their issues on this topic and the characteristics of their communication with physicians can affect their service interaction. Moreover, I assumed that educated and

socioeconomically advantaged women might be more willing to talk to me as a researcher as we would have similar experiences.

Another argument is that the capacity issues in state hospitals could have a unique impact on sexual and reproductive health services due to the taboo nature of the field. The crowdedness and possible inadequacies in equipment and material supplies can disrupt the services, and private health institutions that do not have these challenges could assist with better quality.

Lastly, lack of sexual health education in Turkey could lead to the submission of patients to the expert knowledge of physicians and search of alternative sources of gaining sexual health information. Additionally, I assumed interviewees would develop their own solutions to any problems they might experience during sexual and reproductive health service provision. As a result, these arguments and assumptions were incorporated into both literature review, the selection process of participants, and interview questionnaires to guide the research.

1.3. Definitions

In this research, frequently used terms such as virginity, sexuality, and LGBTI+, which can have vague or unclear definitions, are explained in this section. The explanations for these terms can vary; thus, I provided the definitions I utilized in this study.

Virginity: Virginity is seemingly a straightforward or self-explanatory concept. However, the meanings behind this concept are more complicated. Mernissi relates the construct of virginity to intact hymen of women (1982). Similarly, Cindoğlu states that the intact hymen is the proof of virginity in Turkish society (1997). On the other hand, hymen might not be an indicator of never having had sex and virginity. Not all women have a hymen, or hymen does not break in every penetrative sex. Moreover, if the virgin is constructed as a person who never had sex, then the definition of what constitutes sex is brought to a discussion (Ergün, 2006). In this thesis, I will use the term virginity in the heterosexist and misogynist way that it is defined in Turkey, similar to Ergün's work (2006). The reason for that is to use the term the same way that gynecologists or other health staff would use it. Consequently, a virgin is referred to as a woman who has never had vaginal penetrative sex in this thesis.

Sexuality: Due to the uniqueness of sexual experiences and what can be defined as sexual can be vague and need further clarification. In this thesis, I have used the definition used by World Health Organization (WHO).

> Sexuality is a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can

> include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors. (WHO, 2006, 5)

LGBTI+: LGBTI+ is the abbreviation of lesbian, gay, bisexual, transgender, intersex and + which represents other sexualities such as asexual, queer, pansexual and so on. The ways to experience sexuality, sexual and/or romantic attraction are various. Moreover, diverse gender identities exist outside of binary women and men identities. I use the term LGBTI+ to represent all sexual and gender identities that do not conform to heterosexist sexual and/or romantic attraction and/or binary genders.

1.4. Significance and Contributions

Most importantly, this research is a pioneering academic work that investigates the experiences of single women as a potentially vulnerable group that could face challenges in benefitting from sexual and reproductive health services in Turkey. Although virginity or sexual misconduct that leads to punishment of women in Turkey has been researched, problems in sexual and reproductive health interactions were not studied and evaluated as a form of punishment for sexual misconduct. Moreover, studies on social sciences that assess patient-physician interactions, specifically in sexual and reproductive health experiences in Turkey are limited. Furthermore, the direct impact of not only policies but also discourses employed by the government on sexual and reproductive health practice is demonstrated in this study.

In addition to the effect of the construction of single women's sexuality in Turkey, this research provides how the structural issues in state hospitals and privatization of health care reflect on the sexual and reproductive health services. The inclusion of the structural problems into this thesis could provide a holistic picture of issues in sexual and reproductive health service provision and possible inequalities in accessing those services.

Lastly, the women's agency and coping mechanisms in dealing with obstacles while accessing sexual and reproductive health services are explained through a feminist perspective. The inclusion of women's solutions can contribute to tackling the issues that prevent them from utilizing those services and provide action-oriented results.

1.5. Structure of the Research

This thesis consists of seven chapters. In the second chapter, I explain both the existing literature and theoretical background that affects women's sexual and reproductive health experiences. I began explaining the emergence of the concept of sexual health and right and

the global policies in sexual and reproductive health chronologically. In the following sections, policies and newly introduced services in sexual and reproductive health in Turkey until the end of the 2000s are explained in relation to the developments in the global policy agenda and democratization process in Turkey. This section is followed by how socially and culturally, women's sexuality and virginity are conceptualized in Turkey, along with the state's position on the matter and experiences of women with their own sexuality. In the fourth section of the second chapter, the current government's conservative politics and discourses that oversee women's reproduction and sexuality are evaluated. Finally, the reflection of ever existing control of women's sexuality and the politics and discourses of the government in the last decade on policies and services in sexual and reproductive health will be explained.

In Chapter 3, the methodology of this research is explained. The obstacles and limitations that I faced while conducting this research, my position as a researcher, the selection of participants, and the methodological approach to this study are all explained in this section to provide more insight into the characteristics of this research.

Chapters 4, 5, and 6 are the chapters in which the results of the interviews are analyzed. In Chapter 4, I provide details of how the current structures of state hospitals and privatization of health care influence the service provision of sexual and reproductive health. I explored in detail how the cultural and social norms and current conservative policies in sexuality and reproduction of the government affect the sexual and reproductive health service interactions between single women and health staff in Chapter 5. Lastly, the women's response and coping mechanisms that form a women's solidarity in a taboo and forbidden topic in Turkey are analyzed in Chapter 6.

The concluding remarks and summary of the results of this research are provided in the last chapter. The policy recommendations in sexual and reproductive health are provided in response to the findings of this study in this last chapter. Additionally, I lay out the contribution and uniqueness of this research in the final part of this chapter.

CHAPTER 2

LITERATURE REVIEW

Sexual health is a specific branch of health and health care that intersects complex issues such as income inequality, stigma on sexuality, religion, and misogyny. In that sense, it is not only affected by health policies or funding models of government for health care but also population policies, gendered policies, construction of sexuality and hegemonic ideology in that specific country, as well as global policies in sexual and reproductive health.

In the following sections, I will lay out the topics that can impact sexual and reproductive health services in Turkey and women's relation to sexual health services. In the first section, I will explain the progress of global policies and the development of the field of sexual and reproductive health from mere population concerns to an issue of individual rights. After that, I will demonstrate the effect of the rights-based approach and funds on sexual and reproductive health services in Turkey, which has been effective until the 2010s. Before moving onto the current state of sexual and reproductive health services in Turkey, I will explain how women's sexuality is conceptualized along with the importance given to virginity in the third section. Fourth section covers ongoing discourses and policy environments that shape 'politics of intimate' and modes of control of women's sexuality. Lastly, the state of sexual and reproductive health services in Turkey in the last decade is mapped out.

2.1. Global Policy in Sexual and Reproductive Health

In the global policy arena development of concepts and definitions are relatively recent in sexual and reproductive health. Since the first definition of WHO in 1975, the purpose of sexual health evolved and expanded in relation to the global policy arena and emerging needs in sexual and reproductive health, such as advocacy efforts of women and LGBTI+ right groups, HIV/AIDS epidemic, and increasing population (Coleman & Edwards, 2004). The most inclusive definition of sexual health was published in 2006, whereas sexual rights were fully defined in 2010 by WHO (WHO, 2006, 5; WHO, 2010, 4). According to the latest WHO definition, sexual health is as follows:

> …a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO, 2006, 5).

In order to fully understand what this definition entails, the definition of sexual rights should also be visited. According to WHO, sexual rights involve "application of existing human rights to sexuality and sexual health" (WHO, 2010, 4). Some of those rights would be,

> …rights to life, liberty, autonomy and security of the person; the rights to equality and non-discrimination; the right to be free from torture or to cruel, inhumane or degrading treatment or punishment; the right to privacy; the rights to the highest attainable standard of health (including sexual health) and social security; the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage; the right to decide the number and spacing of one's children; the rights to information, as well as education; the rights to freedom of opinion and expression; and the right to an effective remedy for violations of fundamental rights. (WHO, 2010, 4).

In light of these definitions, not only the sexual health should address medical interventions and introduce preventive measures but should also seek to eliminate inequalities and power relations concerning sexual relations. The definition of sexual health remains ambitious. On the other hand, the practices to realize that for each individual might fall behind these ambitions, which I should illustrate in the following paragraphs.

Sexual health started to be included in the global policy agenda firstly when population control emerged as a common need of governments, which raised the concern on contraception; however, its importance peaked especially with the HIV epidemic. In the first United Nations (UN) Population Conference in Bucharest in 1974 due to a successful collaboration of the developing world, issues in front of slowing the population growth were raised, including power relations between the developed and developing world and the lower status of women (Joachim, 2007). Along with the efforts of organized women health activists, sexual health issues of women, especially in the developing world, were brought to the attention of global policymaking (Joachim, 2007). The conference focused on the link between development and population trends, promoting individual's informed choices on family planning and ensuring the presence of medical professionals wherever needed (United Nations, n.d., b) UN Population Conference in Mexico City in 1984 was not favorable for family planning as the United States (U.S.) declared withdrawal from providing fund to family planning and called for avoiding abortion (Joachim, 2007).

International Conference on Population and Development (ICPD) in Cairo in 1994 has been a pioneer for the advancement of reproductive and sexual health and reproductive rights. The conference's outcome opened up a rights-based approach to population issues to what has been previously discussed as demographic and developmental issues and recognized sexual and reproductive rights as essential human rights (United Nations Population Fund 2014; Willis & Yılmaz, 2020). In that sense, a broader concept of reproductive and sexual health that empowers individuals for their own informed decisions and provides the necessary services for their needs and informed decisions has been made a global policy target (United Nations Population Fund, 2014). The action plan specified in ICPD in Cairo emphasized the public sector's role in delivering those reproductive and sexual rights to citizens (Willis & Yılmaz, 2020). Since ICPD in Cairo in 1994, there has been a steady support for rights-based approach for sexual health in global agenda by efforts of feminist and LGBTI+ activists; however, opposing voices that condemn pro-choice arguments in reproductive and sexual health policy has been active as well (Joachim, 2007; Willis & Yılmaz, 2020). Especially the Vatican, along with faith-based groups, political Islamist and African states, placed themselves on that side of the policy approach regarding reproductive and sexual health (Joachim, 2007; Willis & Yılmaz, 2020). The opposition to rights-based regarding reproductive and sexual health policy is essential to show as global policy dynamics can affect the policy position of Turkey along with the extent of support that UN other international organizations can provide for reproductive and sexual health services.

The progress of reproductive and sexual health policy continued after the ICPD in 1994. Millennium Development Goals (MDG) that the UN introduced in 2000 aimed to mobilize global solutions to global problems such as poverty, hunger, environmental issues, health and well-being issues, and gender inequality. MDG 5: Improve maternal health that includes targets that are "Target 5. A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio" and "Target 5. B: Achieve, by 2015, universal access to reproductive health" were goals and targets added for improvement of reproductive and sexual health (United Nation, n.d., a). MDGs were criticized for falling short of incorporating the action plan of ICPD in 1994 by focusing on the only maternal health aspect of reproductive health. Target 5 B was added later in 2007 to include other aspects of reproductive and sexual health, and the success of the target was measured by indicators on "contraceptive prevalence rate, adolescent birth rate, antenatal coverage, and unmet need for family planning" (Boulanger & Yamin, 2014). Nevertheless, targets for MDG Goal 5 could not be fulfilled, and the need to monitor broader definition of reproductive and sexual health services such as addressing the need for contraception, adolescent and young people's reproductive and sexual health needs, the effect

of gender inequality and gender-based violence on reproductive and sexual health became evident (Khosla, Say & Temmerman, 2014).

Sustainable Development Goals (SDGs) introduced in 2015 and followed MDGs have been more inclusive of sexual health and reproductive rights. Target 3.7 "By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes" and Target 5.6 "Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action and the outcome documents of their review conferences" are the targets for the advancement of the reproductive and sexual health services. Despite sexual rights being defined clearly and incorporated as a precondition for maintaining sexual health, SDG indicators or targets do not explicitly include sexual rights. As Logie defends, the wording of sexual rights not being mentioned is political and can lead to the omission of support to some reproductive and sexual health services such as consultation on improving sexual pleasure or neglect of rights of LGBTI+ people and sex workers (2021). It can also create loopholes for the states that are not supportive of the sexual rights of certain groups. For instance, considering Turkey, in which monogamous heterosexual marital sex is the norm, the needs, and rights of other groups such as LGBTI+ people, single sexually active people, or sex workers can be neglected.

Despite shortcomings mentioned here, the rights-based approach continues to be influential in the global policy of reproductive and sexual health policy. Nairobi Summit in 2019 once again emphasized commitment to sexual reproductive health and rights and addressed gender inequality, sexual and gender-based violence, prevention of maternal deaths and access to safe abortion, access to contraceptives, needs of adolescents and youth (United Nations, 2019).

In this context, global policy on reproductive and sexual health has been progressing towards a rights-based approach, despite the setbacks and shortcomings of commitment in implementation and/or monitoring of the realization of sexual rights due to the presence of objecting voices from politically Islamic or Catholic states and faith-based organizations. The reflection of this shift towards individuals' rights can be seen in sexual and reproductive health services in Turkey, primarily until the end of the 2000s. In the following section, I will explain the new services that are introduced in this era.

2.2. The Progress of Reproductive and Sexual Health Services in Turkey until the 2010s

In this section, I will explain the past and current policies and implementation of reproductive and sexual health in Turkey by referring to previous research and reports, guidelines and policy documents published by the Ministry of Health and ministries' consulting institutions.

After the foundation of the Turkish Republic, the first approach to reproductive health was to adopt a pro-natalist population policy due to drastic population decline caused by long-lasting wars, disease, and loss of land (Karaca Bozkurt, 2011). Pro-natalists policies that prohibit the use of contraceptives and abortion that is punishable by prison sentence have been effective from 1926 to 1965. The sentence for abortion has been increased with changes in the law in 1936 and 1953, and abortion was framed as a crime against the nation by being listed in the title "Felonies Against the Integrity and Health of the Race" in 1936 (Karaca Bozkurt, 2011). Additionally, monetary incentives and exemption from the tax were introduced for each additional child throughout those years (Karaca Bozkurt, 2011). Maternal and Infant Health services started to be delivered in 1952 with the establishment of the Directorate of Maternal and Infant Health (Çakmak & Şimşek, 2019). It is important to note that the marriage age for women was decreased to 15 and for men to 17 in 1938 to encourage population growth (Türk Kanunu Medenisinin 88inci Maddesini Tadil Eden Kanun, 1938). Evidently, prohibiting all contraception and abortion, allowing child marriage, and framing abortion as a crime against the nation meant women did not have control over their own reproductivity, and their reproductivity was instrumentalized for the country's development.

With the shift in global policy agenda towards anti-natal population policies, the conceptualization of rapid increase in population as an obstacle to development and research that indicate ban on all contraception and abortion resulting in increasing number of maternal mortalities caused changes in policies on reproduction (Karaca Bozkurt, 2011). In 1965, Law No. 557 on population planning was introduced, allowing the use, application, and sale of contraceptives, informing the public on contraceptives and abortion or surgical sterilization in the presence of medical indications (Turkey | Law on population planning, 1965). In this first period of switching to anti-natalist policies until the 1980s, reproduction was added to biology classes, IUDs were provided free of charge, other contraceptives could be bought, and mobile teams were established for informing the public on contraception and application of IUDs free of charge (Akın, 2007). These newly introduced family planning services were funded by the Ministry of Health, the U.S. Agency for International Development and other foreign funds (Akın, 2007).

Despite increased contraception use, abortion rates were high, and contraception users mainly used ineffective traditional methods after the changes in the law in 1965 (Akın, 2007). Due to

advocacy efforts and scientific research that call for change in the law, The Law on Population Planning No. 2827 was introduced in 1983. With that change, abortion was legalized until the 10th week of pregnancy and sterilization on demand (Turkey | Law on population planning, 1983). Trained health staff was authorized to apply intrauterine devices (IUD), and trained general practitioners were permitted to perform abortion. Additionally, collaboration with different sectors on improving family planning services was included in the law. With these additional changes, women were able to access abortion and different contraceptives more freely. The number of abortions decreased after an initial increase, complications due to abortions decreased, and the use of effective contraceptive methods increased as the result of policy changes (Akın, 2007).

Another wave of new services emerged after ICPD, which shifted the focus of reproductive health from population concerns and maternal health to women's health and a more comprehensive reproductive and sexual health approach that also covers topics like sexually transmitted infections (STIs) (Akın, Akın & Özvarış, 2004). From 1994s, series of actions are taken from publishing ''Women's Health and Family Planning Strategic Plan'' in 1995 that reflects the adoption of ICPD Programme Action to reproductive and sexual health needs in Turkey and forming of The Family Planning Advisory Board, later revised to be Women's Health and Family Planning Advisory Board that coordinates the cooperation of different sectors for ICPD goals (Akın, Akın & Özvarış, 2004). Injectables and implants were introduced in 1997, national service guidelines were developed and disturbed to all primary health care centers in 1994, safe motherhood programs were started in eight pilot provinces with the support of NGOs, United Nations Population Fund (UNFPA) and United Nations International Children's Emergency Fund (UNICEF), post-partum and post-abortion family planning programs were introduced, primary health care centers were converted to Family Health clinics that provide reproductive health services in 1995 (Akın, Akın & Özvarış, 2004). Additionally, involvement of men in reproductive health was encouraged through information, education, and consultation programs (Akın, Akın & Özvarış, 2004).

Most of these initiatives in reproductive and sexual health were carried out with the support of international institutions and funding agencies that include the US Agency for International Development (USAID) and UNFPA (Akın, Akın & Özvarış, 2004). Support by these international agencies has been essential as it affected the prioritization of the budget of the Ministry of Health. Moreover, NGOs in Turkey typically have limited financial capacities and could not participate in large scale service provision in the absence of these international funds (Akın, Akın & Özvarış, 2004). Consequently, once the funds were withdrawn, most of the programs introduced were not sustained and remained as pilot applications. Additionally, the

political shift in Turkey is not without its effect on the continuation of reproductive and sexual health programs that focuses on individual needs rather than demographic targets.

The improvement of rights-based reproductive and sexual health services continued in the first decade of the 2000s. Turkey's reproductive health program that emerged as a collaboration project between the Ministry of Health and the European Commission was implemented between 2003 and 2007. The program was aimed at capacity building in reproductive and sexual health areas in which standards documents that specify service provision in reproductive and sexual health care and national strategic plan of sexual and reproductive health for 2005-2015 were its essential products (Willis & Yılmaz, 2020). The standard document lays out the rights of beneficiaries and responsibilities of service providers in sexual and reproductive health care along with standards services compatible with ICPD Program Action. Standards are listed under seven sections: primary sexual and reproductive health, safe motherhood, family planning, STIs-HIV/AIDS, sexual and reproductive health of youth, other sexual and reproductive health topics, and intersectional topics. The progress of sexual health policies towards comprehensiveness and inclusiveness can be seen in the inclusion of STIs-HIV AIDS and sexual and reproductive health of youth in the main subjects, along with the following statement; "Discrimination based on sex, marital status, fertility, nationality, ethnicity, social class, religion and sexual preference or social obstacles should be prevented in accessing services." (Ministry of Health-Turkey, 2007a, 3).[1] The sexual preference (even if it might be inaccurate to include LGBTI+ people) and marital status being included in the document is important as the aim is to prevent the negative effects of discrimination in sexual and reproductive health service interactions based on sexual experiences not considered the norm in Turkey.

In the national strategic plan for sexual and reproductive health, problematic areas are defined which are the increase in maternal deaths, increase in unwanted pregnancies, increase in STI/HIV/AIDS infections, poor sexual and reproductive health in youth, and regional and locational inequalities (Ministry of Health, 2010a). Throughout the document, social factors of the healthiness, role of gender, and sexual and reproductive health services as rights were emphasized and included under priority areas. There are also mentions of sex workers as a target group for STI services, participation of men within family planning and other sexual and reproductive health decisions, and women's empowerment within the document. Thus, the document paints out a picture of the policy environment that focuses on rights-based sexual

[1] Hizmetlere ulaşmada cins, yaş, evlilik durumu, doğurganlık, milliyet, etnik köken, sosyal sınıf, din ve cinsel tercih gibi konularda ayrımcılık, ya da sosyal engel bulunması önlenmelidir.

and reproductive health and addresses social factors, even if there is no mention of the needs of LGBTI+ people or disabled people.

As strategic documents indicate, improvement of sexual and reproductive health of youth was included in newly introduced services. Youth counseling and health centers were established, and training on youth's reproductive and sexual health was delivered to the staff of these centers (Ministry of Health, 2007b). Guideline for participants of these training presents a comprehensive approach to reproductive and sexual health by addressing sexual and reproductive rights, right to consensual and satisfactory sexual life, the validity of pre-marital sex, the importance of communication in institutions regarding sexual and reproductive health, gender inequality in sexuality and sexual health, social norms, stereotypes and sexual violence. The issue of sexual orientation and discrimination was repeated in few sections, sexual orientation was explained, and heterosexism and homophobia were addressed by emphasizing that patients' sexuality or partners should not be assumed and all sexual identities should be respected. In this program, 67 youth counseling and health centers were formed and had been still active in 2007 (Willis & Yılmaz, 2020). In addition to other strategic documents, guidelines for participants of STI and introduction to reproductive health training were both published in 2009 in which health staff was not only informed in medical applications but also rights of patients and guidance on communication with patients (Ministry of Health, 2009a, 2009b). These developments in sexual and reproductive health signal the inclusion of rights-based sexual and reproductive health services that is in line with global policy direction.

There has been a gradual improvement of sexual and reproductive health services from the first shift to anti-natal population policies from the 1960s until the 2010s. The effect of ICPD and the presence of international funds along with academic and NGO advocacy efforts contributed to these improvements and rights-based approaches to sexual and reproductive health. However, there has been a clear change in sexual and reproductive health policies, which is in line with the government's general neoconservative and neoliberal social policy direction, especially after the 2010s. In the following section, I will explain how women's sexuality is conceptualized in Turkey historically. Then, I will explain the discourses and policy direction in Turkey in the last decade, along with the reflection of these policies onto sexual and reproductive health practices.

2.3. Women's Sexuality and Importance Attained to Virginity in Turkey

Sexual and reproductive health is a unique branch of health that is not only affected by the institution of medicine or health policies. Sexuality, a highly contested area, directly affected by multiple power structures such as patriarchy and heterosexism, affects sexual and reproductive health policies and practices, as I aim to demonstrate in this research. This

intersection with sexuality obligates painting the picture of how sexuality of women is constructed and which mechanisms sustain and control it in Turkey.

2.3.1. The Construction of Women's Sexuality in Turkey

Turkey is a secular state despite the fact that the majority of the population is considered Muslim. It has an ongoing history of modernization that dates to the 19th century of the Ottoman Empire, and secularization of the state was one of the outcomes of modernization of the newly founded Turkish Republic. The modernization project granted rights to women such as equality in marriage, ban of polygyny, employment, right to vote and be elected. However, these rights were not solely granted because of the ongoing women's rights movement but for signifying and sustaining the secularization and separation from the Islamic Ottoman Empire (Kandiyoti, 1997). There was a women's rights movement during the foundation of the Republic; the Women's People Party was founded by Nezihe Muhiddin, which advocated for women's rights. However, further advancing women's rights were deemed redundant within Kemalism once the equality in marriage, politics, and employment in law was maintained and the Women's People Party was transformed into the Turkish Women's Union (Parla, 2001).

Women were placed in the center of this modernization by representing secularism and the new modern Turkish society. Turkish women abandoned the veil and were encouraged to participate in public life as long as they remained modest and protected their chastity (İlkkaracan, 2008). As Kandiyoti suggests, new nationalist modern women could participate in public life only when they act with total abandonment of sexuality and femaleness (1997). Even when the emancipation of women has been incorporated in law, women had to follow certain rules of socializing in order to be allowed into public spaces. Thus, this new image of modest nationalistic chaste women allowed the transformation of the mode of control of women's sexuality.

Rules that women had to follow to claim space in public debates were shaped by concepts such as honor, chastity, or purity that maintain public morality and control of women's sexuality in the absence of veil or gender segregation (İlkkaracan, 2008). Honor as an umbrella term is particularly important in its connection to women's sexuality and how it is perceived and controlled in Turkish society. Honor (*namus*) is a concept that is directly tied to how women should behave (Sev'er & Yurdakul, 2001). Honor draws the boundaries for women's behavior, especially behavior that is considered sexual. In that sense, having pre-marital sex can be considered to bring dishonor and shame but also meeting with a man without a chaperone can also be a dishonorable behavior (Sev'er & Yurdakul, 2001). Women's honor and dishonor do not only consider themselves but it is directly tied to the honor of all family (Ozyegin, 2009). Consequently, women are responsible for obeying the honor code to keep

their and their family's honor. This linkage to the family's honor also means male relatives such as brother, husband, or father are responsible for protecting the honor (Sev'er & Yurdakul, 2001). Consequently, protecting honor becomes the justification of controlling the women's behavior that is considered sexually immoral.

Even if the definition of women's behavior that are categorized as dishonorable can be unclear, one certain precondition is the virginity of unmarried women. According to Mernissi, a woman's virginity becomes a concept directly related to the honor of men who are related to that woman by blood or marriage, and women only become the object of it (1982). Whether a woman had sex before marriage or not becomes the symbol of the status of the man that marries her (Mernissi, 1982). The linkage between the honor of men and women's behavior can be even more important to men's honor than any behavior of men that might stain his honor (El Saadawi, 1980). This claim also explains the practice of pressuring men who had sex or raped a woman to marry her so 'her honor can be saved'; that is, she would not have to find another man who is willing to accept this shame brought onto himself. As Pitt-Rivers explain, honor and shame are linked in the sense that shame is felt and brought onto the men of the family when women act dishonorably (1965). Nevertheless, it should not be forgotten that even if honor might seem like a struggle between men, rarely are men involved punished. As Yurdakul and Sev'er demonstrate in honor killings, usually men involved in sexual impropriety and bringing dishonor and shame to the woman's family are not the target of murders, and the only woman involved is killed by family members and relatives (2001). The exception when men are punished for improper sexual behavior would be when they are believed to be in homosexual relationships, as the murder of Ahmet Yıldız for the honor by his father would prove (Arat & Nuňez, 2017).

Sexual misconduct and honor's relation to pre-marital sex concerns only women's behaviors. A man who had pre-marital sex does not bring shame to his family. Interestingly, religion prevents both sexes from having sex before marriage and does not make virginity of women the status of the related men, but "patriarchal morality" tasks only women with such duty (Mernissi, 1982). One important thing to emphasize is that some women should break the rule for men to have sex outside of marriage. Thus, in this case, men want the impossible; women to have sex before marriage and virgin women to marry. In this context, having sex becomes a degrading experience for women (Mernissi, 1982); if they had sex, they have less value while men who had sex outside of marriage are praised as he convinced a woman to take that risk to have sex with him. Thus, the act of having sex produce different status for men and women.

The transforming nature of women having sex reflects onto the language as well. Whether a woman had sex or not results in classification among women in Turkey. An unmarried woman

is a girl (kız in Turkish), and a married woman is a woman (kadın in Turkish). (Özyeğin, 2009). In order to be called a girl, a woman should be 'innocent and pure', which means she must be a virgin (Özyeğin, 2009). The hymen is called membrane of girlhood (kızlık zarı) and act of tearing hymen is called 'breaking the girlhood' (kızlığını bozmak). A woman who had penetrative sex is no longer innocent, pure, and non-sexual being called a girl (kız). The only way this transition can happen that is acceptable in the honor code is in marriage (Özyeğin, 2009). In a sense, virginity becomes a physical reality of honor. That's why violation of women's body, especially if the hymen is harmed, is considered an attack on the familial values (Özyeğin, 2009); unless, for instance, a rapist marries the survivor and 'restores' her honor. Marrying the survivor with the rapist to restore her and her family's honor is not a rare occurrence in Turkey, which was confirmed by the chief consultant to the Minister of justice Prof. Doğan Soyaslan as he claimed; "No man would like to marry a woman who is not a virgin. Marrying the rapist after a rape is a reality of Turkey. The brother and the father of a girl who was raped would like her to marry the rapist." (Ilkkaracan, 2008, 50). Even if the survivor of the rape did not consent to the sexual act, if her hymen is broken, her honor is stained. She can no longer be deemed an honorable woman, and her family's honor is stained as well. Consequently, unmarried sexually active women are outsiders to the norm of girlhood – womanhood transition.

The relation of women's honor, shame, and virginity can be understood as a cultural construct instead of religious obligation (Sev'er & Yurdakul, 2001). Women's virginity that is directly linked to family's honor is not only experienced in societies where the dominant religion is Islam but also in other Mediterranean societies as well (Schneider, 1971; Goddard, 1987; Lindisfarne, 1994; Cindoglu, 1997). Moreover, the religious obligation of abstinence from sex before marriage applied to both women and men. Thus, honor-shame complex explains the anxieties with women's virginity better than the concept of sin.

So far, the conception of honor and shame and their relation with women's virginity is a patriarchal construct that enables controlling women's sexuality. Where does the state stand on the obsession of unmarried women's sexual purity? As Ortner argues in her anthropological work, expecting virginity before marriage or sexual loyalty in marriage from women was not unseen in pre-state societies; however, linking women's sexual activity and purity to the honor of a group surfaces after the formation of state structures (1978). She connects this phenomenon to giving economic, political and legal responsibility to the patriarch of the family (Ortner, 1978). Moreover, Awwad connects protecting the property and bloodline to protecting women's sexual purity as property in Middle Eastern societies (Awwad, 2011). Consequently, keeping women's behavior under control with social codes and other practices

such as honor killings becomes men's role and responsibility. In that structure, a patriarchal state would be expected to reproduce this culture of honor and protect the authority of the head of its smallest unit that is the family.

The culture of honor that is obsessed with the virginity of unmarried women brings its own control mechanism and tactics to control women's behavior. It frames the behaviors that are allowed or prohibited for women and provides the justification for different forms of gender-based violence (Awwad, 2011). The existing research on the significance of unmarried women's virginity focuses on forms of violence that maintain the control of women's sexuality (Awward, 2011; Sev'er & Yurdakul 2001; Parla, 2001; Ergün, 2006; Cindoglu 1997). Most of this research focuses on the conceptualization and consequences of honor killings and virginity tests in Turkey. By looking at the position of the Turkish state in how virginity tests and honor killings occur, the role of the state on the overall anxiety with sexual purity of women could be revealed.

2.3.2 The Position of the State in the Culture of Honor and Control of Women's Sexuality

Honor killings are the murder of a woman who had behaved in a sexually improper way, or there is a doubt that she did by her male relatives (Sev'er & Yurdakul 2001) or murder of a man by male family members when they believe he had sexual relation with a man and thus brought dishonor to his family (Arat & Nuňez, 2016). As I mentioned before, improper sexual behavior can vary; however, pre-marital sex, thus losing virginity before marriage, is considered behavior that damages a woman's and her family's honor. Honor killing is not a religious practice and was denounced by the department of religious affairs in Turkey in 2004 (Ilkkaracan, 2008). Despite the position of the department of religious affairs on honor killings, men who committed these crimes received reduced sentences in the past (Sev'er & Yurdakul 2001). The justification of reduced sentences was related to the 462nd article of the Turkish Panel Code, which rules the existence of sexual intercourse of spouse, sister, or people from one's lineage unjust provocation and allows a reduction in sentences (Hamzaoğlu & Konuralp, 2018). According to the research on trials on honor killings, the cases were evaluated from the perspective of the male perpetrator instead of the victim (Goztepe, 2005; Hamzaoğlu & Konuralp, 2018), thus legitimizing the concept of honor that controls women's sexuality.

The legitimization and defending of the concept of honor is not only specific to the law in the state structure. In the process of revising the Turkish Panel Code, the debates regarding honor in the parliament indicate how honor is deeply embraced within the government (Ilkkaracan, 2008). During the discussions, a number of member of parliaments from Justice and Development Party (Adalet ve Kalkınma Partisi – AKP) opposed the inclusion of the word 'honor' in aggravated homicide cases by redeeming honor as a reason for provocation

(Ilkkaracan, 2008). Protecting one's honor that is directly linked to any sexual indecency committed seemed the most usual to members of parliament, as evidenced by a quote from Adem Sözüer, who was an independent expert in the sub-commission. He said, "How can we use the words honor and penalty together? One should lead an honorable life, this is one of our basic values, for example if a spouse kills her/his spouse because she/he caught him/her with someone else...' (Ilkkaracan, 2008, 54). As a result, ruling out unjust provocation in 'custom killing' cases was included in the new Turkish Panel Code instead of honor killings in 2005. The extent of these murders was left rather vague in the law and open to definition (Hamzaoğlu & Konuralp, 2018). The inability to oppose the concept of honor and see it as a justification for murder reveals the extent of the importance of that construct and how embedded the need to control women's sexuality within Turkish society is.

Virginity examination is another tool to control women's sexuality. In this practice, a physician checks if the woman's hymen is intact or not. Besides pressuring women to stay virgins before marriage, the practice does not prove virginity as not all women have hymens or hymen might not break during sexual intercourse in some cases (Ergün, 2006). Thus, physical proof of virginity is, in fact, non-existent. The same applies to customs such as expecting blood on the sheet after the first night of the newly married couple. Nevertheless, these practices are employed to prove the virginity and thus sexual purity of unmarried women. When a woman cannot prove her virginity before marriage, this can be utilized against her as justification for domestic violence or honor killings (Parla, 2001).

Virginity examinations were conducted on-demand by state officials or individuals when there was doubt in the occurrence of premarital sex or cheating of spouses (Awwad 2011). Virginity examinations could be requested by anyone, especially staff of state institutions such as dorms, schools, or even private employers, legally until the practice of virginity examination were limited to only the request of court cases with the consent of the victim in 1998 thanks to the efforts of the feminist movement in Turkey (Gülkızı, 2020; Hurriyet 1999). Until then, principles could request virginity examination for women who they believed had sexual relations with men, which resulted in unknown numbers of the suicide of accused women (Gülkızı, 2020). Virginity examinations are a way to punish single women who had premarital sex and are a constant threat to all single women. If they dare to resist the social norms that impose virginity before marriage, 'their secret' could be outed by virginity examinations.

The role of physicians, institutional support to the practice, and discourses adopted by government officials regarding virginity examinations are essential signifiers of the extent of systemic approval for control of women's sexuality and the deep support of social norm that forbids women from having sex before marriage. Physicians who perform virginity tests

participate in signifying the importance of women's virginity and allow the medical practice to be affected by norms of society on women's sexuality (Parla, 2001). Thus, the wellbeing of women was prioritized to the demand of other individuals or institutions to protect their community or themselves from a potentially 'dishonorable woman'. Similar to physicians' compliance, schools, dorms, and the Ministry of Education reproduce the perception that virginity is the precondition of being honorable by imposing virginity tests on girl students. The Regulations on Rewards and Discipline in Secondary Schools, which was published on official gazette on 31st January 1995, announces that 'detection of unchastity' is a ground for suspension from formal education (Millî Eğitim Bakanlığı Ortaöğretim Kurumları Ödül ve Disiplin Yönetmeliği, 1995). Therefore, girls having premarital sex and 'losing' their virginity became a legitimate reason to lose their right to receive education. In this context, single sexually active women constitute a group that is open to be discriminated against with sanctions, deprivation from rights such as health and education, or even pressured to kill herself or be killed by her relatives (Ergun, 2007).

The fact that the state prioritized chastity and sexual purity of single women and girls is further confirmed by Işılay Saygın who was the Minister of women's affairs in the heat of virginity examination discussions (Parla, 2001). She defended the state's position in supporting virginity control as a way to ensure "good upbringing in girls" (Parla, 2001, 67) and "Families should take their daughters to virginity controls, it does not matter that a few girls committed suicide" (Milliyet, 1998). These statements are remarkable in how women and girls' lives matter less than their submission to the norms that control their sexuality and ideals of chaste and sexually pure women. These statements confirm Awwad's point, which is as follows.

> It is fair to conclude that Turkish society, just like many other Middle Eastern societies, places a great deal of value on virginity and is willing to sacrifice women‟s lives and self-esteem to protect a family‟s honor. This preoccupation with female virginity has created a powerful social control apparatus aimed at subjugating women (Awwad, 2011, 107).

According to Parla, the state's position in strict regulation of women's virginity and utilizing gender-based violence forms such as virginity tests or honor killings supports the argument that the Turkish state never eliminated its control over women's bodies with its modernization project (2001). The discussion should not be on the conservative-traditionalist dichotomy regarding women's sexuality but ever-consistent chaste-moral women that the state declares legitimate (Parla, 2001). That claim supports the argument that intense preoccupation with women's virginity is more related to specific patriarchal culture in Turkey rather than religiosity. That is not to say religion has no effect on the control of women's sexuality but

emphasizes that various means to control women's sexuality have always existed in Turkish society.

Virginity examinations and honor killings dominated the discussions on women's sexuality in the early 2000s. Even if the practice of virginity examination is limited to court cases by law and custom killings are no longer punished with remission on the basis of unjust provocation, the practice of these sanctions is not directly linear with law. For example, a private dormitory in İstanbul requested a virginity test from one of the students and informed her parents as they had suspicions that she had sex which she had to prove was false with a 'virginity report' in 2008 (Hurriyet, 2008). Moreover, even in sexual assault cases, the necessity of a virginity examination is questionable. The existence of physical trauma could prove the sexual assault, but whether a woman was virgin or not before the assault should not change punishment or an attack on a virgin woman should not be more serious than an attack on a non-virgin (sexually active) woman (Ergün, 2006). The assumption that violation of sexually active women is less serious continues to signify the importance of virginity of women and puts sexually active women at great risk of sexual assault (Ergün, 2006). An example of this kind of conceptualization of sexual assault and virginity would be when a father who sexually assaulted her 6-year-old child was acquitted of charges of sexual assault because the hymen of the girl was intact (Kepenek, 2020). Consequently, virginity is more important than the women's and girls' rights over their own bodies, which might lead to injustice in cases where a sexually active woman was sexually assaulted as if a sexually active woman cannot be raped.

Another control mechanism of women's sexuality was honor killings which are no longer specifically in circulation in media; however, an umbrella term that is femicide (kadın cinayetleri) is being used, which means the murder of women for gender-based reasons. Then it is feasible to assume legal changes in honor killings and virginity examinations did not necessarily undermine the importance of virginity, but control mechanisms took different forms. Additionally, I will argue in other chapters that inaccessibility and bad treatment that women face in sexual and reproductive health services are part of the systemic response to women who do not adhere to social norms that restrict women's sexuality to marriage.

2.3.3 Women's Experience of Their Sexuality and Their Position within the Culture of Honor and Virginity

Overall, Turkish society and state's response to women's sexual behavior that happens outside of marriage proved to be hostile. Even if that's the case that does not mean women have no sexual behavior and no space to experience sexuality outside of marriage. There are several research on the attitudes of young people, especially university students, towards sexual experiences of both men and women (Ozyegin, 2009; Ellialtı, 2012; Scalco, 2016; Bingol et

al. , 2007; Ebeoglu & Karacan, 2019; Glick & Sakalh- Uğurlu, 2003; Ergun, 2007; Aras, Orcin, Ozan & Semin, 2007; Gürsoy, McCool, Şahinoğlu & Yavuz Genç, 2016; Eşsizoğlu, Gürgen, Özkan, Yasan & Yıldırım, 2011). The common theme in these studies is that the gendered double standard regarding virginity is more common among male students than female students; however, the attitude towards women's sexuality is changing to provide more freedom to women, especially among socioeconomically advantaged educated young people. Nevertheless, this transition to gaining sexual freedom is challenging for women as they have to navigate their position within traditional/modern nexus and prevailing concept of honor that is directly tied to their sexuality.

In Ozyegin's research on university-educated young women who identify themselves as secular and young men were interviewed, students distanced themselves from traditionalism, the concept of honor linked to sexuality, idealization of virginity or chastity and emphasized the importance of desire in heterosexual relationships (2009). One of the important remarks in this work is that young women are expected to demonstrate a capacity for sexual desire, but they cannot be fully sexually available. In that case, they remain 'technical virgins', which means they engage in sexual activities but do not have penetrative sex (Ozyegin, 2009). Moreover, Ozyegin found out that the justification for penetrative sex could be the emotional connection and love for young women (2009). If a young woman is having multiple sexual partners and having sex without committing to a lengthy romantic relationship, she loses control of her sexuality, and she won't be respected by men anymore (Ozyegin, 2009). She is being used by men as if sexuality is something that women grant the men and for men's benefit only (Ozyegin, 2009). Consequently, a conceptual space for possible sexual relations has been open for women among educated young people; however, women still have to meet certain conditions and make sense of contradictions of having sexual freedom and social norms that establish their honor through their sexual behavior.

More recent and similar research by Ellialtı demonstrates that educated and socioeconomically advantaged young women approve of and perform their sexual freedom in the context of loving committed romantic relationships (2012). The research findings point out that young women redefine the concept of honor by approving sexual relations in the context of love and romantic relationships and only when they experience uncommitted, loveless and random sexual interaction that they 'stain' their own honor (Ellialtı, 2012). The fact that these young women judge other women who have multiple sexual partners and have sexual interaction not for love but for pleasure emphasizes that women's sexuality is still subjected to external and self-regulation, however, liberated they might feel. Consequently, even the members of socially, economically, or educationally advantaged parts of society distance themselves from

women's virginity and honor connection, they still come up with limits to which women can experience sexuality, and they are aware of the external gaze that they need justifications such as love to experience their own sexuality.

Lastly, Scalco's research on the relationship between young women's sexuality before marriage and marriage indicates that women are aware that they have to sustain certain control of their own behaviors even before deciding on a partner to get married, which connects to the importance of virginity (2016). Moreover, some of them had penetrative sex with their partners, and they were considering having 'virginity restoration surgery' before getting married to erase the traces of any sexual activity so that they could be perceived as 'marriageable' partners (Scalco, 2016). Thus, even if young women do not completely obey the sexual behavior rules that are set out for them, they employ tactics that give them certain freedom without challenging or undermining the patriarchal control over their sexuality and the importance assigned to the women's virginity. Their position concerning the patriarchal control of their own sexuality reflects on the negotiations of condom use, as well. Condom use is not as common, and participants of Scalco's research claim that it is difficult to convince men to use condoms as negotiating with them raises doubts that if a woman is insisting on condom use, she had too many partners or she does not trust the man (2016). Eventually, women have to trust to withdrawal method that puts men into the position of the one that is skillful and in control in sexual interactions (Scalco, 2016).

As research works by Ozyegin, Ellialtı and Scalco demonstrate, even if women cross the boundaries of virginity, they have to find a way to place themselves within the patriarchal notions of women's sexuality (Ozyegin, 2009; Ellialtı, 2012; Scalco, 2016). Ergün points this out by explaining that not only does law or medicine enable the control of women's behaviors through concepts of virginity and honor that are directly linked to it, but also through women's own self-control and self-discipline (2006). Moreover, they might have to deal with feelings of guilt and responsibility towards their own family when they experience sexual relations, as if they violated their family's trust or stained something that does not belong to them (Ozyegin, 2009). Thus, women not only deal with external pressures, discrimination or threat; but they also have to find their justifications and settle their own contradicting feelings towards their sexual behavior.

To sum up, women's sexual activity and virginity are associated with her and her family's honor. That honor can be stained by women's unchaste behaviors and sexual intercourse. To prevent women from challenging the concept of honor and control of the family and the state over their sexuality, forms of violence such as virginity examinations and honor killings are employed by Turkish society. The state legitimizes these forms of violence. Even if there have

been improvements in the law that challenge the legitimization of forms of violence that work to control women's sexuality and segments of the society started the change their attitudes toward the concept of honor and women's virginity, the control mechanisms do not disappear but change forms. For this reason, I will explain the recent mechanisms for controlling women's sexuality and the government's position in utilizing these mechanisms.

2.4. Discourses and Policies That Shape the Politics of Intimate and Construction of Women's Sexuality in the Last Decade

AKP came to power in 2002 with a promise for political freedom that is free of the pressures of military, democratization, and maintaining stability (Cindoglu & Unal, 2017). AKP claimed their political position as 'conservative democrats' and have focused on fulfilling European Union (EU) standards for the membership process and economic reforms (Çavdar, 2006; Grigoriadis, 2009). Consequently, rather than adopting a far-right Islamic position, the initial political position of AKP was center-right conservative which found broad support in Turkey.

The initial democratization trend in AKP's policies coincided with when the women's rights and feminist movement, which has become more visible since the 1990s, started to affect policies and law (Acar &, Altınok, 2013). EU candidacy process and lobbying for gender equality by this feminist movement resulted in changes in Panel Code, Civil Code, and Constitutional amendments (Acar &, Altınok, 2013). Despite their seeming moderation in Islamism and conservatism in the initial years of being in power and the EU candidacy process, AKP's position on gender equality and family has always been conservative. For example, in their Party program, women are positioned as caregivers and mentioned within the context of the family (Çavdar, 2006). Especially after 2007, when AKP guaranteed the support of many citizens, their conservative rhetoric that references both religion and 'values of Turkish society' became more dominant while neoliberal economic policies were rapidly implemented (Acar &, Altınok, 2013).

Post-2007 discourses and politics of AKP emphasize their conservatism in gender and sexuality. After gaining more than 46,58% of the vote in 2007 and %49,83 in the 2011 elections, their public statements and actions such as incrimination of political opponents have been more authoritarian. Specifically, the shift towards this conservatism and authoritarianism has been obvious in what Acar and Altınok call 'politics of intimate', which they define as follows; "Here the term 'politics of the intimate' is used to denote the web of policies, decisions, discourses and laws and norms which regulate intimate and family relationships, sexualities and reproductive capabilities of individuals." (Acar & Altınok, 2013, 15). Consequently, I will explore discourses and policies on sexuality, marriage, and reproduction along with decisions in the practice of sexual and reproductive health in line with

neoconservative and neoliberal policy and ideology direction that AKP adopted, especially after 2011 in the section.

In reproduction, the official population policy of Turkey has been anti-natalist since the law on population planning was issued in 1965. However, discourses used by high representatives of AKP signal their intention to increase the population, especially the young population. On the 8th of March 2008, Recep Tayyip Erdoğan, who was Prime Minister at the time, announced a plan for a cash support program for child-birth (Acar &, Altınok, 2013). Moreover, he made a habit of asking newlywed couples to have 'at least three children' since 2008 (Acar &, Altınok, 2013). The risk of an aging population and financial difficulties that the aging population could bring have been used to justify the need to encourage increasing fertility rates. Erdoğan phrases that an aging population would have a significant impact on the competitiveness of Turkey in the global economic market and that less than three children per family would mean bankruptcy (Cindoglu & Unal, 2017; Korkman, 2016). Despite economic reasons being used to support pro-natalist population policies, there is the element of unpronounced care work involved in increasing the number of children per couple. Pro-natalist discourses came with no additional support in care services except limited financial assistance and the additional leave given to women in 2016 that allows part-time work or unpaid leave options on top of their 16 weeks maternity leave (Turkey | Labor Code, 2016; Korkman, 2016). There is no parental leave in Turkey, and paternity leave changes from 3 days to 10 days depending on the sector of the father's employment. Consequently, women who are traditional caretakers in patriarchal Turkish society are expected to carry the task of caring for their children.

The shift towards pro-natalist policy and prioritizing child-birth and fertility over other sexual health services reflect on policy documents and guidelines published by the government. For instance, even if the global term is sexual and reproductive health, in official documents, only the term 'reproductive health is used in Turkey, especially after the 2010s (Acar &, Altınok, 2013). While on 8th national development plan, providing reproductive health and family planning to every segment of society and equality in access to services were emphasized, there is no reference to sexual and reproductive health except fertility rate and baby mortality rate in the 9th national development plan (Turkish Grand National Assembly, 2000, 2006). On the other hand, in the 10th national development plan, which covers the 2014-2018 period, all cites to family planning and reproductive health were changed, and the focus of population policies was stated as increasing the young population and protecting the family institution (Willis & Yılmaz, 2020). For increasing the fertility rate, altering women's employment options "to fit into family life", maternity leaves and rights, and encouraging daycare services were proposed

as mitigation measures, further emphasizing women's sole role as being the mothers and caretakers (Turkish Grand National Assembly, 2013) The weakening of family was stated as a problem caused by new technologies, individualization, and lack of communication without addressing forms of violence women are subjected in marriages. The priority actions are stated as protection of the welfare of the family, education, and counseling prior to marriage and family-based social assistance and services.

The Protection of Family and Dynamic Structure of Population Program that was proposed in the 10th national development plan was in line with government policies that focus on fertility and strengthening the family institution. The program targets are listed as protecting the welfare of the family, strengthening solidarity between generations, harmonization of work and family life, and increasing fertility rate over the reproduction rate (Ministry of Family and Social Services, 2015). Similarly, other documents that are published after the 2010s on reproductive and sexual health, namely "Healthy Start to Marriage" handbook, the "Guidelines on Management of High-risk Pregnancies" and "Monitoring and Consultation on Women's Health and Reproductive Health in Family Health Services" handbook emphasize reproductive functions, maternal and infant health while not-birth related sexual health services are glossed over in documents (Ministry of Health, 2014a, 2014b, 2017a). The importance and centrality of the family for reproductive health have been emphasized few times, especially in the former document (Ministry of Health, 2014a). Most of the documents, circulars, and guidelines that are published in sexual and reproductive health after the 2010s focus on maternal and infant health, whereas other sexual health concerns such as STIs or family planning were frequently covered topics from 2000 to 2010.

Criticism of C-section surgeries is another ongoing discourse that is related to population growth that has been used by AKP. The increasing rate of C sections was problematized as the number of C sections that a woman can have been limited, which could restrict the number of birth, as two children per woman (Belek, 2017). Emine Erdoğan (wife of Recep Tayyip Erdoğan) has made various appearances in Maternity centers and hospitals where she advised against C sections (Haberturk, 2017). Moreover, Recep Tayyip Erdoğan, in one of his speeches, emphasized how abortion and C sections are performed for-profit and to fool citizens to limit the number of births (CNNTurk, 2013). In this context, C sections and abortions were tools for a scheme to decrease the population of Turkey to prepare for its downfall. It is a common theme in his speeches that whatever he problematizes, varying from the high rate of abortions to depreciation of the Turkish lira, is part of an external plan to trick citizens into collectively acting in a certain way so that Turkey would collapse. Each time citizens are called to 'disrupt the ruse' and act towards whatever he suggests. Especially when the decrease in

population growth rate or ‘destroying the Turkish family structure’ is concerned, citizens are frequently warned against the scheme of external entities.

Abortion is another topic that is brought to political agenda frequently by AKP. There have been various attempts to shorten the legal duration of pregnancy, which is ten weeks in Turkey, and limit the application. In 2012, Erdoğan made series of speeches regarding abortion. He equated abortion with murder, saying killing a baby after birth and abortion is the same (Ahmadi, 2012). He claimed, “I know that these are planned, and I know that these are steps taken to prevent the country's population from increasing. With this [abortion], the population of this country is stopped somewhere. I see abortion as murder.” (NTV, 2012).[2] He repeats that anti-natalist policies and practices such as family planning or abortion were a part of a greater scheme against Turkey. Abortion is not only the murder of a child but also a tool of that greater scheme that prepares the doom of the country. This repeating rhetoric on the country's future depending on the population increase burdens women with motherly and reproductive duties for the nation. Consequently, the womb becomes a space of political control, and abortion is resisting that political control (Kazanbas, 2019). Limiting access to abortion and family planning services deprives women of choice and control over their own reproductivity.

Through a shift in population policies towards pronatalism, family planning has been deprioritized. Much like other discourses utilized by AKP that indicates lower fertility rates mean the economic doom of the country, family planning has been evaluated as a foreign concept that serves against the development of the country and ‘almost caused the extinction of our lineage’ (BBC, 2014; Cumhuriyet, 2019). The aim of increasing the young population is the apparent reason for his condemnation of family planning and contraception. However, contraceptives are essential for women to have control over their own bodies and reproductivity. Lack of contraceptives can lead to frequent births and the spread of STIs, which means putting individuals, especially women, at great risk of deteriorated health. Thus, denunciation of family planning and contraception services is not simply to encourage population growth but also to control women’s reproductive functions and sexual freedom.

Another change in reproductive health policies was the encouragement of assisted reproduction techniques. It has become a more common practice that is even included in the official curriculum of biology classes in secondary education (Ministry of National Education, 2018). The patients who can prove that they cannot have children can consult for assisted

[2] Bunların planlı yapıldığını biliyorum ve bunun, ülke nufüsunun artmaması için atılan adımlar olduğunu biliyorum. Bununla bu ülkenin nüfusu bir yerde durduruluyor. Kürtajı bir cinayet olarak görüyorum

reproduction techniques which Social Security Institution covers with additional patient payment. Regulation Concerning Treatment Centers for Assisted Procreation which was revised in 2010, and the 63rd article of Law on Social Security and General Health Insurance list the rules and criteria for incentives in assisted reproduction techniques (Turkey | Law on social security and general health insurance, 2010). According to those documents, couples have to be married through the insemination duration, which excludes unmarried couples of all sexual orientations and single women who wish to have children from the practice (Acar &, Altınok, 2013). Accordingly, while the government is encouraging increasing the number of births, it is ensured that births will take place within the institution of the heterosexual family. Therefore, discourses and changing practices in reproduction are not independent of AKP's views on the institution of marriage and family.

The focus on strengthening the family institution is the obvious continuation of its neoliberal and neoconservative policies. On the one hand, the institution of the familial ideology of AKP considers family as the main space of existence for women (Acar &, Altınok, 2013). One symbolical change that signifies the priority of the family institution over individuals, especially women, is that ministry that was previously called the State Ministry of Women and Family Affairs was replaced with the Ministry of Family and Social Policies in 2011 (Birgün, 2018). On the other hand, the family serves as a resource for social welfare that allows neoliberal restructuring of social services. AKP's desired family institution is the unit which social services, especially care work, can be transferred (Acar &, Altınok, 2013). Examples of the transfer of social services to the family would be the "Back to Family" program where children who are in institutional care would be delegated to host families with financial assistance (Acar &, Altınok, 2013) and home care allowance that is paid to the caregiver of disabled people (Cumhuriyet, 2021). The common theme in both applications is that social services that are the responsibility of the state are transferred to the family with limited financial assistance. Consequently, the family is not just an ideological tool for AKP to ensure a conservative patriarchal society but also an entity that the responsibilities of the state can be delegated.

According to the conservative familial approach of AKP, a strong family is the core of social order where problems such as domestic violence or unemployment are solved within the family and members of the family share the same values (Acar &, Altınok, 2013; Bozkurt, 2013). The power structure within the family is not problematized as children should respect their parents, and women are meant to be caregivers and mothers. Erdoğan gave various speeches on how motherhood is not separable from womanhood.

> I do not accept that career became an alternative to motherhood. A woman who hesitates to become a mother by saying, 'I am working' denies her womanhood. That's my sincere opinion. A woman who denies motherhood and gives up from looking after her home is against losing her freedom regardless of how successful she is in her career. She is deficient, undone. (Sözcü, 2016)[3]

He also emphasizes the sacredness of motherhood by reciting a hadith that says, "Heaven is beneath the feet of mothers." (Top, 2019). Thus, women are expected to prioritize becoming mothers and wives and devote themselves to their families. In line with this description of mother/woman, the ideal family for AKP has specific features. Only families with heterosexual, Turkish, and married couples committed to conservative values and morals are approved (Cindoglu & Unal, 2017).

Heterosexual, conservative, Muslim, and Turkish family ideal embedded in the current government's discourses and policies creates a group of multiple 'others' (Mutluer, 2019). Discourses utilized by AKP become more crucial in identifying who falls into the group of others than the policies as others and their needs are merely absent in policies and official documents. Women who do not behave with chastity and are not modest belong in this group of others, as proved by many speeches given by the high rank of AKP officials. For instance, then deputy prime minister Bülent Arınç made comments on how women should not laugh in public, should not be inviting towards men, and overall be the symbol of chastity (Birgün, 2014). Even an act as simple as women laughing in public can become a way to be called unchaste and fall outside of the ideal conservative behaviors drew by the government. Another example would be the firing of a television presenter after AKP spokesperson criticized her for wearing a low-cut top (Hürriyet Daily News, 2013). In line with the ideal of chaste/modest women, Erdoğan frequently criticizes feminists as denoting feminism as an outsider construct that is not compatible with Turkey's religion and national values (Hürriyet, 2015; Mutluer, 2019). Erdoğan clearly stated he does not believe in gender equality and that genders complement each other in his speeches (Cindoglu & Unal, 2017). Accordingly, women who do not behave in the expected chaste/modest/honorable way could expect to be excluded, discriminated and targeted as the other.

Another practice that is denounced by the AKP rule is premarital sex. As sex and sexuality are taboo topics, they are not voiced explicitly by the conservative AKP government. However, disapproval of premarital sex reflects on discourses in which they encourage young people to

[3] İş hayatının, anneliğin alternatifi haline getirilmesini kabul edemiyorum. 'Çalışıyorum', diye annelikten imtina eden bir kadın aslında kadınlığını inkar ediyor demektir. Bu benim samimi düşüncemdir. Anneliği reddeden, evini çekip çevirmekten vazgeçen bir kadın, iş dünyasında istediği kadar başarılı olsun özgünlüğünü kaybetme tehlikesiyle karşı karşıyadır. Eksiktir, yarımdır.

get married as soon as possible (Euronews, 2021) and criticism of cohabitation practices of young men and women. In 2013, a debate regarding the houses shared by male and female students and mixed gendered dorms revealed the government's position of cohabitation practices. In his speech that explains the government's position in cohabitation practices and mixed dorms, he claimed;

> [The separation of gender-mixed dorms] this has been realized at 70%. We, as the responsible conservative democratic party, everyone's children are entrusted to us. We do not allow girls staying all mixed up with boys in state dorms, and we will not. …[On cohabitation of students] We confront denunciations of this kind that are submitted to governorships and our organizations. (Milliyet, 2013)[4]

Evidently, male and female students are not supposed to stay in the same place due to the risk of sexual contact between them. According to Erdoğan, 'nasty things' can happen in those dorms and houses, and after that, parents cry out to ask what the government is doing about it (Cindoglu & Unal, 2017). The justification for intervening with these dorms and houses was stating that this type of setting is not compatible with the conservative nature of the society. In another of his speeches, he pointed out the danger of being in a period where premarital affairs are normalized, and divorces are encouraged (Cumhuriyet, 2019). Thus, sexual contact before marriage is disapproved, found out 'not normal', and out of line with the conservative ideology of the government.

Besides disapproval of premarital sex, the value attributed to the virginity of women is reflected in a commission meeting that is gathered for the revision of the Turkish Panel Code. Consultant to the Ministry of Justice Prof. Dr. Doğan Soyaslan claimed that nobody would marry a non-virgin woman (Milliyet, 2003). He stated that if a woman is raped, nobody else will marry her, and it is best if the rapist married her and was pardoned from any punishment (Milliyet, 2003). Even if these statements received a backlash and no pardon for rapists were introduced to the law, the norm that unmarried women have to be virgins to have a place in society has been reproduced by an academic and expert working with the government.

Another segment of society that constitutes the other for AKP is LGBTI+ people. When AKP first came to power, their approach towards LGBTI+ people seemed somewhat moderate owing to Erdoğan's answer to a question in which he claims that discrimination towards homosexuals is not approved and they should have rights and freedoms (Mutluer, 2019). However, this rhetoric changed to condemning same-sex marriage as it does not fit into the

[4] Yüzde 70 oranında bu gerçekleştirildi. Biz sorumluluk makamında muhafazakar demokrat bir parti olarak herkesin çocuğu bize emanettir. Biz kızların erkeklerin devletin yurtlarında karışık kalmasına müsaade etmedik etmiyoruz… Valiliklerimizle, emniyet teşkilatımızla bu tür ihbarları değerlendirip, üzerine gidiyoruz.

norms of Turkish Muslim society (Mutluer, 2019). Debates on LGBTI+ people became more heated in 2021 when an artwork that combined LGBTI+ flags with religious figures and Kabe (where Muslims go for haj) was exhibited in the campus during the protests against the unelected/appointed rector of Boğaziçi University. After that LGBTI+ student club in Boğaziçi University was shut down, few students were arrested, and continuing protests were stopped with the police force. While addressing the events in Boğaziçi University, Erdoğan called protests terrorist acts, that he would not allow similar activities such as Gezi protests again (BBC Turkce, 2021).

> LGBT, that does not exist. This country is nationalistic, moral and would continue to march towards the future with these values. …Our youth is the youth that goes hand in hand bolt upright with their police unlike youth in Boğaziçi University that is divided by LGBT supporter, this supporter that supporter. (BBC Turkce, 2021)[5]

In this context, being LGBTI+ became a political position that is opposed to the government rather than an identity. LGBTI+ people, women who do not act modest and chaste, or sexually active single women are the segments of society that do not belong in the mainstream and are unfitting to the conservative familial ideal of AKP. Similarly, debates on withdrawing from the İstanbul convention revolved around the incompatibility of the convention with the Turkish family structure and the unacceptability of the inclusion of sexual orientation in the document. Despite the efforts of feminist and LGBTI+ activists, the Turkish government, who was the first signatory, withdrew from the convention officially on the 1st of July 2021. Withdrawing from a convention that aims to end gender-based violence at a time when femicides are increasing and getting more visibility signifies the extent of the commitment to maintain conservative moral order in Turkey.

2.5. The Reflection Discourses and Politics of Intimate of AKP onto Sexual and Reproduction Health Services

Categorizing people into the 'other' group based on their adherence to the conservative social order manifests itself in policies and applications especially in sexual and reproductive health, as conservative social order mainly organizes sexual relationships. Aiming for population growth and denying the existence of non-heterosexual relations and premarital sex entail a shift away from the previous rights-based approach in sexual health policy (Willis & Yılmaz, 2020), towards prioritizing reproduction and child-birth related services over other sexual health services such as prevention and treatment of STIs, family planning, abortion, C section

[5] LGBT, yok öyle bir şey. Bu ülke millidir, manevidir ve bu değerlerle geleceğe yürümektedir. … Bizim gencimiz Boğaziçi gibi yok LGBT'ci, yok şucu, yok bucu değil, polisine saldıran değil, tam aksine tüm polisiyle beraber el ele dimdik yola devam bir gençliktir.

surgeries, and comprehensive sexual health education. Consequently, the services that do not serve population growth or the restoration of the conservative social order of AKP are neglected more, and the needs of sexually active single women and LGBTI+ people might be ignored.

Among sexual health services that might be neglected due to the conservative position of the government, there has been no change in the coverage of STI tests and treatment insurance. STI tests and treatment, including HIV, are continued to be provided in state hospitals. However, anonymous testing and treatment are not possible except for initiatives of few municipalities in İstanbul, İzmir, Ankara, and Bursa that the opposition party Republican People's Party (CHP) is running (Willis & Yılmaz, 2020; Positive Living Association, n.d.). Moreover, women between the ages of 30-65 are screened for HPV in Caner Early Diagnosis Screening and Training Centers (KETEM) every five years. However, women who are younger than 30 who have suspicions of HPV contact are not included in this screening program which could lead to a late diagnosis that raises the risk of cancer. Prevention of STI services can be considered as important as treatment as STIs are preventable diseases. Thus, sexual health education and accessibility of contraceptives are essential in the prevention of the spread of STIs. Sexual health education in Turkey is limited to biology classes in high school which mainly covers information on anatomy, pregnancy, menstruation, and reproduction (Ministry of National Education, 2018). Additionally, no other source of information is utilized to raise awareness of STIs. Health centers distribute condoms; however, the supply of condoms has not been consistent (Willis & Yılmaz, 2020). Consequently, STI prevention and treatment services are not consistently accessible for all women.

Family planning has been one of the sexual and reproductive health services that were the most affected by structural changes in the health system, along with a shift towards pronatalist policies. The Health Transformation Programme that was implemented between 2003 and 2011 brought the closure of General Directorate of Mother and Child Care and Family Planning (Adalı, Çavlin, Dayan & Topgül, 2017) and implementation of performance-based scheme (Aydın & Demir, 2007). The sexual and reproductive health services that were included in the performance-based scheme have been limited and arguably involve birth-focused reproductive health components, which lead to neglect of other sexual health services (Çiçeklioglu, 2010; Acar &, Altınok, 2013). Moreover, family planning services are not included in performance criteria for family physicians, and service provision of family planning is delegated to nurses or midwives (Adalı, Çavlin, Dayan & Topgül, 2017). Condom distribution that became a common practice in the mid-2000s was interrupted in the 2010s as a result of the negative reaction of conservative media outlets (Willis & Yılmaz, 2020). Despite

these changes, family planning services and consultation continue to be delivered in hospitals and family health centers. However, as Yılmaz demonstrates in the report published by Turkish Family Health and Planning Foundation (TAPV) family planning services tend to be overlooked unless they are monitored and encouraged (Yılmaz, 2020). This explains the unmet need for contraceptives that increased from 6% to 12% between 2013 and 2018 (Hacettepe University Institute of Population Studies, 2019).

There has been no policy change or revision of the law regarding abortion. However, the political position of the government affects service provision. Recent research on the availability of abortion services indicates that access to abortion in state hospitals is limited, the price for getting an abortion in private hospitals are high, and for this reason, the need for abortion services is not met, which leads to childbirth in unwanted pregnancies (Altuntaş, Keskin & O'Neil, 2020; Foster, MacFarlane, O'Neil & Tekdemir, 2017; Adalı, Çavlin, Dayan & Topgül, 2017; Akin, Dogan, Mihciokur & Ozvaris, 2014). The most commonly stated reason for not providing abortion services in state hospitals is that abortion is prohibited by the state even if there is no legal basis for those claims (Altuntaş, Keskin & O'Neil, 2020). Thus, discourses employed by Erdoğan and other AKP officials are not mere efforts to change the political agenda, but they guide the politics of intimate and affect the daily lives of women, children, and LGBTI+ people (Korkman, 2016).

As part of the efforts of the government in decreasing the number of C-section births, an addition to Public Health Law was made in 2012, which states that C-section surgeries can be done in case of medical necessity (Turkey | Public Health Law, 2012). There has been debate on what constitutes medical necessity and that this law prevents women from having a choice on how they will deliver their babies in which Recep Akdağ, who was the minister of health at the time, responded that even a woman fearing childbirth can be a medical necessity (Hurriyet, 2012). The guidelines on the management of labor and caesarian surgeries document were published in 2010, which listed the details of obstetrical indicators of caesarian surgeries (Ministry of Health, 2010b). Despite these efforts, the rate of C sections increased from 51.1% to 54.4% from 2014 to 2019 (TUIK, 2021a). This resistance can be attributed to the high rate of C sections in private hospitals as they are more likely to meet the demands of patients (Girit, 2017).

Another factor that affects the utilization of sexual health services is the stigma and neglect of sexually active single women. When single women consult to family health centers, the possibility of their sexual activity can be ignored by family physicians (Yılmaz, 2020). Registration of sexual health information on databases such as e-nabız or Central Population Management System (Merkezî Nüfus İdare Sistemi-MERNIS) can be discouraging for

sexually active single women as her information can be accessed by family doctors or workplace doctors (Kazanbas, 2019). Additionally, single women who are socialized to know that premarital sex is not the norm might feel ashamed and shy to reach out to sexual and reproductive health services (Giray & Kılıç, 2004; Şimşek, 2011). Finally, the discriminatory attitudes of health workers can prevent access and continuation of treatment as medical education does not include sexual rights (Willis & Yılmaz, 2020; Şimşek, 2011). Consequently, even if there is no prohibition or written rule against sexually active single women accessing sexual and reproductive health services, the politics of intimate that has been employed by AKP, especially in the last ten years, could prevent women from actively benefitting from those services.

Despite obstacles in accessing and effectively benefitting from sexual and reproductive health services, it should be noted that women can develop their own strategies and solutions to receive those services. Section 2.3.2 provides examples that even if the culture and political atmosphere exclude and shame sexually active single women, women continue to find ways to experience sexuality. Similarly, women can find ways to reach and benefit from sexual and reproductive health services. For instance, abortion was not legal under any circumstances in Colombia until 2006 and in Chile until 2017; however, the number of abortions exceeded 150.000 per year in both countries because women would pay for semi-safe underground facilities for abortion or start the procedure themselves with home remedies and then consult to medical facilities (Center for Reproductive Rights, 2021; Shepard, 2000). Consequently, consulting for unsafe abortions is one of the strategies that women frequently employ in countries where abortion is illegal (Glasier, 2006). Moreover, women who wish to seek abortion might travel to other countries when abortion is not legal in their country, or their gestation duration exceeds the legal duration in their residing country (Garnsney et al., 2021). Another research indicates that sex workers who are not able to regularly visit health centers for sexual health services try to hide that they are sex workers during their doctor appointments in order to receive sexual health service without judgment (Chacham, Diniz, Maia, Galati, & Mirim, 2007). Moreover, sex workers reported using cotton in the absence of contraceptive tools such as diaphragm (Chacham et al., 2007). Thus, in the face of structural and cultural barriers, women can employ coping mechanisms or find an alternative solution, including negative ones such as unsafe abortion, to receive the demanded service.

CHAPTER 3

METHODOLOGY

In this chapter, I will explain the details of how I conducted this research. The design process of deciding on the structure of the thesis, research method, details of the data collection process, my position as a researcher, methods, and details of data analysis will be explained in this chapter. Details of interviews with experts are also included in this chapter to explain why that part was necessary and details of the procedure. Finally, limits and areas that require further research will be indicated.

3.1 Design of the Study

As soon as I knew I would conduct social policy research on a topic of my choosing, I was already set on researching the sexual health of single women. My curiosity on the subject as a researcher comes from my personal experience and my friends' experiences. I wanted to focus on single women's experiences because I was aware of the stigma around single women's sexuality and that it was possible this can have reflection both on sexual and reproductive health policy and doctor-patient interactions. My brief initial research revealed that even if sexual and reproductive health has been represented in academic research, it mostly focused on specific policies or the availability of services. There was no research that considers the specific vulnerability of single women due to disapproval of their sexual experience.

I would like to give examples of why I considered my experiences might not be mere coincidence but a common issue that a lot of single women experience. One of them was my first visit to a gynecologist where a gynecologist saw fitting to yell at me, 'are you single or married' as I was entering the room. 'Are you single or married' question sounded odd to me, and I did not know how to answer. Additionally, I remember feeling ashamed as if I did something wrong by not exactly fitting into the options given to me. Later on, I found out that all gynecologists would ask me the same question. Another instance where I could not locate myself while I was seeking to receive sexual health service was a visit to a specialized hospital for sexual and reproductive health. I was told I was too old to consult their youth clinic, and I could go to the infertility clinic for consultation even if I was not consulting for infertility. I felt- I was 25-year-old back then- my gynecological concerns do not fit into what our health

system thinks possible. After few experiences in state hospitals where I felt that they did not listen to me, my concerns were not taken seriously, or I could not get the tests I requested done, I started to go only to private hospitals for sexual and reproductive health.

My curiosity that was triggered by my personal experience, pushed me to talk to my friends and research this issue. I came across 'Gynecology Talks' by Kaos GL, which is a series of articles that voice the hardships women and LGBTI+ people experience in their interactions with gynecologists. After reading those stories, I was convinced that the construction of women's sexuality in Turkey could have an effect on sexual and reproductive health service interactions.

I researched to find out that no academic research on single women's sexual and reproductive health in Turkey interaction exists. The academic research that might be related to this topic usually only briefly mentioned that single women might be struggling to reach those services. Thus, I prepared a research proposal on this topic and selected this as my research topic.

3.2 Methodology

This research centralizes women's perspectives and experiences. In line with this, I have approached this study from a feminist standpoint and employed feminist research methods. According to Harding, the feminist standpoint involves looking at the lives and experiences of women as a starting point to produce knowledge (1992). On the other hand, the experiences of women are affected by historical and social conditions (Harding, 1992). Providing the historical and social reality of that situation where women's experiences take place enables maximizing the objectivity of the research while producing knowledge about the subjective realities of women (Harding, 1992). For example, without providing how women's sexuality is constructed in Turkey, producing knowledge on women's sexual health experiences would not provide information on why and how often those experiences happen. Moreover, Hirschmann explains that knowledge generation through a feminist standpoint takes into the researcher's point of view (2004). For example, I am a Turkish feminist researcher, and the way I explain the aspect of the reality would be different than a feminist researcher from a European country. However, that does not mean our positions are wrong; we are simply looking at the different aspects of women's experiences. Therefore, I am looking at women's experiences in my subject to uncover the truth while being an insider of the subject, which is a single Turkish woman.

Feminist research methods usually but not always imply the utilization of qualitative methods. The researcher and participants form connections that are not hierarchal (Neuman, 2014). The researcher's personal position and participants' feelings are incorporated in the research, and

the research aims for change in power structures (Neuman, 2014). I have used qualitative research methods for this research. How respondents felt during sexual health service provision and how they framed the behavior of gynecologists, and health staff was crucial to the study. For this reason, semi-structured in-depth interviews were used. By choosing that method, previously academically unexplored experiences could be incorporated into research without limiting the women's own interpretations of their experiences.

3.3 Data Collection and Respondents

I have used qualitative research methodology and semi-structured in-depth interviews for this research. Twenty-two women (assigned female at birth) who consulted sexual and reproductive health services were interviewed. I collected all data from interviews of single and married women from September 2020 until February 2021. A combination of convenience and snowball sampling methods has been used.

Among the 22 women I interviewed, 11 of them were single, and 11 were married. I wanted to interview married women and single women to be able to compare their experiences and see if being single affects how they are treated by health staff. Additionally, married women who had sexual and reproductive health service experience while they were single also contributed to analyzing the difference between single and married women's experiences. Among married women, only Ayşe, Sena and Pelin did not have sexual and reproductive health service experience while they were single where they revealed they are sexually active. I was still able to use their experiences due to their contributions in Chapter 4 and their observations of friends and acquaintances' experiences.

Initially, my plan was to interview a diverse group of women from different socioeconomic backgrounds. I was planning to get help from some of my acquaintances that work in primary health centers to reach out to women from more diverse backgrounds. However, because of the coronavirus outbreak that became effective in Turkey in March 2020, which was exactly when I started to search for participants, I had to use online platforms to find interviewees, which limited the socioeconomic diversity. I could reach out to women who are from a similar background that I am. I tried to find and post on Facebook groups and platforms that could be more diverse such as district Facebook groups or women's groups. However, I have encountered an understandable hostility. Members of these groups did not trust me and were afraid that I might be a pervert trying to trick women into talking about their sexuality. Had I been able to reach out to those women via mutual contact, it could have been easier for them to trust me. Consequently, I ended up being able to reach university-educated and mostly middle-class participants due to pandemic conditions.

Having participants consist of only women who are more socioeconomically advantaged and educated is a significant part of the research; all findings represent the experience of those women. Women who are less educated and/or from lower-income groups could have different experiences. For example, one of the gynecologists I have interviewed stated that they have only very few patients from low-income groups, and one of the women stated that she knows women who are prevented from seeking sexual health by their husbands. This might point out that women who are socioeconomically disadvantaged might be facing even more serious obstacles in accessing and benefitting from sexual and reproductive health services.

I chose Ankara as the basis location that women consulted to sexual and reproductive health services. The first reason for that is convenience, as I reside in Ankara. The second reason is that it is a big city in which diversity of participants can be maintained. Moreover, options for different types of health institutions are various in Ankara. There are plenty of university hospitals, private hospitals and clinics, specialized state hospitals, and health centers in Ankara, which can create a chance to analyze different experiences in different institutions. I could not include the answers of one interviewee as she moved from Ankara 3 years ago. Additionally, because a lot of students come to Ankara from different cities, the experiences of interviewees in different cities are still included in this study when it was relevant. If the experience took place in another city, it is specified in the text.

I have set an age limit of 25-30 for participation in the study. Initially, my plan was to interview women between the ages of 20 to 30. However, my advisor warned me that there is a big difference between the accumulated experience of a 20-year-old woman and a 30-year-old woman. I decided it would be best if I interviewed women between the ages of 25 to 30 as it would be easier to find both single and married women at that age as the average age of getting married in Turkey has been around 25 in the last two years in Turkey (TUIK, 2021b). Despite that, it was more difficult to find married women to interview than single women. The reason for that might be that the marriage age among socioeconomically advantaged and educated women could be higher. Additionally, one interview could not be included in the study as the woman who participated was 23-year-old.

I have used a combination of convenience sampling method and snowball sampling method to find participants. I began searching for participants from my social circle. After I completed interviews with my acquaintances, I asked them to tell their friends about this research. At this point, I have to state the specific difficulty of finding participants for this research. Sexual health and sexuality are taboo topics in Turkey and people find it hard to talk about them. It is even more difficult for women to talk about their experiences when they are harshly shamed for their sexual life. Some of the participants told me that they asked their friends and family,

but they refused to participate because they didn't feel comfortable talking about their sexual health. Three of my friends who did not qualify for the participation conditions each referred one of their friends to me. Among those participants, one of them suggested two of their friends to me, which forms the snowballing sampling part of the research. The rest of the participants were from district-based Facebook groups and Middle East Technical University (METU) Women's Solidarity Facebook group.

Sexual orientation has significance in this research as heterosexism intersects with the social norms that control women's sexuality. I did not specify sexual orientation as selection criteria for participation while searching for respondents. I wanted to conduct the interviews initially to see the diversity of experience among women. Nevertheless, I ended up with mostly heterosexual women participating in the study. Only one participant defined her sexuality as bisexual. One participant stated that she defines herself as heterosexual, but it is flexible for her. One other participant stated that she might be bisexual, but she is not sure as she did not have any experience. I find it is best to write undefined for her sexuality in order not to assume anything other than her statement.

20 of the 22 interviews with single and married women took place through video calls due to pandemic conditions. The duration of interviews varied from 30 minutes to 1 hour and 20 minutes. I made sure that all participants did not have trouble talking about their sexual health experiences while they are at home. One interviewee had trouble talking freely because she was staying with her parents at the time, so we postponed the interview and conducted it later when she could speak comfortably. Among 20 of those video calls, one interviewee did not feel comfortable turning on her video, so we continued with only audio. One of the interviews took place in a café that the participant chose where she felt comfortable. The other interview took place at my home as I already knew the interviewee, and she felt that was the setting that she would be the most comfortable. I explained the research and the nature of their participation to all participants. I asked for permission to record and participant's approval of participation in this study in each interview. General information of the participants can be seen in the table below. (See Table 1.) All original names are changed to protect the anonymity of participants.

Table 1: Summary of relevant information of the respondents

NAME	**AGE**	**SEXUAL ORIENTATION**	**OCCUPATION STAUS**	**EDUCATION**	**MARITAL STATUS**	**CLASS**	**INSURANCE**
Melek	29	Heterosexual	Full time employed	University	Single	Middle	SGK
Ceyda	29	Heterosexual	Full time employed	Graduate student	Single	Middle	SGK

Table 1 (continued).

Beril	27	Heterosexual	Full time employed	Graduate student	Single	Middle	SGK
Mine	27	Heterosexual	Part time employed	University student	Single	Middle	SGK
Zehra	29	Heterosexual	Recently quit	Master	Single	Middle	Private
Damla	30	Heterosexual	Part time employed	University	Single	Lower-middle	SGK
Nalan	27	Heterosexual	Student	University	Single	Lower	SGK
Begüm	25	Heterosexual	Full time employed	University	Single	Upper-middle	SGK
İlayda	26	Heterosexual (self described flexible)	Student	University	Single	Lower-middle	SGK
Bahar	28	Bisexual	Unemployed	University	Single	Lower-middle	SGK
Hande	26	Undefined	Student	University student	Single	Upper-middle	SGK
Gonca	26	Heterosexual	Part time employed	University	Married	Upper-middle	Private
Seda	26	Heterosexual	Unemployed	University	Married	Lower class	SGK
Canan	28	Heterosexual	Full time employed	Graduate student	Married	Upper-middle	SGK
Pınar	26	Heterosexual	Student	University	Married	Middle	SGK
Gökçe	26	Heterosexual	Full time employed	PhD student	Married	Upper-middle	SGK
Nazlı	30	Heterosexual	Full time employed	Master	Married	Middle	SGK
Ayşe	26	Heterosexual	Full time employed	University	Married	Middle	Private
Deniz	29	Heterosexual	Full time employed	Master	Married	Middle	SGK
Tuğba	29	Heterosexual	Full time employed	University	Married	Upper-middle	Private
Sena	26	Heterosexual	Full time employed	Master	Married	Upper-middle	Private
Demet	29	Heterosexual	Full time employed	Graduate student	Married	Middle	SGK

3.4 Interviews with Experts

I have conducted 5 interviews to get the opinions of experts in the area. 2 family physicians, 2 gynecologists, and 1 NGO worker participated in this research. I asked their expert opinions on sexual and reproductive health services in Turkey. Moreover, I aimed to learn the doctor's side of sexual and reproductive health interactions. I selected family physicians and gynecologists who had 20 years or more experience that currently work in Ankara, and I did not specify gender for experts. All experts work in state hospitals and family health centers in Ankara in various locations. Gynecologist 1 works in a maternity hospital and Gynecologist 2 works in a state hospital that is specialized in another branch of health. The reason why I

preferred experts from state hospitals is connected to my assumptions in designing this research. I assumed that structural issues in state hospitals and health centers could disrupt the sexual and reproductive health services more compared to private institutions and state institutions could be more closely affected by government policies as private institutions can have relative freedom. Additionally, when I tried to include experts working in private institutions, my requests were not responded, and I could not find a participant to my research.

Initially, my plan was to only interview family physicians and gynecologists. However, an NGO worker has reached out to me through my posts on an invitation to participate in my research in social media and offered to help. They worked on sexual and reproductive health in NGOs and international organizations for approximately 5 years. I cannot name the organizations that they worked for the sake of protecting their anonymity.

I prepared a separate questionnaire for expert interviews. The questionnaire I prepared was essential for physicians. After the NGO worker that I interviewed offered to help, I used the same questionnaire with physicians except for few wording changes and skipping few questions that only concerns physicians.

The data collection process for expert interviews started in March 2020 and ended in October 2020. All family physicians and gynecologists were reached through acquaintances and friends. The interviews with 2 family physicians and 1 gynecologist were conducted face to face prior to the coronavirus outbreak. Interview with the other gynecologist (Gynecologist 2) was conducted on the phone and in two separate calls as they were allocated to the filiation task team due to the pandemic. The NGO worker preferred to talk on video call due to the pandemic, as well. In all interviews, consent for participation was obtained; I took written permissions in face-to-face settings, and I asked for verbal confirmation in online and phone calls. The interviews with 1 family physician (Family Physician 2), 1 gynecologist (Gynecologist 1), and NGO worker were recorded. The other family physician (Family Physician 1), and the other gynecologist (Gynecologist 2) stated they prefer if I could take notes during the interview. Listening, asking questions, and writing at the same time was challenging for me. One of my respondents (Gynecologist 2) was helpful, and they waited patiently while I was taking notes. On the other hand, the family physician (Family Physician 1), who preferred that I took notes, seemed bored and gave me short answers.

Overall, I believe interviews with experts contributed to the research with a perspective on doctor's approach and expert views on trends and changes in sexual and reproductive health in Turkey.

3.5 My Experience as a Researcher and Insider

I mentioned my relation to sexual and reproductive health as an insider. I have been in the position of a single woman who consulted on sexual and reproductive health. I tried to make my position as someone who can share common experiences and has been through similar issues myself with my respondents. I did not explicitly mention my personal experiences to everyone in order not to affect their perception of their own experiences. However, if I noticed that they are struggling to explicitly mention their experiences, I gave examples without framing them as discrimination or judgment.

I recognize sexual health is a hard topic to talk about. It is not only many prohibitions and taboo nature imposed by society that we live in, but it is also difficult to recall and talk about bad and traumatic experiences that interviewees explained. I found myself getting mad and upset about the unjust treatment that interviewees had to face. I also felt this feeling of solidarity with them. It made me proud that even if those women had to overcome many hardships just to receive health care service in this field, they were not defeated; they collected themselves and came up with their own strategies, supported and helped their friends. I felt proud that I was able to tell their stories and help amplify their voices. Consequently, I tried to pass on this feeling of solidarity to them and show that I am empathetic to their problems and that we are working together in these interviews.

3.6 Data Analysis

I have conducted interviews with women and experts rapidly, one after another. Thus, I started transcribing the records after completing most of the interviews. I transcribed the interviews with experts, which I could record by taking notes right after the interviews in order not to corrupt any information that is provided to me. Transcribing the records and notes was a lengthy process that took longer than I initially planned. Nevertheless, I managed to finish transcribing without requiring any external help.

While analyzing the narrative that is provided to me by interviewees, I used the coding method that is explained by Auerbachand and Silverstein (2003). According to their method, firstly, the whole transcription is read at least twice to highlight the text that is relevant to research concerns and questions (Auerbachand & Silverstein, 2003). Later similar relevant texts are grouped together under themes and are connected to the theory (Auerbachand & Silverstein, 2003). This method required me to read the whole transcript many times, which altogether was more than 200 pages. However, by doing so, I believe I did not miss any important points in the transcript that can contribute to the arguments that I raised in this research.

3.7 Ethical Permission

As I mentioned in previous sections, I have prepared two separate questionnaires for this research. I submitted the first draft to my thesis advisor. Upon receiving her feedback, I updated the questions. I sent the last version of the questionnaires to Middle East Technical University Human Research Ethics Committee. They approved the questionnaires and my thesis research with no revision request. Consequently, it was approved that research I was planning to conduct will bring no harm to participants.

Before the start of each interview, I informed participants the voluntary nature of the interview and that they could end the interview or refuse to answer any question that in case they feel uncomfortable or even just do not want to answer. I informed them that the records and transcript would be deleted as soon as I complete the research. I did not share transcripts or voice records with anyone else. Moreover, I ensured the anonymity of participants by changing their names and omitting to include any information that can be traced back to identify them.

3.8 Limitation and Challenges of the Study

The interviews were conducted during the coronavirus outbreak. For this reason, face-to-face interviews were not possible, and all interviews except two of them had to be done through video calls. Similarly, I had to find potential interviewees to interview through online channels. Evidently, it was harder to find people who were willing to talk about their own sexual health experiences to a researcher they did not meet face to face. Diversity in the socioeconomic background was limited, and all respondents were university graduates or students.

Experiences of women from more disadvantaged economic or educational backgrounds, refugee women, and trans-men were not represented in this study and require further research. Similarly, even if there were bisexual respondents and respondents who did not define themselves as heterosexual, different experiences of LGBTI+ people who need to consult to gynecologists for sexual health care could not be included in this study and require further research.

While interviewing experts, I did not consult and interview experts working in private health institutions. I favored experts working in health institutions due to reasons I provided in section 3.4. Nevertheless, including an expert working in private institution could have brough another perspective and enrich the findings of this study.

Additionally, due to pandemic conditions and qualitative methods employed for this research, the number of interviews conducted remained limited, and the results of this study cannot be representative of all populations. Despite this obstacle, the results of this study were essential to understanding the existing conditions of sexual health care for single women in Turkey

along with the existing policy environment that affects it. Conducting qualitative research on experiences of groups that were not included in this study and quantitative research that is representative of the population to understand various experiences on sexual health services in Turkey would be the next step to improve the research on sexual and reproductive health services in Turkey.

CHAPTER 4

EFFECT OF STRUCTURE AND LIMITS OF HEALTH INSTITUTIONS ON SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Sexual and reproductive health services are affected by the current structure and limits of the state and privatized health system in Turkey. Arguably, the taboo nature of sexual and reproductive health, the inferior position attributed to single women who are sexually active and women's overall vulnerability in seeking sexual and reproductive health services interact with shortcomings and privatization of health care. This interaction results in women favoring private health institutions and creates undesirable service provision outcomes, which I will explain in this chapter.

One of the main structural problems is that the time spared for each sexual and reproductive health appointment is not enough for patients to communicate effectively with doctors and have an examination in state hospitals. Gynecologists have to rush, which is translated into action by neglecting to get consent and informing patients on the interventions. Patients' bodies are treated as the object of the medical practice. Thus, the rush in state hospitals exaggerates the already present objectifying approach of medicine. Patients whose needs are neglected and whose bodies are treated as mere objects end up feeling not listened, and violated.

I explained other aspects of differences between private and state health institutions through the advantages and disadvantages of being customer-patient. Patients who are seeking sexual and reproductive health care in private institutions access these services not on the basis of rights but the purchase of a service. Consequently, they expect to be treated better to continue to purchase that service. This brings additional accountability, and private institutions are forced to provide a better service that includes fair treatment of sexually active single women, easier access to health care, more attentive staff and ensuring the privacy of the patient. On the other hand, patients still depend on the expert knowledge of health staff that could mean unnecessary medical procedures can be done just to increase profits. Moreover, private hospitals and clinics are expensive, which means sexually active single women who cannot afford these services are at most risk of deteriorated sexual health.

I used experiences of both married and single women in this chapter. As I explained in Chapter 3, eight out of eleven married women I interviewed had experiences of sexual and reproductive health services. Moreover, both married and single women experience the hardships of structural problems in health system in Turkey. The reason why single women are more affected by these issues is that unfavorable behavior of health staff, such as lack of communication, objectification of patients or lack of respect towards patient's privacy and confidentiality of private information produce different result for married and single women. Sexually active single women are in more vulnerable position as they fear being judged and treated poorly or that their family or employers can find out that they are sexually active as the result of sexual and reproductive health interaction. When single women encounter a problem they have to risk that the information that they are sexually active might be revealed and have to demand justice as a single woman whereas married women are perceived as part of the family and they do not risk their private information in that process as their sexuality is accepted as valid.

4.1 Time Limit in State Hospitals and its Relation to Patients' Feelings of Being Objectified

One of the biggest challenges that most women voiced is that state hospitals have too many patients consulting for sexual and reproductive health, which results in a shorter time for each examination/consultation. There is an appointment system where patients can choose the doctor and time of the appointment; however, patients can also go to the hospital ask for any available appointment within the day. Consequently, the number of patients each doctor sees per day can be high, and doctors have to adjust the duration of appointments accordingly. 16 women out of 22 women interviewed mentioned time constraints as a problem in their sexual and reproductive health service experiences in state hospitals. Among the rest of 6 women, 2 of them never went to state hospitals for sexual and reproductive health services.

Inadequate duration for appointments can be a challenge for proper communication and right diagnosis in all branches of health care. However, patient-doctor relations and service provision can be affected disproportionately in sexual and reproductive health. One of the reasons for this is that in sexual and reproductive health services, patients expect gynecologists to be attentive, kind, and good listeners so that they can open up more easily about their health issues and sexual problems. Being listened to more carefully and kinder approach is one of the reasons that patients prefer private hospitals and clinics over state ones in sexual and reproductive health services. In this matter Canan stated that:

> Necessarily, as physicians accept fewer patients (in private hospitals and clinics), they can be more attentive and spare more time. I don't think I can have an appointment that lasts 30-40 minutes with a physician in a state hospital. [6]

Ceyda claimed that:

> In state hospitals, time is limited, and before you can express yourself, they have to give you a diagnosis. It is relatively more relaxed in private hospitals. But it is arguable how much you can go to private ones. …The duration (of appointment in private institutions) is longer, and I feel I can talk more clearly. [7]

In line with Ceyda's claim Bahar added that physicians expect patients to talk shortly and state only one of their issues and ignore patient's other complaints when they have multiple due to limited time. Demet added that:

> That lack of capacity in state hospitals….one of them (health workers) sees 1000 cases per day whereas the other one sees 5 cases, the one with 5 cases can ask in detail and pay special attention (to patients). The one with 1000 cases has to work rapidly.[8]

As it can be deducted from these quotes, interviewees experienced problems in state hospitals due to insufficient time allocated and physicians having to rush throughout appointments. Most of the interviewees emphasized the communication with gynecologists and other health workers affects the quality of sexual and reproductive health care services. When there is limited time, most of the appointment is spared for vaginal examination and ultrasonography screening. Consequently, there is not much time left for patients to explain their concerns or for gynecologists to inform their patients. In that case, patients feel neglected and they might struggle to trust the diagnosis or treatment.

Another difference between sexual and reproductive health services is that patients need time to get ready when a vaginal examination is necessary. It is not only getting undressed but also, they feel the need to emotionally prepare themselves and relax before the penetration with speculum or ultrasonography device occurs. Gynecologists that are rushing for examination and not informing the patients on physical interventions that they are about to perform result in violation of the autonomy of patients' bodies. In that matter, Demet stated that:

[6] İster istemez doktorlar daha az hasta gördükleri için daha çok ilgileniyorlar, bana daha çok vakit ayırabiliyorlar. Ben sanmıyorum ki yarım saat 40 dakika ben bir doktorla görüşebileyim devlette

[7] Ya mesela devlette zamanı kısıtlı belki sen aktaramadan onlar bir teşhis sunmak zorunda gibi, özel hastanede tabi biraz daha şey yani konu geniş gibi. Ve ama özel hastaneye ne kadar gidebiliyorsun o da tartışılabilecek bir konu. Sürenin biraz daha uzun olduğunu ve daha en azından net konuşabildiğimi düşünüyorum.

[8] Bu devlet hastanelerindeki kapasitesizlik yani. … günde biri 1000 vaka görürken biri 5 vaka görürse, 5 vaka gören tek tek sorar ihtimam gösterir. 1000 vaka gören mecburen böyle tatata çalışmak zorunda.

> When you go for ultrasound screening, you need some relaxation time because they do stuff to your certain places. … Because it was too crowded, they acted too quickly and before I could relax or understand what is happening, it happened. That made me nervous.[9]

Gökçe also has a similar experience where she said that:

> I felt uncomfortable during Smear test. Because without questioning anything or how I am doing at that moment… Okay, that is a professional thing, but without thinking was I ready or not, how I am doing; they did it without asking as if my body does not belong to me. [10]

Beril adds that during the ecamination speculum was 'shoved in to her vagina' while health staff were yelling her to relax and it was impossible to relax for her in that situation. Mine also complained that:

> Everything is done swiftly, so they push the device in when you least expect it. … If they cannot push it, they take that ultrasound thing (lube) and wet the device and push it again without asking you.[11]

Demet, Gökçe, Beril and Mine all had similar experiences in which gynecologists who were rushing with their appointments did not inform them on vaginal examination and carried th procedure before they were ready for it. Consequently, gynecologist rushing to finish vaginal examination can mean patients feeling unsafe and violated as intervention occur before they approve.

Fear of penetration of speculum is not uncommon among women, and bad experiences that are caused by gynecologists rushing and not prioritizing patients' consent and rights over their bodies can make the fear worse for women, which can lead to overall avoidance. For example, Hande mentioned she does not prefer to have a vaginal examination as it is painful for her. Even if this act of rushing and not taking the consent of patients before vaginal examination did not cause any future problems, it is a violation of patients' bodies. According to the Regulations of Patients' Rights, patients can reject or stop any medical operation, and no operation that the patient did not approve can be performed on them. Additionally, patients

[9] Ultrasondayken böyle orda da bir rahatlama süreci gerekiyor ya sonuçta senin bazı yerlerine bazı şeyler yapıyorlar vesaire falan orası da çok kalabalıktı. Aşırı kalabalık olduğu için hızlı davrandılar ben böyle bir rahatlayamadan falan ne oluyor ne bitiyor anlayamadan bir şeyler oldu. O da beni biraz şey yapmıştı, çıktığımda şey olmuştum, gergindim.

[10] Smear testi yapılırken ki şeyde rahatsız hissetmiştim. Çünkü o an çok sorgulamadan bir şeyleri, ben nasılım o an. Tamam orada çok profesyonel bir şey yapıyor ama ben hazır mıyım değil miyim bir şeylere ne yapıyorum falan demeden, bedenim bana ait değilmişçesine bir şey yapmıştı sormadan.

[11] Seri bir şekilde olduğu için hiç beklemediğin anda bir anda o aleti sokuveriyorlar. ...Baktı sokamıyor, sana hiç sormadan oradan ultrason şeyini alıp biraz ıslatıp aleti öyle ittirmeye çalışıyor

have to right to be informed of the steps of the procedure. Consequently, it should be a patient's right not to be caught off guard with the vaginal examination.

Bahar, Beril, Ceyda, Demet, Gökçe, Mine, and Nazlı had experiences in which gynecologists performed vaginal examinations when they were not ready and informed, or their choices over their bodies was not respected. Beril's first vaginal examination experience took place without being informed of the procedure, which ended up painful with her hymen being torn. Beril said that:

> Speculum was shoved into my vagina and opened immediately. …Of course, it started bleeding. They asked me, 'Your hymen is not healed. Why didn't you tell me?' … my hymen was flexible, and it was torn there in the hospital for the first time …I had been through a lot then. After that, she told me to go to ultrasonography rudely. After that, I didn't want to continue with that service; I wanted to end it. But I actually wanted to be treated. I avoided that. …after that started to have great refrainment and hesitation (towards sexual and reproductive health services). I never wanted to go. [12]

Beril avoided sexual and reproductive health services around 2 years after that experience. In her case, she was not informed of the steps of the procedure, which caused pain for her, and the gynecologist did not establish proper communication with her before the vaginal examination. It is likely that from a gynecologist's perspective, the longer the vaginal examination takes for each patient, the shorter time they have to spend for the next patient. In that attempt of rushing and finishing their work with a patient as soon as possible, consent of the patient can become trivial. Of course, the time limit cannot be presented as the only reason for health workers' disrespect towards patients' bodily autonomy. Beril stated she was yelled at, scolded and her hymen was torn because the gynecologist acted without establishing proper communication with her. She expects health staff to communicate with her and not to be "perceived as an object". With that statement, it cannot be only the time pressure that gynecologists and other health workers behaving rudely to patients and ignoring their rights over their bodies. Similarly, Ceyda had an experience where her consent and right over her body were denied when she requested a gynecologist to switch to full anesthesia during an abortion. She explained that:

> They said we could use local anesthesia, and I accepted it. During the procedure, I told them that it hurts too much and I can't continue this way. Then she said with an

[12] Spekulum direkt vajinama sokuldu ve açıldı direkt. …Kanamaya başladı tabi orada. "Senin himenin iyileşmemiş, neden bunu söylemedin?" gibi bir soru sordu bana. …Kızlık zarım her neyse esnekmiş ve yırtılma ilk kez o hastanede olmuş. … Bir sürü bir şey yaşadım. Ve sonra bana ultrasona gitmemi söylemişti böyle çirkin bir şekilde. Daha sonra o hizmeti devam ettirmek istememiştim sonlandırmak istemiştim. Aslında ondan tedavi olmak istiyordum yani ama. Kaçındım bundan. .. Ondan sonra çok büyük bir çekincem başladı benim. Asla gitmek istemiyorum.

> offensive attitude, 'Then why did you get pregnant. You should have known to protect yourself better.' and judged me liked that. I was in agony there. It was a very bad experience for me, and I had prejudice towards women gynecologists afterward. …She had a demeaning approach saying stuff like 'I can leave the procedure here if you want…. Stop moving.'[13]

Ceyda felt judged, and her demand regarding the operation was not respected. According to her, this might have happened because the gynecologist actually judged her for being sexually active and getting pregnant or that she wanted to finish her job immediately, and she thought Ceyda was making her job harder. After this experience, Ceyda avoided going for sexual and reproductive health services for at least 3 years. Demet, Bahar, Gökçe, and Mine were exposed to similar treatment with Beril and Ceyda in which vaginal examination was performed in a rush when they were not informed and ready for it.

I have explained Bahar's experience in section 5.2 of Chapter 5. In that experience, a gynecologist rushed her before and during vaginal examination and inserted an ultrasonography device even before she knew a vaginal examination was being performed. Bahar asked for them to stop the examination after that. Mine had multiple cases where gynecologists rushed her with vaginal examination and a similar experience in cryotherapy operation. In cryotherapy, she was not sure if that was the best treatment for her, and she was nervous. She stated that:

> I lay down on the table and told the woman, can we wait for a little. She kept trying to insert the speculum. I said can we wait. She didn't do anything, waited for a while. Then she said, is it okay now? I said I do not feel fine. She tried to insert again. I said I don't want the procedure. She said, are you sure? You have to sign papers (implicative). I said I am sure, signed the papers, and left. …I was very nervous and clenching myself. It hurts. I told her not to do it. No, she has to get her job done and leave.[14]

Nazlı's pants were pulled down by a gynecologist during abdominal ultrasonography. Instead of explaining the procedure, the gynecologist laughed at her, implying she is new to it and continued with the ultrasonography anyway. In Ayşe's case, a gynecologist could not perform

[13] Lokal anestezi yapalım dediler ve ben de kabul ettim. Lokal anestezi sırasında canımın çok yandığını ve bununla şey yapamayacağımı, bu şekilde yapamayacağımı söyledim. Ama o da bayağı itici bir tavırla, "O zaman neden hamile kaldın. Korunmayı doğru düzgün becerseydin." gibi yargılarda bulunmuştu ve bu beni bayağı şey yapmıştı yani orada çok can çekişmiştim. Bu da benim için kötü bir tecrübe olmuştu ve ondan sonra kadın doktorlara karşı önyargı geliştirdim. Kadın kadın doğumculara karşı. … Bayağı aşağılayıcı bir tavır falan takınmıştı. Şeyi böyle, "O zaman bırakayım. Burada bırakayım. Bu şekilde zaten bırakamam ama. Kıpırdayıp durma." Falan gibi bu şekilde davranmaya devam etti.

[14] Yattım masaya kadına şey dedim, biraz bekleyebilir miyiz dedim. O da sürekli şeyi, spekulumu sokmaya çalışıyor. Biraz bekleyebilir miyiz dedim. Bir şey yapmadı, durdu bir. Sonra tamam mı dedi. Yok dedim iyi hissetmiyorum. Bir daha bir denemeye çalıştı. Ben yaptırmayacağım ya dedim. Yaptırmak istemiyorum dedim. Emin misiniz kağıdı imzalamanız lazım dedi (imali bir şekilde). Eminim dedim. Kağıdı imzaladım rızamı, çıktım. … Bir de gerginim, sıkıyorum kendimi. Canım acıyor. Yapma diyorum. O yok işini yapacak gidecek. Hemen işini bitirecek gidecek.

the vaginal examination on her due to her pain. It was Ayşe's first vaginal examination, and she consulted the gynecologist because of continuing bleeding. The gynecologist complained and said, "Puff, but I can't do my job like this"[15] to Ayşe and did not inform her of her condition.

Another frequent experience among interviewees is that doctors were unable to provide solutions to period pain because they did not take the patient's pain seriously. Bahar, Begüm, and İlayda had been told that period pain is normal and needs no further medical attention even if they identified unusual pain that prevents them from continuing with their daily life. Bahar mentioned that:

> When I went for painful period complaints to 4-5 doctors, I came to a point where I had to diagnose myself. …I remember one of them very clearly; they told me, 'You will give blood for no reason. If your condition was that bad, you would be constantly hospitalized with that pain. It can't be that bad; you are paranoid.'.[16]

Similarly, Begüm explained that:

> I got a reaction that normalized the issue, as to say women have periods and they are painful anyway. I got a reaction where I was not cared for enough. Maybe there was a problem, and they were not taking it seriously; I felt worthless in that experience.[17]

İlayda also shared her experience where she had to go to gynecologist to ask for a medical report due to extreme period pain and the gynecologist only told her to take painkillers. Similar to insensitivity to pain a patient might feel during the vaginal examination, the painful period problem here is seen as a trivial and normal topic that does not need special attention from health staff. As pain can be difficult to measure and prove, it can fall under more subjective experience, which health staff can ignore when they adopt a medical case-based approach instead of healing individuals. The same medical-case-based approach can be seen in period irregularity problems which gynecologists tend to prescribe a common contraception pill to all patients without looking further into individual differences. Ayşe and Tuğba believe they were prescribed contraceptive pills when their issue with period irregularity was not hormonal.

[15] Pff, ama ben işimi böyle yapamıyorum ki.

[16] Bu ağrılı regl dönemi şikayetiyle gittiğimde herhalde gittiğim yaklaşık 4-5 doktor da bu konuda bir, ben kendi teşhisimi artık kendim koyma durumuna gelmiştim. …Bir tanesini çok net hatırlıyorum, boşu boşuna kan vereceksin dendi. Ya zaten o kadar ciddi bir şey olsa sen sürekli hastanelik olursun o ağrıyla gibi. Öyle değildir sen kendini kuruntu yapıyorsun gibi bu sebeple yapmadılar

[17] Çok kabullenilmiş bir tepki aldım, zaten kadınlar regl olur ve ağrır gibi. Çok da umursanmadığım bir tepki almıştım. Belki de bir sıkıntı var sanki yeterince (ilgilenilmedi), değersiz hissettiğim bir deneyim olmuştu.

Hande was not offered an alternative option to contraceptive pills when those pills trigger her migraine.

The common theme in all these experiences is that gynecologists acted without consent and proper informal of patients as they all acted in a rush. When physical and emotional responses of patients caused appointments to be longer, they were inclined to get mad and blame patients. More subjective and individual needs that can be emotional or even medical were ignored. Time pressure and attending a high number of patients per day can affect gynecologists and other health workers emotionally and push them to finish their work with each patient as quickly as possible. However, concluding that gynecologists' negligence of the subject position of their patients is caused merely by the short time allocated for each appointment would be an oversimplification of events.

According to Foucault, modern medicine requires physicians to look at their patients and see not a human being and an individual, but symptoms and irregularities which they need to relate to their medical knowledge (1973). In that approach, a patient needs to be abstracted and reduced to the external body in which is only in relation to the disease (1973). This erasure of the patient against the disease and the effect of illness on their organs is the medical gaze (1973). As part of modern institutions such as prison and mental health systems, modern medicine has been objectifying people for disciplinary mechanisms and producing knowledge (Almeling & Timmermans, 2009). Thompson defends that objectification can be desired by patients themselves, as long as it is purposeful for them (2005). Almeling and Timmermans emphasize the role of objectification in the production of knowledge and points out that health workers do not necessarily deliberately objectify patients as objectification can mean simply proceeding with diagnosis or treatment as abstraction removes distractions (2009). In addition to that objectifying approach patients can be perceived as customers which I will be discussing in the next section of this chapter.

I would argue that the experiences of interviewees point out the harmful consequences of objectification and medical gaze. As I mentioned previously, sexual and reproductive health is a highly emotional branch of health for patients. Women are aware they can receive judgment and be treated poorly by gynecologists and other health workers due to being sexually active, having multiple partners, or being in queer sexual relationships. Sexuality and sexual health are taboo topics, and they might find it hard to talk about it and find it hard to open part of their body that they are supposed to protect the best. The vaginal examination itself is emotional as it can't happen if the patient is nervous about the procedure. When women's bodies are treated as mere gateways to diagnosis, all these unique features of sexual

and reproductive health services are ignored. Mine explained how she was treated as following:

> When you are laying down on the table… they act like you are not there, …If need be, they go as far as fiddling. … Physicians do not care about you, they talk to their students about you and only answer to you when you ask (your condition), it is all because of arrogancy of physicians.[18]

Beril also stated that:

> I think they have to stop seeing us as an object. This can be difficult in state hospitals. There are too many patients; it is really crowded. …I understand that weariness. But still, I don't want my questions to remain unanswered, that it all happens in this weariness. Tell me anything that is informative. [19]

Mine and Beril explain how their body is perceived just as the body for health staff devoid of individuality and emotions. Nazlı also stated that she expects of being informed before intervention to her body happens and being informed like that makes her feel 'as a human being'. Objectifying the patients and ignoring subjective individual realities of patients result in bad emotional or physical experiences for patients and frequently hinders the treatment. Interviewees frequently emphasized that they mostly cut the service short when the communication with gynecologists or health workers felt rude and disrespectful. Another example is not using the medicine prescribed by a gynecologist. I would like to add a quote here from Beril as I believe she explained clearly why the communication of gynecologists and the subject position of patients is important. She argued that:

> I think health staff shouldn't see treatment as something only anatomical. They can start to perceive it more communicatively. For example, most people don't use contraceptive pills that doctors prescribe for polycystic ovary syndrome. If they could talk about it, just a bit. There could be more positive outcomes if they explained to patients saying, 'these pills have this kind of side effects, I prescribed these pills and it will affect you this or that way'. But I don't know if they care about positive or negative outcomes (of treatment).[20]

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[18] Sen orada mesela masada yatarken… sen sanki orada değilmişsin gibi kurcalamaya kadar giden şeyler olabiliyor. …Onun dışında polikliniklerdeki doktorların seni sallamayıp öğrenciyle birlikte üzerinde konuşup konuşup sen sorduğunda cevap vermemesi yine aslında toplumumuzdaki bu doktorların kıçının kalkıklığından.

[19] Bence biraz nesne gibi görmekten çıkmaları gerekiyor. Devlet hastanelerinde biraz zor olabiliyor bu iş. Çok fazla kişi var gerçekten çok kalabalık. … O bıkkınlığı anlıyorum. Ama ben yine de sorulara cevap verilmemesini, bir bıkkınlık çerçevesi içerisinde olmasını istemiyorum. Bilinçlendirici şeyler söyle.

[20] Bana kalırsa doktorlar, sağlık personelleri tedaviyi sadece hani anatomik bir şey olarak görmemeleri gerekiyor bence. Biraz da iletişimsel olarak da buna başlanılabilir. Örneğin polikistik over sendromunda çoğu kişi doktorun verdiği doğum kontrol haplarını kullanmıyor. Bununla ilgili belki biraz konuşsan, bir süre konuşsan. Bak bu hapların böyle yan etkileri var ben sana bunları vereceğim ama böyle de olacak gibi biraz daha açıklayıcı şeyler yapsalar biraz daha olumlu sonuçlar verilebilir. Olumlu ya da olumsuz sonuç alınması doktorun umurunda mı bilmiyorum ama.

Consequently, both diagnosis and treatment can depend on the way doctor communicates with patients and recognizes their needs. Moreover, physicians should communicate with patients in order for patients to make informed choices. Sexual and reproductive health services should not be approached by physicians and institutions purely from an objectifying and detached of humane interaction. I added institution to this approach because the medical knowledge itself enforces the objectifying medical gaze position. I asked family physicians and gynecologists whether they have received training on sexual rights and communication with patients. Family physicians did not receive such training in medical faculty; however, they have received information on reproductive rights in-service training. Only Gynecologist 1 mentioned that they were trained on privacy, consent, and bodily integrity of the patient in medical faculty. Family Physician 2 and Gynecologist 2 emphasized a disease-focused approach of medical faculties. Gynecologist 2 said that:

> No, they did not mention rights. Organic complaints, patients with symptoms, those were the target of our attention. … We dealt with clinical cases when we were assistants, so it (communication training) was never mentioned.[21]

Family Physician 2 stated that, "In faculty, it was more disease-based, you treat this disease that way"[22]. These statements can be related to Wilson's explanation that a purely objectivist approach in medicine begins in medical school (2000). Medical knowledge is taught within the frame of detached observer and repeating patterns of symptoms independent of the context (Wilson, 2000). On the other hand, doctors I have interviewed all point out how women can be shy and find it hard to talk about their condition to them in sexual and reproductive health, which means that they recognize there is an emotional element to sexual and reproductive health services. Consequently, patient-doctor interaction is important and has an impact on the outcome of the health care service (Wilson, 2000; Butler & Evans, 1999). I need to add that the incorporation of emotions and importance assigned to patient-doctor interaction by health workers may differ in state and private institutions which I will explore more in the next section.

To sum up, the limited time allocated to each appointment in sexual and reproductive health services amplifies the objectifying approach of medical practice. Procedures are done rapidly without getting the consent of the patient or properly informing them. When procedures take longer than usual due to patients' needs, patients are blamed for being difficult and preventing doctors from doing their job. The reason for that is on top of time pressure for each

[21] Yok haklardan bahsedilmedi. Organik rahatsızlıklar semptomlu hastalar bunlarla daha çok ilgilenildi. … Asistanlıkta da klinik vakalarla uğraştığımız için hiç konuşulmadı.

[22] Daha ziyade okullarda hani hastalık bazlı gidildi, bu hastalığa şu tedaviyi uygulayacaksın.

appointment; health staff looks at patients with medical gaze by perceiving patients as organs and symptoms that are devoid of emotions and subjectivity. This leads to ignoring the individual needs of patients in sexual and reproductive health, such as the need to be physically and emotionally relaxed and being listened carefully to establish a trust relationship with gynecologists. Ignoring patients' agency and not communicating with them properly lead to the discouragement of patients from sexual and reproductive health services and ineffective outcomes in diagnosis and treatment.

4.2 Being Customer-Patient in Sexual and Reproductive Health and its Effects

The projection of differences between state health institutions and private ones onto sexual and reproductive health services can be different than other branches of health. Patients that go to state hospitals for other services might prefer consulting to private hospitals and clinics in sexual and reproductive health if they can afford it. Patients that benefit from services in private clinics and hospitals are also customers of a business.

Privatization of health care in Turkey, which accompanied the Health Transformation Program of AKP, affected the accessibility of health institutions and options available to patients. Private hospitals received incentives, and integration of Social Security Institution to private hospitals allowed citizens to have easier access to private hospitals with additional payment (Yılmaz, 2013). Moreover, supplementary private insurance is introduced, which means those who can afford it could pay for this additional supplementary insurance to benefit from private hospitals with no additional charge (except contributory payments). As private health services were encouraged to take part in the health system in Turkey, the number of private hospitals increased from 271 to 575 from 2002 to 2019 (Ministry of Health, 2021). The effect of this privatization in health care on sexual and reproductive health services has been multifaceted as patients also become customers. In this section, I will explain the nature of being a customer-patient in sexual and reproductive health services with its advantages and disadvantages.

Privatization in health sector does not only affect the services provided in private hospitals and clinics, but state services can be affected as well. One reason for that is state institutions go through privatization within themselves. Patients have to pay contributory payments to benefit from outpatient services and medication in state hospitals and autonomization of secondary care health services leads to profit-oriented management model (Yılmaz, 2013; Doğan, 2017). Moreover, commodification of health services can affect health staff's performance, as well. Performance criteria that determine salary of health staff can change the focus of health staff from being patient-focused towards realizing the necessary level of fulfilment of these criteria.

Similarly, the pressure of privatization and the market mechanism to reduce costs might increase the workload and stress level in the public sector (Aydemir & Çetin, 2020). Salary differences and better working hours could encourage experienced health staff to prefer working for private hospitals and clinics. I explained how privatization create differences in service provision of sexual and reproductive health between private and state hospitals and clinics in this section.

I should note that when I address being customer-patient I only refer to the effect of privatization and the act of being customer in private health institutions. However, the ongoing privatization in state hospitals which I mentioned earlier in this section should be considered, as well. Nevertheless, factors such as considerable payments, market competition or customer satisfaction are not of concern to state hospitals. For this reason, I only conceptualized patients in private hospitals and clinics as customer-patients.

4.2.1. Advantages

When consulting to private hospitals, patients do not expect to access health care as their citizenship rights but at purchase of a service and expect it to be delivered in the best way. Consequently, they expect doctor-patient interaction to be an open communication in which they will not be judged and be informed in detail and to easily reach services that they cannot in state hospitals. In that matter, Seda mentioned that she expects services to be the best as she pays extra for them. Beril said that: "I don't expect coldness, weariness, or annoyance. …I purchase a service from you and I pay you. It is not a state institution; I pay for that service directly to you."[23]. Seda and Beril have a similar position in that they expect the best service and attentive staff because that's the service they are willing to pay. Additionally, Gonca mentioned that:

> I don't know, I go to a private hospital. They work less and work more comfortably. I am happy as I leave. I can share more and learn more. And they can share more with me. … Being a customer besides being a patient works.[24]

As Gonca says, being a customer and patient at the same time can help patients avoid problems they would have to face in state hospitals. Consequently, paying for a service that should be

[23] Bir soğukluk bıkkınlık bezginlik de istemiyorum. …Ben senden bir hizmet alıyorum ve sana bir para ödüyorum. Devlet değil ben ödüyorum sana direk o kurumda.

[24] Bilmiyorum, özel hastaneye gidiyorum daha az saat çalışıyorlar, daha rahat çalışıyorlar. Daha mutlu çıkıyorum, daha çok şey paylaşıp öğrenebiliyorum. Ya da onlar benle daha çok şey paylaşabiliyorlar. … Bir hastanın yanında aynı zamanda bir müşteri olmak işe yarıyor yani.

their right to reach freely raises their expectations, and private health institutions might have to respond to those needs in order to keep their customers.

Attentive health staff that establishes open communication and longer appointments that are not rushed are some of those advantages of being customer-patient in sexual and reproductive health services. On this matter, Zehra argues that private hopsitals are not crowded which enables staff to attend to patients more comfortably and all staff was very attentive. Sena stated that:

> They were very attentive. They do everything necessary; there is no approach that tries to brush you off. Maybe it is a sensitive topic; in internal diseases, they say, 'Okay, okay' and move on. But in dermatology and gynecology, they were always attentive in my experience. I can't say I encountered the same attention in other branches consistently.[25]

Additionally, Begüm explained that, "In private institutions, they tend to give more importance to privacy, the matter of money interferes. We pay money for it, so people have that expectation. We pay for it; at least they have to be a bit more attentive."[26]. As interviewees explained, their expectations that health staff to be more attentive and kinder can be easier to be met in private institutions due to working hours of the health staff and because they are also customers of the institution. Sena emphasizes that private institutions are also aware that patients expect different, more understanding, and attentive approaches from physicians in sexual and reproductive health services. If patients are not happy with the service, they would not prefer it again, and the institution loses customers. For this reason, private institutions seem to be subjected to a different kind of accountability compared to state hospitals.

Interviewees expressed their opinions on how private hospitals are subjected to different kind of accountability. İlayda stated that:

> I suppose they worry of complaints in private hospitals. Because of that, the approach of physicians is as if they are trying to understand the issues of patients and trying to make them more comfortable – not only in gynecology (but also in other units).[27]

[25] Gayet ilgililerdi. Hani gerekli işlemleri yapıyorlar, başından atmaya çalışan bir tavır olmuyordu. Belki de hassas bir konu, dahiliyeye gittiğinde mesela özel de olsa hı hı hı yapıp böyle geçiyor. Ama dermatologlar ve kadın doğumda hep böyle daha ilgili denk geldi benim deneyimlerimde. Diğer birimlerde aynı ilgiliyi hep tutarlı bir şekilde gördüğümü söyleyemem.

[26] Özel kurumlarda biraz daha hem o aradaki o mahremiyete daha önem veriyorlarmış gibi, biraz araya para meselesi de giriyor. Para veriyoruz insanlarda da o beklenti oluyor zaten. Para veriyoruz bari biraz daha özenilsin gibi belki.

[27] Sanıyorum özel kurumlarda biraz daha şikayet etme gibi kaygılar oluyor. O yüzden hastaya doktorun yaklaşımı, sadece kadın doğum için de değil bu, biraz daha önemsiyor gibi, biraz daha sorunu anlamaya çalışıyor gibi, biraz daha rahat ettirmeye çalışıyor gibi gelmişti.

Zehra mentioned that when gynecologist treat their patients badly, it becomes an incident in private health institutions whereas it is not as important in state hopsitals. Pınar argued that:

> People go to gynecology not only for examination but also for birth-related services, so they pay extra attention. They have to be extra attentive. That's why I believe they are better. …They have to be better so that they can get recommended. People do not take the risk of going to a place even if 10 people commented positively, but 1 person commented negatively. [28]

İlayda, Pınar and Zehra point out that health staff in private hospitals have to be more careful with how they treat patients due to the importance of customer satisfaction. Concerns of private health institutions to have a good reputation so they will not lose their customers bring an additional layer of accountability. For that reason, complaints of patients can be taken more seriously compared to an incident in state hospitals.

Patients can leave comments on various rating websites for doctors and hospitals that are accessible to everyone. Out of 22 interviewees, 15 of them stated they research gynecologists and ask their friends about their experiences before consulting for sexual and reproductive health in any hospital. Consequently, comments on these websites and prior experiences of acquaintances are important for patients. This could be the case for any other branch of health care. However, I would like to point out what Begüm said on the subject:

> I can do this (researching and asking for a recommendation on gynecologists) not only for gynecology; I can research doctors for other health problems as well. But asking around has specific importance in gynecology. …What women themselves experienced has so much importance in sexual health.[29]

Thus, patients need to hear the first-hand experience in sexual and reproductive health because they need to make sure that they won't encounter any judgment or bad treatment from health staff while trying to benefit from sexual and reproductive health services. Therefore, customer satisfaction tied to satisfaction as a patient becomes an accountability issue that pushes health workers working in sexual and reproductive health in private institutions to fulfill the communication needs of patients.

[28] Bir kadın doğum uzmanına sadece muayene olmanın dışında doğum için, kontroller için gittikleri için insanlar ekstra özen gösteriyorlar. Bu yüzden de ekstra özenli olmak zorundalar. O yüzden çok daha iyi olduklarını düşünüyorum. …Tavsiye edilebilmek için iyi olmak zorunda. 10 kişinin yorumu iyi olsa, 1 kişinin kötü olsa insanlar doğum yapacakları zaman bu risk almıyorlar.

[29] Bunu aslında sadece jinekoloji için de değil, ya doktor araştırmayı diğer sağlık problemlerinde de yapabilirim. Ama çevreye soruşturmayı yani ayrı bir önem arz ediyor jinekolojide. …Cinsel sağlık açısından kadınların kendi deneyimleri yaşadıkları o çok önemli.

This additional mechanism of accountability for private institutions can manifest itself in the way doctors reflect their personal approach to women's sexuality to patients. Consequently, another reason patients might prefer private institutions for sexual and reproductive health is that they believe health staff in private institutions will not explicitly judge them, treat them badly or refuse any service due to their sexual activity. In that matter, Canan expressed that she heard of cases of health staff judging patients and treating them badly from social media and her friends and she assumes that there are less cases of these bad treatment of single women in private hospitals. Gonca said that she was afraid of what she may encounter in state hospitals and she only went to private hopsitals for that reason. Additionally, Melek expressed that private health institutions are hygienic, they do not violate patients' privacy and they do not cause patients to feel bad. Moreover, Begüm stated that:

> I think there is a difference (between private and state hospitals), receiving service quicker, being more relaxed in terms of attitude (towards different sexual experiences) and being more understanding are the differences in my experience.[30]

Consequently, interviewees seemed to agree that it is less likely to be treated badly, judged, or denied a service because they are sexually active and single in private hospitals and clinics compared to state hospitals. The reason for that might be the additional accountability that private institutions are subjected to due to the fact that patients are also customers. Therefore, patients might prefer private hospitals and clinics to feel safer from judgment and bad treatment.

For the sake of customer-patient satisfaction, private institutions also need to respect the confidentiality and privacy of patients. Moreover, private institutions can be alternatives for women who fear their online medical records can be accessed by their families or employers as they can opt-out of registering the services to insurance in private institutions. For example, Hande and Ceyda prefer private institutions for this reason. Additionally, the absence of time pressure on appointments and a manageable number of patients per day in private institutions make it easier to create conditions where gynecologists can respect the privacy of patients. In the topic of pribacy in private helath institutions, Ceyda claimed that:

> And this privacy topic, for example, it is very unlikely for someone to enter the room (during the appointment) in a private hospital, but in a state hospital, you do not know if another patient or an assistant will enter.[31]

[30] Daha hem hızlı hizmet almak açısından hem de biraz daha tutum olarak daha rahat mı desem daha mı anlayışlı öyle bir fark var bence en azından benim deneyimlerime göre.

[31] Ve işte bu mahremiyet konusu atıyorum özel hastanede odaya birinin girmesi çok zor ama devlet hastanesinde arkadan başka bir hasta mı girecek, asistan mı girecek.

Beril argued that:

> (In university hospital) There is a curtain pulled, and they perform vaginal examination behind it directly there with a steel speculum. I didn't like that. The environment – there wasn't much privacy there. Nurses would look at your vagina. …Later, I went to a private clinic in İzmir. …There was patient privacy there. But in state hospitals, that's not the case.[32]

Moreover, Sena added that:

> In private hospitals, I feel- when you need to get undressed as you will get examined from below the waist, they give you that skirt, and they take you to a private space and give you as much time as you need. Men or women (gender of the expert) doesn't matter; they prepare that space only for you.[33]

Due to maintaining patient-customer satisfaction and lack of time pressure in appointments, patient privacy can be protected better in private hospitals and clinics compared to state hospitals. As Sena explains, the examination room is arranged for patient's needs, and their comfort is prioritized. In addition to those experiences, Deniz explained how she had to enter for her appointment with 3 other patients as there were too many patients waiting for examination in a state hospital whereas she was the only patient in her appointment in a private hospital and nobody entered the room during the appointment. Consequently, the number of patients per doctor and customer satisfaction can affect how much health staff in private institutions can respect patient's privacy and confidentiality more in private institutions.

Another complaint of interviewees regarding sexual and reproductive health services in state hospitals is that all processes of being diagnosed and receiving treatment can be very time-consuming. Booking appointments can be difficult for a gynecologist that women recommend to each other, and patients can end up being able to visit the doctor weeks after. In some hospitals, ultrasonography devices can be in separate room and patients might need to wait another line or book an appointment for another day to get screened. In the case of private institutions, interviewees state that they can usually go for sexual and reproductive health service whenever it is convenient as they can find an appointment easily, including Saturdays, all tests and screening can be finished quickly, and mostly they do not have to visit the clinic

[32] Orada perde çekilmiş ve direk vajinal muayene yapılıyor yani demir spekulumlarla yapılıyordu bir de. O benim çok hoşuma gitmemişti. Ortam – mahremiyet yoktu yani çok fazla. Hemşireler vajinana bakıyorlar falan garip bir şeydi. … İzmir'de bir kere daha gitmiştim özel bir kliniğe. …Ve hani bir hasta mahremiyeti vardı. Ama devlet hastanelerinde çok olmuyor.

[33] Ama özelde şey gibi hissediyorum geldiğimde soyunacaksın ya mesela belden aşağı muayene var sonuçta, eteğini veriyor seni özel bir alana alıyor orda istediğin kadar vakit veriyor. Kadın erkek (doktorun cinsiyeti) farketmez o şeyi, alanı tam olarak sana özel ayarlıyor mesela.

for treatment as they can reach their doctor through phone call or messages and receive their prescription. This difference between state and private can be related to customer satisfaction that private institutions have to provide. Additionally, private institutions typically have fewer patients as the number of patients that can pay for these services is less than state ones.

Interviewees expressed how they struggle with accessing the sexual and reproductive health services in state hopsitals. Demet stated that, "The most tiring part is that if I could receive all services within a day, I wouldn't need to take leave from work, and they could start treatment immediately. That's why I stopped going. It is a really deterrent procedure.". Tuğba pointed put that it is difficult to find appointments in state hospitals as they are usuallt fully booked. Gonca mentioned that:

> In high school, I didn't go to private hospitals. I was not aware of this difference that there is this much gap. They were not adequate. …After telling them my complaint and giving a test, sometimes it took a month to get screened with ultrasonography when they wanted to check cysts.[34]

Demet, Tuğba, and Gonca explain the hardships of accessing sexual and reproductive health services in state hospitals. Demet and Gonca point out the amount of time required to spend in hospitals to get services and delays due to the high demand for ultrasonography devices in state hospitals. Tuğba states how 'good' gynecologists, meaning non-judgmental and attentive ones, are hard to book for an appointment as they gain reputation among women and are overbooked. On the other hand, private health institutions provides means to patients to make access to sexual and reproductive health services easier. Sena mentioned that:

> You finish up everything within half an hour. That makes it easier to go. I mean, I know I will be done within half an hour. If you took leave from work, you could finish up in half an hour. It is good in that sense. I don't think it works that way in the state. For example, you need to go tomorrow, even now I can go this afternoon and finish up. Private ones have that comfort.[35]

Similarly, Seda mentioned that she can always find an appointment in private hospitals. Damla expressed that:

[34] Lise döneminde vesaire özel hastaneye gitmiyordum, o zaman bu kadar farkın arada uçurumun açıldığına dair bilgim de böyle değildi. Bu kadar yeterli değildi. Sıkıntımı söyleyip bir tahlil verip ki bazen bir ayı buluyordu ultrasonsa ya da kistlere bakılacaksa çok uzun sürelerde dönüyorlardı.

[35] Yarım saat içinde bütün işlerini halletmiş oluyorsun. O da gitmeyi kolaylaştırıyor. Yani biliyorsun ki yarım saat içinde işimi halledeceğim. İşten izin aldıysan yarım saatte bile gidip gelebilirsin, iyi o açıdan. Yani devlette bu şekilde işleyeceğini sanmıyorum. Mesela yarın, şu an bir ihtiyacın oldu, şu an bile öğleden sonra gidip halledebilirim yani. Kolaylığı var özelin.

> You do not wait too much in private (hospitals and clinics). It is easier to communicate as well. Plus, because of this pandemic, I did not go there; thankfully, I was able to contact them on whatsapp.[36]

Sena, Seda, and Damla emphasize that they can quickly get an appointment, finish off all procedures quickly, and easily communicate with gynecologists through phone or whatsapp in private hospitals. The difference in ease of access between state and private health institutions is clear in these statements. These differences in accessibility and duration of procedures between state and private hospitals can affect the choices of patients on whether to seek sexual and reproductive health services or not. Consequently, patients who seek sexual and reproductive health services in state hospitals can get discouraged to go for regular controls in time if they can't afford the private ones.

There are differences in terms of medical supplies and equipment used in private and state hospitals, as well. Deniz mentioned she had to bring her paper towels for her appointments in a state hospital. Beril pointed out that they use steel speculums in state hospitals compared to single-use plastic ones in private ones and might neglect using lubes for vaginal examination tools. Demet, Gonca's mother, and Pınar could only get screened with ultrasonography weeks later as there wasn't a separate one in the examination room. Bahar, Gökçe, Demet, and Tuğba emphasized the difference in technology of equipment used; in Tuğba's words, "The devices are less scary.". Lastly, Nazlı and Melek stated they could not be sure of state hospitals' hygiene and haven't encountered such problems in private hospitals. Lack of materials, especially the lack of contraceptives in family health centers, are voiced by family physicians and the NGO worker, as well. Gynecologist 1 stated they have no problems in terms of material supply as they work in a training and research hospital, whereas Gynecologist 2 claimed they lack devices for colposcopy, hysterectomy, in vitro fertilization, or cancer surgery and treatment.

The difference in equipment and tools between private and state institutions can be tied to the funding of each hospital. For example, not all state hospitals continue to use steel speculums or necessarily have ultrasonography devices in a separate room shared with other branches. However, there seems to be a noticeable trend that state hospitals either have lower funding approved by Ministry of Health or less inclination to invest on new equipment funded by either budget approved by the Ministry of Health or their own working capital compared to capital and investment choices of private institutions.

[36] Çok beklemiyorsunuz özel olunca. İletişim kurmak da kolay oluyor. Bir de bu pandemi sürecinden kaynaklı sağolsun sürekli gitmedim, whatsapptan da iletişim kurabildim.

4.2.2. Disadvantages

Before moving onto the disadvantages of the customer-patient aspect of private institutions, I want to emphasize advantages that I previously mentioned do not necessarily apply to all patient-doctor interactions in private institutions and all private clinics and hospitals. Interviewees had service provision interactions in which previously mentioned aspects were not met. For example, Beril was told by a gynecologist that a patient that left before her had HPV, which violated another patient's privacy and confidentiality. Nazlı felt her treatment was rushed, and the gynecologist was not informative and attentive. Gökçe encountered invasive questions about her sexuality which made her felt judged for her sexual life. These experiences all happened in private institutions. However, the advantages of being customer-patient reflect experiences of interviewees as well as customer's expectations from being a customer patient. Ayşe explains that attentiveness she expects from health staff in private institutions after her unpleasant experience with a gynecologist in a private hospital is as following:

> That physician was very cold, only asked some questions. She doesn't have to smile, but it is a service purchase; it is not the case in the state, but it is a paid service here. She could explain more and be more understanding.[37]

Accordingly, advantages such as more respect for privacy and confidentiality, more informative and attentive health staff, less judgment and discrimination based on a patient's sexual life can vary among private institutions based on different capacities of those institutions or individual interests of gynecologists.

An obvious disadvantage of being customer-patient would be that patient, or their private insurance are charged for any additional test or operation requested by doctors or themselves. In other commercial interactions, the customer would be relatively freer to opt-out of buying the service or product and typically have more information on whether they need the service or product or not.[38] In patients' experiences, the purchase of the service is advised by the expert of the field themselves, the gynecologist. The patients have considerably less information on the necessity of the service than the gynecologist; opting out of the service can mean

[37] O doktor soğuktu sadece bazı sorular sordu. Gülümsemek zorunda değil ama bence hizmet alımı dediğimiz gibi olduğu için, devlette öyle değil ama burada ücretli bir hizmet alıyorsun özel. Orada en azından ne olduğunu daha açıklayıcı olup daha anlayışlı olabilir.

[38] Free choice in consumption is debatable in the sense that necessity and needs can be created by different strategies of the brands. However, the effect of expert opinion could be less important in other type of purchases that are not health related.

deterioration of their own health. In private hospitals and clinics, health staff might use that to this advantage to increase both their own and institutions' profit.

Interviewees had concerns which they believe that health staff suggested unnecessary tests or applications for profit in sexual and reproductive health services in private hospitals and clinics. Ayşe was pushed to hospitalization for biopsy when there was no need, and every follow-up appointment was registered as a new appointment which meant charging her insurance additionally. Moreover, health staff in a private hospital pushed her friend's newborn baby to new tests consistently, that parents had a perception that they won't be able "to reunite with their child in health". Beril had a similar experience in which a gynecologist could not find what she thought was a wart and insisted on biopsy, saying that it is nonsensical to check it. Gökçe shared her experience by saying that, "I couldn't trust them for some reason. Besides, they ask for too many tests but are those really necessary; I can't be sure of that, so I consulted one other place as well."[39]. Hande mentioned that when health staff request more tests, they earn more and she cannot be sure if all the procedures requested are necessary. Additionally, Tuğba stated her concerns as, "In private hospitals, you can have concerns such as, oh, do they do this for profit?"[40]. Thus, interviewees perceived that some tests and operations in private clinics and hospitals are performed for profit which can affect patient's trust in these institutions and make them less accessible as the necessary payment increases with each additional test and operation.

The cost of sexual and reproductive health services in private hospitals and clinics can be difficult to afford for patients, especially if they do not have private insurance. Patients might need to push their budget, save money or even borrow money to benefit from sexual and reproductive health services from private institutions. On this matter, Beril says that:

> It is not the examination fee but usually cost of a blood test, other tests, ultrasonography those are expensive. It is difficult to spare your budget for this stuff. I thought about getting complimentary private insurance.[41]

Similarly, Ceyda mentioned that tests were too expensive for her. Damla added the following on that matter:

[39] Onlara çok güvenmemiştim niyeyse. Bir de özel olmasından kaynaklı çok fazla test istiyorlar orada ama işte buna gerçekten gerekiyor mu işte.

[40] Bir de özel hastanede ay para için mi yapıyorlar acaba diye bir tereddüt de oluyor.

[41] Muayene ücreti olmuyor genelde bu hani kan alma, tahlildir, ultrasondur o ücretler çok fazla oluyor. Sürekli de bütçeni böyle şeylere harcayabilmek zor oluyor. Bir ara acaba tamamlayıcı sağlık sigortası mı yaptırsam diye düşünmüştüm.

> I would prefer if I could go to state. We pay a serious amount of money. Despite these special packages I paid too much money. I have other health conditions as well. When I have to go to private hospitals for everything, I have to spare a considerable budget for hospitals. I would prefer state hospitals if they had it. I am still not sure. I do not know what I will encounter in the state. Of course, it depends on the physician. If they had these physicians I met, I could have gone to state hospitals.[42]

All three interviewees express that costs in private hospitals are too expensive for them. For patients who cannot get the sexual and reproductive health services they need from state hospitals, private hospitals and clinics can be the sole options, and the cost of services can prevent that as well. In urgent and essential services like abortions, patients who can't afford those services might be pushed to non-medical and/or illegal options, which can have serious consequences on their health. Thus, inaccessible sexual and reproductive health services in state hospitals and unaffordable sexual and reproductive health services in private institutions create a health gap and inequality between different income groups. Additionally, as presented in the previous section, single women who are sexually active and/or LGBTI+ patients are likely to have more problems in benefitting from sexual and reproductive health services in general. Therefore, income inequality can affect these groups more than assigned females at birth, heterosexual women who are married.

Regarding income inequality in benefitting from sexual and reproductive health services, Bahar, Begüm, Demet, İlayda, and Nalan emphasized they had to prefer state hospitals because they can't spare their budget for private ones. Additionally, Demet prefers going to state hospitals for sexual and reproductive health as she claims that health care is a citizenship right that the state should provide. Deniz stated that she finds privatization of essential services like health and education unethical. Melek mentioned that, "If you have financial resources, you can reach better services. But we are talking about the right to health which is an essential right; when we look at the general population, I don't think it is easy to reach services.". Accessing sexual and reproductive health services is a right, as Melek suggests, that should not depend on being able to pay for private hospitals or clinics. Considering almost all interviewees stated they were in a middle-class group, inequality in benefitting from sexual and reproductive health services can be assumed to reflect worse on lower-income groups.

In summary, being a customer-patient in sexual and reproductive health services can be favored as being a customer brings additional accountability of ensuring customer satisfaction to protect the reputation of the private health institution. In order to sustain their commercial

[42] Devlet olsaydı tercih ederdim. Çok ciddi paralar ödüyoruz. O kadar paket var demelerine rağmen bir sürü para ödedim. Ben başka sağlık sorunları da olan biriyim. Böyle her şeyde özele gitmek zorunda kalınca çok ciddi bütçe ayırıyorum hastaneye. Tabi ki devlette olsa tercih ederdim, emin değilim yine de. Devlette de neyle karşılaşabileceğimiz bilmiyorum. Tabi doktoruna göre bu görüştüğüm doktorlar orda olsa gidebilirdim.

success, health staff working in private health institutions are likely to be more attentive, kind, and less judgmental, while patients' privacy is better protected. Services such as abortion that are difficult to reach in state institutions can be reached easier in private ones. It is easier to access services and takes a shorter time to finish the procedure in private hospitals. Private hospitals are likely to have a better supply of equipment compared to state hospitals. On the other hand, being able to afford private hospitals can be difficult as services are expensive and unnecessary operations or tests can be suggested by health staff for additional profit.

4.3 Conclusion

The objectifying attitude of medical practice is exacerbated by the short time provided to each session in sexual and reproductive health care in state hospitals. Gynecologists having to rush with examination and consultation results in minimal communication with patients, and examinations can be carried out quickly. When patients are not informed of procedures and examinations are rushed, patients can feel violated and dehumanized. Moreover, gynecologists can blame patients for making their job harder for them if patients need to relax before an examination or state that they feel pain. The reason behind this is that, in addition to being under time constraints for each meeting, health care providers view patients through medical gaze, viewing them as organs and symptoms devoid of individuality and emotions. As a result of this objectifying approach, particular needs of patients in sexual and reproductive health, which are having the space and time to emotionally and physically relax, establishing open and informative communication with a gynecologist, are neglected.

While patients access health services in state hospitals as their right, it is a purchase in private health institutions. They become customer-patients in which their satisfaction as a customer is tied to their satisfaction as a patient. Thus, private hospitals and clinics that need to maintain customer satisfaction are pressured to deliver sexual and reproductive health services according to the needs of their patients. According to interviewees' experiences, private hospitals and clinics usually deliver those needs, which are attentive health staff, to be treated as any other patient as sexually active single women, protection of their privacy, and easier access to services. On the other hand, gynecologists in private health institutions still have the position of the expert, which means they can request medical procedures that are needles just to increase the profit. Additionally, being able to pay for service in private hospitals might be challenging due to the high costs which creates an income based inequality in accessing sexual and reproductive health services.

CHAPTER 5

WOMEN'S SEXUALITY IN TURKEY AND SEXUAL AND REPRODUCTIVE SERVICES

In this chapter, I will explain how the norm that women's sexuality can only happen in heterosexual marriage and the construction of sexually active women as dishonorable affect single women's sexual and reproductive health service interactions. Practices and attitudes of gynecologists and other health staff to patients that reflect the approach to women's sexuality that is collected from interviews with patients and experts will be analyzed along with the consequences and women's response to it.

The concept of honor that is constructed over the control of women's sexuality that prevails to this day concurred with increasingly authoritarian conservative discourses and politics of the government. Sexual and reproductive services that were becoming aligned with a rights-based approach in the 2000s that was reflective of ICPD, increasing donor options and democratization process in Turkey withered away in the 2010s. Services that are indicative of rights-based approach such as youth centers, free contraceptives, prioritization of STI prevention and treatment, pilot sexual health pieces of training were replaced with a focus on increasing the fertility rate and obstetric services. This shift in policy also brought an unofficial ban on services such as abortion or IUD applications on women who did not give birth. Moreover, on top of the negligence of sexual health services that are not related to childbirth, current conservative ideology affects the behaviors of health staff, as well.

The first obstacle that patients are challenged in sexual and reproductive health services is the assumption that single women are virgins and married women are the only ones that experience sexuality. This assumption is reiterated in many ways, but the most important one is to ask sexual activity of the patient through marital status. Sexually active single women who are greeted by this question are made to explain their experiences. This additional effort and explanation that single women have to put into get the service that they need remind them that they are not what society considers possible and normal. They are the outliers of the norm. Moreover, single women who are approached by this dichotomy of single-virgin/married-sexually active struggle to establish a relationship with a gynecologist that is based on trust

and open communication. They can get worried that they will be judged, or their needs will not be met because they are sexually active. Gynecologists that emphasize that they categorize women into those two groups fail to provide this trust and non-judgmental relation with patients who might react by limiting the information they share or cutting the service.

Sexually active single women are punished in sexual and reproductive health services for not confirming the norms that are produced by the culture of honor and increasingly conservative political environment in Turkey. Their sexual health problems are seen as not any other sickness but the consequence of their 'immoral' sexual behavior that they deserved. Because their sexuality is not perceived as normal and judged within the concepts of modesty, honor, and impurity, gynecologist and health workers can justify their bad treatment, insults, denying services to patients and even physical mistreatment of these women. Lack of accountability and the government's oppressing and conservative position on women's sexuality ensure that health staff does not receive any repercussion for their mistreatment. Sexually active women's bodies being perceived as violated or less honorable puts single women at risk of physical violation such as sexual assault or vaginal examination that took place before the patient is informed or ready. These sanctions women receive for experiencing sexuality outside of marriage can bring severe consequences for their sexual health. Thus, mistreatment in sexual and reproductive health can become a control mechanism of women's sexuality, much like virginity examinations or honor killings.

Another aspect of sexual and reproductive health services that prevents women from receiving those services and ensures the monitoring of women who do not conform to norms on women's sexuality in Turkey is violations of privacy and confidentiality. Lack of anonymity options and the recording of all sexual health information on databases that are accessible to any health staff that can be accessed without patient's consent threaten women with exposing their private sexual health information. Being exposed as sexually active can bring serious problems both in the family and workplace for single women. Additionally, gynecologists and other health staff can share private information with other people as gossiping, inform their family without the patient's consent, assistant or other patients can be present in the room during consultation or examination. The reason for this violation of privacy can be desensitization toward patients, a lack of awareness of patient's rights and sexual rights, and the assumption that personal information (particularly on sexual health) of women belongs to her family.

People who do not fit into the heterosexual marriage-based norms on how to experience sexuality and conservative familial ideals are the 'others' that are ignored, neglected, and disapproved by the government (See Section 2.4 of Chapter 2). As I argued in Chapter 2, LGBTI+ people and sexually active single women are in this group of 'other'. Consequently,

sexual and reproductive health policies do not include their needs which reflect on the existing services. Moreover, gynecologists and health staff are socialized and directed to prioritize obstetric services over other sexual health services. Performance criteria that determine the income of gynecologists do not include non-obstetric sexual health services. Thus, the sexual health needs of sexually active single women and LGBTI+ people are ignored and neglected both in policies and practices of sexual health.

The reflection of current conservative policies and discourses along the culture of honor on sexual and reproductive health services indicates the impartialness of medical practice. Even though physicians defend that medical practice is a science that cannot be affected by politics and blame the taboo nature of sexual and reproductive health for unmet needs of patients, structural problems, subjective positions of gynecologists that discriminate and judge single women are the main problems in access to those services, at least among socioeconomically advantaged and educated women.

5.1 Married Women as Sexually Active and Single Women as a Virgin Stereotype

Placing the possibility of sexual activity only within marriage is reflected in the way physicians communicate with their patients. They ask about sexual activity through marital status and patients have to explain that their condition does not fit into married- sexually active /single-virgin categorization. Because comprehensive sexual health education is not provided in formal education, patients who are not aware that they need to for through regular checks might be deprived of vaginal examination even if they need it.

Assuming single women to be virgins can damage the necessary open communication and trust relationship that patients need in sexual and reproductive health services. Women are aware that being sexually active single women can place them at a disadvantage and they fall outside of what is considered the norm in Turkey. In order to be able to communicate comfortably with their gynecologists, they need to trust them and believe that they will not be judged. When this trust relationship cannot be established due to health workers' position on women’s sexuality, women might end the communication or ongoing service or hide information regarding their sexual health from health staff.

At the beginning of each sexual and reproductive health appointment, the nurse or physician asks questions regarding the patient's medical history. These questions would include whether the patient is sexually active, number of partners, frequency of their sexual experiences, history of sexual problems, diseases and infections, etc. However, evidently many patients who consult gynecology clinics encounter a non-medical question, which is "Are you single or married?". Even in guidance books published to improve sexual and reproductive health

services, it is suggested to ask, "Are you married?" to patients (Ministry of Health, 2009b, 11-12). Being asked about their marital status instead of sexual partners and sexual activity seems to be common as 15 women (9 single, 6 married) emphasized that their marital status was asked at the beginning of their appointment. Starting the conversation with this question is vital as patients can take this as a sign that being single and sexually active is considered outside of the norm by health staff. Melek clearly states how she feels about this question: "When they ask, 'Are you married or single?' they draw a line in which they won't let you cross"[43]. Beril expresses how she despises the question as:

> When I first started receiving those services, (they would ask) are you married, I am not. The thing that bothered me the most and that I would beg in my head was 'please don't, please don't ask. Please ask if I am sexually active.' I am not shy to answer that question, anyway.[44]

Moreover, İlayda states that: "'Are you single/married 'question is a question that makes everyone nervous, and I still cannot understand why they do it. I cannot understand why they are doing this disturbing act."[45]. As interviewees own words suggest, patients can feel annoyed, mad or attacked when the type of examination that can be performed is asked through their marital status. The question symbolizes their position regarding marriage and sexual activity is not normal. Moreover, as Melek explained, after hearing this question, they get worried they might not be able to get much from the appointment regarding their health concerns.

There is limited research on the approach of health workers towards sexually active single women; however, research on the attitudes of health college and midwifery students points that sexual activity outside of marriage is not approved among health workers (Berberoğlu et al., 2011, Altun et al., 2013). Moreover, physicians performing virginity tests (Parla, 2001) and recent cases of denying abortion to women (Altuntaş, Keskin & O'Neil, 2020) can be considered their cooperation with conservative ideology and contributing to the patriarchal control of women's sexuality. Consequently, even in the case that they do not have a bias towards sexually active single women, they might be reluctant to provide service for them in order not to undermine the state's position on sexual and reproductive health.

[43] İlk başta "Evli misin, bekar mısın?" sorusunu sorduğunda sana zaten sınır çekiyor onun ötesine geçmene fırsat tanımıyor.

[44] İlk başlarda işte Evli misin, değilim. En çok gıcık olduğum, "lütfen sorulmasın, lütfen sorulmasın. Aktif mi diye sor aktif mi diye sor." Diye içimden yalvardığım şeydi buydu herhalde. Onu da yine de cevaplamaktan çekinmiyorum.

[45] Bekar mısın sorusu zaten herkes için çok gergin ve neden hala yapıldığını anlayamadığım bir soru. Bu rahatsız ettirmeyi neden yaptıklarını hala anlayamıyorum.

Physicians that I interviewed did not exhibit open disapproval towards sexually active single women and claimed they do not do any medical practice differently for single women; however, 2 family physicians and 1 gynecologist mentioned asking the marital status of the patient to ask for sexual activity. The NGO worker emphasized that health workers ask for sexual activity over marital status, which can discourage single women.

It is not only the question that is problematic, which makes patients nervous, but also women's concerns of explaining themselves and whether they will be able to get the service they need. If health workers do not ask about their sexual activity, patients have to explain that they might need vaginal examination, and this explanation can be difficult for them as they do not know how to express themselves or they struggle as talking about sexuality might not be easy for them. Besides talking about sexuality being taboo, as Ozyegin demonstrates, single women who are sexually active do not necessarily overcome feelings of guilt and shame regarding their sexuality and are aware that their status of being a sexually active single woman can affect people's opinion of them (2009). In this matter, İlayda stated that:

> Are you married or not is a very standard question. You would know, everybody you have talked to would tell you. You would hear it when you go (for sexual health service). 'Are you married?' I am not. There are very few physicians who ask the following question to this question. 'Do you have a sex life? Are you sexually active?" rarely comes as the following question. If you do not insist, they do not perform the detailed examination.[46]

By these words, İlayda remarks how commonly that this question of marital status is asked and examination can be determined based on the answer. Moreover, Ceyda expresses that, "Because they think that sexual intercourse comes with marriage; they keep asking questions in this way, and you have to explain it."[47]. She verbalizes that the question is asked that way because single women are assumed to be virgins. In that case, women are expected to explain that they are sexually active single women, which can be difficult for them due to their contradicting feelings of shyness towards sexuality or nervousness that they might receive bad treatment or be discriminated against. Thus, by asking about marital status instead of sexual activity, women are pushed to struggle and explain their situation as the 'outlier'. Their struggle and exclusion from the normal become standard and usual.

[46] "Evli misin değil misin" çok standart bir soru. Biliyorsunuzdur zaten konuştuğunuz herkes size söylüyordur. Siz de gittiğinizde biliyorsunuzdur. "Evli misin?", değilim. Buna following question soran çok az doktor var. Cinsel hayatın var mı, cinsel olarak aktif misin gibi following question çok az geliyor. Ayrıntılı muayene yapmamak gibi bir durum oluyor ısrarcı olmadıkça.

[47] Çünkü direkt evlilik üzerinden bu ilişki, yani evlilikle ilişkiye girildiğini düşündükleri için sorular bu şekilde gelmeye devam ediyor ve bunu sen açıklamak zorundasın gibi.

Asking marital status instead of the patient's sexual activity can be misleading as the type of examination is decided based on the answer to that question. Patients might not know that marital status is being asked to learn about sexual activity. They might not receive a vaginal examination if they are not aware they have to explain themselves. Damla mentioned that:

> These questions (marital status) are being asked, and people might not know that this refers to this kind of thing (vaginal examination). Why are you asking it this way?... It is a reality in our country; women do not say that they should go for a sexual health check when they turn 18 years old. I started it because I had a health problem.[48]

Similarly, Begüm argued that:

> I told them that I do not have a problem but that I came there for routine examination. They didn't ask the type of examination they can perform, or they didn't inform me about it. They checked with ultrasonography and checked my blood test. …I didn't say I have to have a vaginal examination. I trusted the expertise of the physician. …I didn't have a comprehensive examination; they didn't explain that to me.[49]

Much like the experience of interviewees, women might not know the necessity of vaginal examination or marital status is being asked if the vaginal examination can be performed. Sexual health knowledge that would enable women to learn more about terminology and their sexual health needs is not common in Turkey. There is no comprehensive sexual health education in formal education aside from biology classes and one-hour-long sessions of Changes in the Adolescent Period Project, which gave brief information on menstruation, genital hygiene, and proper use of hygienic pads to girls. Thus, the knowledge that sexually active women need to get sexual health services and PAP Smear test done regularly is not known by many women as they can only learn that necessity through informal resources even if they prefer to be informed by experts (Akın et al., 2003; Evcili & Gölbaşı, 2017). Consequently, single women who are sexually active might not go through regular checks due to the miscommunication caused by asking about sexual activity through marital status, which might postpone diagnosis and treatment of STIs or other health problems.

Beginning the interaction with a patient by asking a non-medical question that categorizes them into two groups of single women-virgin and married women- sexually active which they feel they do not fit. Experience of patients not being recognized by health staff from the beginning can disrupt the trust relationship that needs to be built for an effective service

[48] Çünkü bu sorular sorulabiliyor ve direkt böyle bir şeye refer ettiğinin düşünmeyebilir insanlar. Niye bunu bu şekilde soruyorsunuz ki. …Bu ülkemizde bir gerçeklik, kadınlar 18 yaşına gelince hadi ben gideyim senelik kontrol yaptırayım demiyorlar. Ben de bir sağlık sorunum olduğu için böyle bir şeye girdim.

[49] İlk kez geliyorum. Bir muayene olmak istiyorum. Bir problem hissetmiyorum ama bir rutin muayeneye geldim, dedim. Şeyi sormadılar, muayene şeklini ya da bununla ilgili bir bilgilendirme kesinlikle yapmadılar. Ya da ultrasonla bakıldı ve kan değerlerime bakıldı. …İlla bana vajinal muayene yapılsın demedim. Doktorun o expertliğine güvendim. … Kapsamlı bir muayene olmadım ben, buna bana açıklamadılar.

provision. Patients need that trust relation to feeling safe and believe disclosing their sexual activity and sexual health concerns will not bring them harm. Patients expect to share their concerns with no judgment and be informed by their gynecologists as spaces that sexuality and sexual health can be talked with correct information are limited for them. For this open communication and trust relationships to be achieved, they expect gynecologists and other health care workers to be kinder and non-judgmental. Thus, disclosing their sexual experience puts single women in a more vulnerable position against health workers and brings additional expectations such as kindness and a non-judgmental approach which would not be the case in other branches of health. Regarding this issue, Begüm mentioned that:

> I might postpone the appointment, and that might misdirect me. I don't know, in the diagnosis of a disease or if I feel shy and can't ask for vaginal examination. Of course, this is also about me. I shouldn't be ashamed, and I am aware of that, but the attitude of the physicians and these experiences we hear are important too.[50]

Zehra also states her opinon by saying:

> As I told you, it is a very intimate thing. It is something that requires you to trust the physician a lot. …Like I told you, this is a very unique branch. A woman needs to trust her gynecologist hundred percent.[51]

Additionally, Demet stated that:

> This is a topic that can make you nervous actually, even if you think you are comfortable, that you would not be ashamed, at least I think I wouldn't when you go there, different stuff can come up. Oh, I can be embarrassed by this. That's why when the communication is open you can tell your problems. Even basic stuff like, this part hurts, this is itchy can even make you feel embarrassed, but you can tell those when the communication is open.[52]

Demet and Begüm express how they might have hesitations or feel shy depending on the communication with their gynecologist. If gynecologists expose that they think sexual activity can only happen in marriage from the beginning, that trust and chance for open communication can be damaged. Zehra emphasizes the uniqueness of sexual and reproductive health in how her trust in gynecologists is important. It is important to add that the last gynecologist Zehra has been visiting was able to establish this trust relationship with her. She was able to have her

[50] Muayene olmayı erteleyebilirim ve bu yani yanlış yönlendirebilir. Ne bileyim dediğim gibi hastalığın teşhisinde, ya da ben orada vajinal muayene yapabilir misiniz demedim, ondan utandım diyelim. Tabi ki bu evet benimle de alakalı utanmamam gerekiyor farkındayım ama doktorun tutumu da önemli ve bu duyduğumuz deneyimler de önemli.

[51] Dediğim gibi intimate bir şey. Bence doktora çok güvenmeni gerektirecek bir şey. …Dediğim gibi bu çok daha ayrı bir branş ya. Bence bir kadının 100% güvenin olması lazım doktoruna.

[52] E bu da biraz insanı geren bir konu aslında ne kadar böyle bizim kafamız rahat ya da en azından kendi açımdan ben mesela utanmam gibi düşünsem de oraya gidince insanın karşısına başka şeyler çıkabiliyor. Aa utanıyormuşum. O yüzden iletişim daha açık olunca başka sorunları söyleyebiliyorsun. Çok basit şeyler, şuram acıyor veya buram kaşınıyor buram bilmem demek bile utandırabiliyor insanı ama iletişim olunca söyleyebiliyorsun.

sexual health needs met, including an IUD application and abortion. Thus, trust relationship with a gynecologist can encourage patients to communicate more easily and improve patient's sexual health.

When a trust relationship cannot be established between patient and doctor due to the approach and judgment of gynecologists towards sexually active single women, the communication necessary for meeting the sexual and reproductive health needs of the patient is severed. In these cases, patients tend to cut the service short, distrust diagnosis and treatment, hide relevant information, or lie about their sexual life. Gonca gave an example to that by saying:

> After the examination, they prescribed the medicine, but I was not married back then. They told me the reason is sexual intercourse. They had some prejudice such as saying never show this medicine to your parents and acted without communicating, after that, I cut the communication completely.[53]

Gonca stopped the communication with a gynecologist when they made her feel that being sexually active is considered wrong and that she should hide it from her family, which led to her receiving the wrong treatment. Melek expresses her position as following:

> To be able to speak on anything with someone, I need to know I can be comfortable with someone and know that I won't be judged. There are certain molds we have to fit in as women in this world, in this place. It is hard to live with them anyway. We struggle to express ourselves. On top of that, if a health worker tells me, 'Okay, then go there! (in a rude manner)', I will struggle to explain my issue for sure. I can say with no hesitation, the extent and specialization of the content of what I will explain to them changes depending on the attitude (of health workers).[54]

Canan has a smiliar experience with not being comfortable enough to share information with her gynecologist. She mentioned that, "While I was in İstanbul, we used to go with my mom, and I didn't open this subject to my mom. I never had a real examination with that physician. I didn't mention that I had a (sexual) relationship"[55]. Hande had to hide that she was sexually active from health staff because she used to go there with her family and she would receive reaction in which health staff seemed to believe that she was lying about her condition. Canan and Hande both lied to gynecologists about their sexual activity as they did not trust them to

[53] Muayene ettikten sonra ilacı yazdı ama o sırada evli değildim. Cinsel ilişki sebebiyle olduğunu söyledi. Verdiği ilacı asla annene babana gösterme gibi önyargıyla, kesinlikle iletişim kurmadan davrandığı için ben iletişimi kestim orada.

[54] Herhangi bir konuyu biriyle konuşabilmek için öncelikle o kişinin yanından kendimi rahat hissetmem, yargılanmayacağımı bilmem gerekir. Bir de zaten dünyada, böyle bir coğrafyada kadın olmanın getirdiği hepimize biçilmiş belli kalıplar var. Ve zaten bunlarla yaşamak zor. Kendimizi ifade etmek için mücadeleler veriyoruz. Sonra da üstüne bir de "işte tamam o zaman geç şuraya" diyorsa mesela bir sağlık çalışanı tabi ki yaşadığım herhangi bir sorunu anlatmakta güçlük çekerim. Şunu çok net söyleyebilirim o muayenehaneye girdiğimde karşılaştığım tavır nasılsa benim orda anlatacağım şeyin içeriği ve ne kadar geniş ya da özelleştirilmiş olabileceği değişiyor.

[55] Ama İstanbul'dayken genelde annemle gidiyorduk ve ben annemle gittiğim için hiç bu konuya girmemiştim. Hiç o doktora gerçek bir muayene olmamıştım. Hani ilişkim olduğunu söylememiştim.

not share their information with their families that could affect their health. In that sense, family interferes with women's sexual health as the status of being sexually active would disrupt the relations and could lead to a form of punishment for single women. Melek successfully summarizes why it is difficult to talk to gynecologists and how communication can affect the appointment. I believe "The certain molds that we have to fit in" represents the way that women are expected to behave. The coexistence of the ideal of chaste and modest women and the expectation of modern women to engage in sexual activity can create contradictions for women where they are expected to behave differently in different environments. Consequently, women want to make sure that their interaction with a gynecologist is a 'safe' interaction in which they can disclose their sexual activity and communicate freely. Not only do they feel ashamed, shy, or judged; but also, they are scared of ill-treatment because of their prior experiences or stories they heard from their friends and families.

To sum up, health staff reproduce the married- sexually active/single-virgin norm in their interactions with patients. Patients feel that their sexual activity is not seen as normal and feel excluded when health staff chooses to ask about sexual activity through marital status. Sexually active single women are left to explain themselves or receive inadequate sexual health service. This obstacle challenges patients as they expect open communication and an understanding approach from their gynecologists. If the expectation of patients to establish a trust relationship with their gynecologist fails, they cannot benefit from sexual health services properly as they stop communicating, hide information or lie about their condition.

5.2 Insults, Bad Treatment and Physical Interventions

After single women disclose that they are sexually active to gynecologists and health workers, they might face changing behaviors from gynecologists and other health workers. Interviewees mentioned being insulted, judged, being treated rudely, being denied services, or their body integrity not being respected due to their status as sexually active single women. Married women or single women who are not sexually active do not face these obstacles and bad behavior, according to the experiences of interviewees.

The foremost reason for the mistreatment and discrimination of single women is caused by the perception of women's sexuality in Turkish society. Women who engage in sexual interactions, especially if they are non-virgin (if their hymen is not intact), are considered to be 'less valuable' and not honorable. Moreover, the current politics of intimate of the government encourages the bias that sexuality can only be experienced within marriage. Women are expected to behave with chastity as self-sacrificing mothers and caregivers. Thus, women who do not conform to these norms are outsiders and immoral. When gynecologists

or health workers have similar views on women's sexuality, they can express it or act on it more freely when the government openly supports their position. Especially the lack of accountability due to the absence of effective complaint mechanisms, concerns of patients that their private information might be revealed, and lower social status that is attained to sexually active single women makes it easier for gynecologists and health workers to act upon their judgment and discrimination.

Health personnel acting on their views of sexually active single women does not mean that all health staff is socialized to shame the sexual activity of single women and have a bias towards their patients. Indeed, some of the interviewees mentioned that some gynecologists helped them get over their shame or shyness and were able to get the service that they needed. However, 9 single women and 10 married women I have interviewed, or their friends were exposed to some type of bad treatment due to being sexually active as single women.

When patients feel they are being judged by health workers, this can be through verbal insults, communication that feels rude to them or changes in body language after health workers find out they are sexually active while being single and/or they have multiple partners. Canan's friend had some experience which se explained as:

> For example, my friend went to get herself checked because she had multiple partners. When she went there for her health, she heard bad things such as 'You do this sh*t and then came to us looking for help,' and she felt horrible. Why would you hear such things? I go there to receive treatment, not and get myself judged.[56]

Beril summarized her and her friends' experiences as follows:

> The people (health workers) who made my friends cry, people who give lectures on 'you should not experience sexuality at this age', the ones who say, 'I hope my daughter won't turn to be like you'; it is deeply wrong that health workers say this stuff.[57]

Additionally, Melek explained her experience of being judged:

> There is a systematic thing that is similar to what we call mobbing at work. …Usually, you would expect them to say you can go there and lay down there, but their approach was 'okay, go over there (in a rude manner)'. A nurse, a technician, and a gynecologist

[56] Mesela bir arkadaşım kendini kontrol ettirmek için, çünkü birden fazla kişiyle beraber oluyordu. Kendi sağlığı için şey yapmak için gittiğinde, "Hem böyle haltlar yiyorsunuz hem de bizden medet umuyorsunuz." Gibi kötü sözler duymuştu doktordan ve çok kötü hissetmişti kendini. Niye öyle bir şey duyasın. Ben oraya yargılanmaya gitmiyorum tedavi olmaya gidiyorum diye düşünmüştü.

[57] Arkadaşlarımı ağlatan insanlar, toplum – cinselliği bu yaşta yaşamamalısın dersi verenler, umarım benim kızım da senin gibi olmaz diyenler; bunları sağlık çalışanlarının demesi o kadar yanlış ki.

> came close to me, and they made me feel like they are hellhounds waiting on my head, as if to say, 'You are not one of us, we don't like people like you'.[58]

In the case of Canan, Beril, and their friends' experiences, gynecologists and/or health workers insulted them for being sexually active. Patients are blamed and shamed for their sexual life. Melek emphasizes the aspect of behaviors of health staff that is rude and dismissive towards sexually active single women. Compared to obvious verbal insults, it might seem that change in body language is not as important; however, women who are already in a vulnerable position against health workers learn to read those expressions and carry the fear that change of attitude might escalate. They might expect to be judged or treated badly. Regarding this awareness of being judged Begüm mentioned that:

> There is a difference; I was able to feel the difference between going to a doctor and getting prescribed Nurofen with a neutral attitude and getting prescribed birth control pills. …I felt the look of 'She is taking these pills and having extramarital sex'.[59]

Similar to Begüm, Gonca mentioned that:

> When you speak with confidence, you can feel there is an additional change in the way they look at you, or maybe we easily get suspicious because we have a lot of reservations. We hear from people around us. I have my own experience in that. Even if it is only one, it was a big one for me.[60]

Begüm and Gonca explain how they understand the difference in body language. As Gonca states, women hear from media or their friends that being a sexually active single woman can be a disadvantage while receiving sexual and reproductive health services. Patients know the source of that disapproval not only through their or their friends' experiences in sexual and reproductive health but also through the norms that they have been exposed to regarding women's sexuality in Turkey in their everyday lives. Virginity examinations and honor killings which both functions as tools to control women's sexuality and punish women who won't obey, were publicized not so long ago (Parla, 2001; Sev'er & Yurdakul, 2001). Even with the tone of condemning, news on virginity examinations and honor killings can deliver the message that there is punishment and accountability for women when they choose to have

[58] O iş yerindeki mobbing dediğimiz gibi aslında çok sistematikleşmiş bir şey var. … Yani normalde şöyle demesini beklersiniz, şuraya geçebilirsiniz, uzanabilirsiniz demesini beklerken "Tamam geç şuraya" gibi yaklaşımları olmuştu. Yanıma gelen hemşire de doktor da bir başka teknisyen de geldi, sanki üçü başımda zebani gibi şeyi hissettirdiler, "Sen bizden değilsin, biz senin gibi insanları sevmiyoruz.".

[59] Çünkü arada farklılık oluyor, o nötr tavırla gidip doktora nurofen yazdırmakla doğum kontrol hapı yazdırmanın o ikisinin farkını hissedebildim en azından. … Sanki bu hapı alıyor ve evlilik dışı ilişkisi var bakışını hissettim ben.

[60] Bir de kendine özgüvenli konuştuğunuzda ekstra bir bakışlarda değişiklik olduğunu hissedebiliyorsunuz ya da biz ekstradan fazla huylanıyoruz belki çok çekindiğimiz için. Çevreden duyuyoruz. Bir de kendi deneyimim de var bu yönde. Bir tane de olsa bence fazlasıyla etkili bir deneyimdi.

sex outside of marriage. Moreover, they witness how educators present the "dangers" of sexual activity before marriage. Politicians publicly state that they do not approve of premarital sex, and their families clearly disapprove, so that women mostly choose to hide that they are sexually active from their families. Similarly, interviewees that were married at the time of interviews emphasized how much it differs when you seek sexual health care as a married woman. Nazlı explained that difference by saying that, "They couldn't treat me like that if I was married. I would be more acceptable as I would have done what is acceptable to them."[61]. Similarly, Deniz mentioned that she felt relaxed after she earned the legal status. Demet also had a similar opinion which she explained as:

> Back then, I was not married. I still felt a bit of pressure on whether I will face any problems. …Because now I am married, that pressure is lifted automatically. I don't think that's a good thing, but it gave me a chance to relax, personally.[62]

Additionally, Gonca explains the difference in her experiences after she got married as follows:

> Despite meeting those social norms, I still have some hesitations. …Even if I still have hesitations, there is a big difference in terms of comfort. I think that is not a good thing, but it is what it is.[63]

In these examples, interviewees state that they feel more comfortable and accepted in sexual and reproductive health interactions after they got married. They also agree that it is not a good thing that the approach changes once they conform to the norm that allows sexuality only in marriage and that marital status should not change anything. That is also confirmed by the statement of the NGO worker I have interviewed. Their statement emphasized that married women can access sexual and reproductive health services easier and do not receive bad treatment for conforming to norms and expectations of women's sexuality. Moreover, their reproductive function that is central to the familial ideal and population policies place married women as "a superior social class".

Besides verbal and body language cues of judgment and disapproval, gynecologists can deny services to women. Patients specified the reason for gynecologists not wanting to perform a vaginal examination or any other examination on women due to disapproval of sexual activity

[61] Evli olsam öyle davranmazlardı. Onlar için daha kabul edileni yapmış olduğum için daha kabul edilebilir biri olurdum muhtemelen.

[62] O zaman mesela atıyorum işte evli değildim, bir tık da olsa üstümde o baskıyı hissediyordum sorun olur mu vesaire. … Şimdi mesela evli olduğum için bu baskı ortadan kalkmış oldu otomatik olarak. Bunu iyi bir şey gibi söylemiyorum kötü bir şey aslında ama benim için bireysel olarak daha rahat olabilme olanağı oldu.

[63] O belli toplumsal normları yerine getirmiş olmama rağmen hala çekincelerim var. … Hala çekincelerim olmasına rağmen arada epeyce rahatlık açısından fark var. Bence bu iyi bir şey değil ama öyle oldu.

of single women. They do not want to help or heal those single women due to disapproval of their sexuality.

Physicians have the right to refuse treatment to a patient unless it is an emergency in Turkey. Physicians can refuse treatment under certain conditions; professional reasons such as lack of equipment or lack of expertise, personal reasons that can affect the treatment, contagious diseases, conscientious objection (Türe & Türe, 2017). For example, abortion can be denied to a patient by a physician for moral reasons. However, if a physician refuses to attend for a patient or refuses treatment, there should be another physician that is accessible and can attend to the patient, and a prior physician should inform the patient on their condition, medical needs, and steps of the treatment (Türe & Türe, 2017). Unless these conditions are met, a service cannot be denied to a patient.

The most commonly denied service to single women consulting to sexual and reproductive health services is vaginal examination. According to the experiences of interviewees, they often have to convince health workers to get a vaginal examination. The procedure is not openly denied in most cases; however, physicians evidently do not prefer to provide that service for single women. Gonca explained the situation as follows:

> You are being asked if you are married, and you get examined based on that. I didn't prefer to go there because of that. Because I was in a sexual relationship and not married. …I have heard different approaches to examination and change of attitude of physicians depending on marital status.[64]

Tuğba argued that:

> I went to state institution before I got married. In that case, they are not willing to do a vaginal examination. But I actually was supposed to have a vaginal examination. So, in order not to experience that struggle, I preferred private hospitals later.[65]

Gonca and Tuğba witnessed that health staff ask for marital status and decide on the examination based on that in state hospitals. Moreover, İlayda stated that:

> I have friends that say the communication style of physicians has changed after they tell them they are sexually active (as single women) …as if they respect you less. They

[64] Evli olup olmadığınız soruluyor ve ona göre bir muayene alıyorsunuz. O yüzden ben oraya gitmemeyi tercih etmiştim. Çünkü ben evli olmadığım halde cinsel ilişkideydim. … Bu evli olup olmama durumuna göre farklı muayene yöntemleri ya da doktorun tutumuna dair çokça paylaşım duydum.

[65] Bir de evlenmeden önce gitmiştim devlet kurumuna aslında. Yani o zaman jinekolojik muayeneye yanaşmıyorlar zaten. Ama aslında jinekolojik muayene yaptırmam gerekiyordu. Dolayısıyla o mücadeleyi yaşamamak için özeli tercih ettim daha sonrasında.

> approach with social label…and say I should not do this (vaginal examination) if you are single. [66]

İlayda emphasizes that health staff do not prefer to perform vaginal examination to single women. In addition to denial of vaginal examination, patients can be requested to sign a paper that states their consent on allowing vaginal examination. Both Demet and Pınar were requested to sign those papers as their marital status appeared single on their records. This practice can indicate that doctors might be denying vaginal examination to patients not only because of their disapproval but also, they might be concerned with possible malpractice complaints. The value given to the virginity of women can be a problem for physicians as well. A gynecologist tearing the intact hymen of a patient can be sued and charged and the gynecologist might avoid taking that risk (Milliyet, 2020). Nevertheless, the concern of legal procedure seems to be secondary as doctors denied vaginal examination to patients who had an examination in previous appointments.

In other cases, physicians refused to inform patients on contraception methods. Begüm's friends who were single at the time were scolded by physicians who told them, "How young are you? Nobody obeys traditions anymore!" when they asked for a recommendation on contraception. Begüm and İlayda themselves were also denied proper consultation on contraception methods. They both wanted to get their hormones and blood values checked to see which contraception method is the best for them. Health workers were hesitant to consult Begüm as they said if she is sure and using pills can be a bit harmful at her age. İlayda was told that pills could not be prescribed, and she can go buy them herself if she wants. Begüm said, "Maybe they refrain from talking about it (contraception methods). After all, they do not approve of being sexually active before marriage. I felt as if they think, 'Am I supposed to suggest a method?'.". As Begüm also mentioned, she was trying to make a conscious choice on contraception while health workers were discouraging her and not being helpful not because of her age as they suggested, but because she is a sexually active single woman. Moreover, health staff might be hesitant to guide women on contraceptives as discourses utilized by government officials demonized contraceptives as 'a way to make our nation go extinct' (Cumhuriyet, 2014). Denying consultation on contraception to patients can be damaging as there is no widespread information campaign on modern contraception methods in Turkey, and young people's awareness on contraception methods is limited (Akın et al., 2003; Başcı et al., 2015). When health centers are the sole and most easily accessible sources

[66] Cinsel olarak aktif olduğunu söyledikten sonra doktorların kendisi ile iletişiminin değiştiğini söyleyen çok arkadaşım var. Ben böyle çok, daha az saygı duyar gibi mi diyeyim. Çok böyle bir sosyal yaftayla yaklaşıp alttan muayene etmem, ederim. Ama bekarsan bence bunu yapmayayım gibi.

for reliable information on contraception, denying that services to patients based on age and marital status can be damaging and lead to an increase in STIs and unwanted pregnancies. For example, Mine was infected with various STIs due to a lack of information on the importance of contraception. She stated that:

> Seriously, my experiences thought me. I find out about HPV when I got infected. I learned all of it with experience. I learned that I need to use protection by experience. I didn't know that it was this necessary to be protected. To my surprise, we really need to be protected; I find out when I got infected seriously.[67]

When asked whether they inform patients on contraception methods, a common response of both family physicians and gynecologists was that they do it when there is demand from the patient. The main responsibility of family physicians is to provide preventative health care; however, patients are informed on contraception only on demand, and mostly the informing of patients on contraceptives is a task left to nurses and other health staff. On that matter, Family Physician 1 claimed that:

> Preventative practices on sexual and reproductive health and contraception are being told to patients when there is demand. We are very busy, so we can't explain family planning to everyone. Nurses usually explain.[68]

Family physicians are responsible for the monitoring of women between the ages of 15-49 twice a year to ensure the healthiness of the fertile women population. Contraception is one of the topics that is covered in this monitoring. However, as Family Physician 2 emphasizes, monitoring of women between the ages of 15-49 or informing patients on contraception are not included in performance criteria for family physicians. Family Physician 2 stated that:

> Neither 15-49 monitoring nor family planning is in performance criteria. I am sorry, but that affects (the service provision). If 15-49 monitoring were in performance criteria, no one's 15-49 monitoring would be incomplete. Easily, we would do it and reach everyone, but now look at anyone of us if we could even complete 30% (of the target population).[69]

Consequently, in the case of lack of accountability and intense patient load, informing patients on contraception seems to be left to enthusiasm and willingness of each physician. The

[67] Gerçekten deneyimlerim bana öğretti. Ben HPV ile enfekte olunca tanıştım. Bartholin kisti muhabbeti olmuştu mesela onla da enfekte olunca tanıştım. Ben hep yaşayarak öğrendim. Korunulması gerektiğini de yaşayarak öğrendim. Bilmiyordum o kadar korunması gerektiğini. Meğerse korunmamız gerekiyormuş çok ciddi bir şekilde enfekte olunca öğrendim. Gerçekten yaşayarak öğrendim.

[68] Cinsel sağlık ve üreme sağlığı ile ilgili önleyici uygulamalar, koruma yöntemleri Talep olunca anlatılıyor tabi. Çok yoğunluk var o yüzden herkese aile planlaması anlatılmıyor. Hemşire hanımlar anlatıyor genelde.

[69] Maalesef çok üzgünüm ama etkiler. Yani 15-49 performans dahilinde olsaydı, hiç kimsenin 15-49u eksik kalmazdı. Çatır çatır hepsini yapardık bir şekilde hepsine de ulaşırdık ama şimdi yani herhangi birimize bak yüzde 30u tamamlamış mıyızdır?

research on sexual and reproductive health services that Yılmaz conducted had a similar result that stated provision of family planning services depended on the coincidence that a trained person that is willing to provide service without financial gain is present (2020). For instance, Family physician 2 has been more willing to help patients inform them on contraception and sexual and reproductive health, whereas Family Physician 1 did not even know that their colleague has the certificate for IUD application. Family Physician 2 explained her position on family planning as following:

> Be it, women or men. I try my best to inform them. After they start talking, (you can see) the needs of that individual if they want this service, I believe it is important to make people more literate on certain health issues.[70]

Gynecologists that I interviewed had different answers regarding informing patients on contraception as one of them worked for a research and training hospital and the other one in a state hospital that is specialized for another branch. Gynecologist 1 works in the research and training hospital in which they have specialized units for different sub-branches of gynecology and obstetrics, including a separate unit for family planning. According to Gynecologist 1, patients with family planning demands, women who recently gave birth, or women who went through abortion in the hospital are directed to this unit and informed. On the other hand, Gynecologist 2 explained that they inform women on contraception if they see a need with following statement:

> We warn women with many kids or women who do not pay attention to their hygiene. We explain how to use protection to women who don't use it, women who don't have 2 years gap between childbirth.[71]

Gynecologist 2 emphasizes it is not possible to inform every patient at length on contraception or other sexual health issues as they are very busy because of the high number of patients, childbirths, and surgeries. This is in line with patients' claims as well; a common complaint regarding state hospitals was that time allocated to each appointment is not enough and that gynecologists don't inform them on sexual health unless they ask questions. Therefore, not only do some of the gynecologists and family physicians refuse to inform single women on contraception and sexual health due to disapproval of their choices regarding their sexual life, but also a time limit for each appointment and lack of accountability are the other obstacles,

[70] Kadın olsun, erkek olsun. Yani anlatmaya çalışıyorum daha doğrusu. Konuşmaya başlayınca kişinin ihtiyacı, bu hizmeti istiyor mu? Hani en azından belli sağlık konularında insanları okur yazar konuma getirmek önemli diye düşünüyorum.

[71] Mesela çok çocuğu olan ya da hijyeni yerinde olmayan kadınları uyarıyoruz. Korunmayan doğumlar arası 2 yıl süre bırakmayan çok çocuklu kadınlara korunmaları gerektiğini nasıl korunacaklarını anlatıyoruz.

which was an outcome of Adalı, Çavlin, Dayan and Topgül's research (2017). This has a negative impact on women's sexual health as their main and preferred source of information on sexual health is health workers, and lack of information on contraception can lead to risky sexual behavior and late diagnosis of sexual and reproductive diseases and issues.

Another example of being denied service was Deniz's experience in which a dermatologist refused to treat a genital wart due to disapproval of patients' choices regarding her sexual life. Deniz explained the situation as following:

> I believe he was a bit conservative guy, made me uncomfortable. …It is a vaginal wart; there is nothing to do. I am not keen on showing a part of my body, but you are a physician, and you have to look at it. It was around the end of the working day, and he told me that he is trying to catch his plane. I told him I am in a difficult position, it is relapsing, and I don't know what it is if he could check. He examined me, he was supposed to do one puff, and he didn't. It would take 3 seconds. Probably, he did not intervene thinking, 'You ate this s*** yourself, suffer![72]

This is another case where single women experiencing sexuality is perceived as something immoral and bad. By that logic, Deniz being infected with HPV might have been perceived as her punishment, and the dermatologist refused to treat the consequence of this immoral act. Moreover, the dermatologist refused to treat her while there was no alternative physician that is easily accessible as they were the only dermatologist in the only state hospital in that city where she was residing at the time. Consequently, not only a physician involved their own values and moral codes in the health care service and denied the treatment patient needed, but also, if the patient were to start a legal process, he could have been found guilty.

There are other incidents of bad treatment towards single women where women are intentionally hurt during an examination or other medical procedures. These incidents involve verbal insults of patients that signify the reason for them to act that way is related to the disapproval of the sexual activity of single women. In one of the instances, Bahar was not informed of the type of examination, and the physician did physical intervention without informing her. Bahar stated that:

> She didn't inform me in any way, such as saying I am doing this step now. Then, you know the ultrasound gadget they use for internal examination (vaginal) - by the way, I didn't see what she was doing during the examination. All of a sudden, she pushed the gadget inside, and I got irritated. She told me something like, "As if it is something you are not used to.". I felt bad, and I made my reaction clear to her. I said, "Why do you say something like that? I can't see what you are doing. I wasn't expecting it. I

[72] O da birazcık tutucu bir abimizmiş galiba beni rahatsız etti. …Vajinal siğil yani buna yapacak bir şey yok. Ben de çok meraklı değilim bedenimin bir yerini açmaya, sen hekimsin ve buna bakmak zorundasın. Tam mesai bitimi sırasıydı, uçağım var yetişmeye çalışıyorum dedi. Ben de dedim ki zor durumdayım, yine bir nüks durumu yaşıyorum ve hani ne olduğunu bilmiyorum. Bakabilirseniz en azından. Beni muayene etti de bir fis fis yapacak, yapmadı onu. Oysaki 3 saniyesini falan alacak. Muhtemelen "bu boku yedin çekmeye devam et."

> came here with an itchiness complaint, and you didn't say anything, so I didn't expect it". She told me, "You are not a virgin; why does it matter?".[73]

This gynecologist takes not having a hymen as the same thing with open consent to insert anything to push into the vagina. Consequently, she does not feel the need to explain the examination to the patient and can treat the patients' body as the object of medical interventions. This is similar to what Ergün points out on virginity examinations in rape cases (2006). If being a virgin (having intact hymen) prior to rape defines the punishment that the perpetrator will receive, then violating sexually active women is not as important as the violation of virgin women (Ergün, 2006). Similar to this distinction of virgin and non-virgin, gynecologists do not see that pushing a device into a patient's vagina without informing her is a violation. This is made clear by the gynecologist through her statements quoted by Bahar, as well. After this incident, Bahar recognizes that this is not the normal procedure and stops the examination. She stated that:

> I got mad, and I told her, "Can you please stop? I want to go.". She got up and looked at my face as to say, "What is the big deal about this?". I was really annoyed. I got up from the chair and was getting dresses. She told me, "There is no reason to make a big deal out of this" and I told her, "I want to get dressed if you will let me." She told me, "What is the issue as if it is something that I didn't see.". … As I was exiting, she said, "All types of people. You get infected with stuff from here and there, then you come here and complain.".[74]

It is a repeating theme that health workers who act upon their judgment use phrases that emphasize that patients deserve their deteriorated sexual health due to having multiple sexual partners. Bahar adds that the majority thinks that it is normal for marital status to be asked for the type of examination and that sexually active single women to feel shy as they think women should be virgins before they marry and should not have multiple sexual partners. This reflects the norm that sexual activity can only be confined to heterosexual monogamous marriage, and women who do not obey this norm are seen as outsiders and bad and less valuable women. The feeling of being outsiders and being discriminated against for this reason is also voiced by interviewees. On this subject, Melek expressed that:

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[73] Bu arada hiçbir bilgilendirme yapmadı, şimdi şunu yapıyorum şimdi bunu yapacağım diye. Sonra bu içerden muayene yaptıkları bir ultrason cihazı var ya ben tabi görmüyorum onun ne yaptığını o esnada. Bir anda içime soktu o cihazı ben de irkildim. Kendisi "Sanki alışık olmadığın şey." Gibi bir laf etti. Ben kendimi kötü hissettim açıkçası. Tepkimi de belirttim. "Neden böyle bir şey söylüyorsunuz? Sonuçta ben görmüyorum. Ne yapacağınızdan haberim yoktu. Dışarıda bir kaşıntı şikayetiyle geldiğim için siz de bir şey söylemediğiniz için beklemiyordum" dedim. O da "Zaten bakire değilsin ki ne olacak" dedi.

[74] Ben de sinirlendim. Durur musunuz ben çıkmak istiyorum dedim. Kalktı suratıma baktı, "Ne var şimdi bunda?" der gibi. Benim gerçekten sinirim bozuldu. İndim koltuktan, giyinirken "Ya bu kadar da abartılacak bir şey yok", ben de dedim ki "İzin verirseniz giyinmek istiyorum" hani. Sanki ne olacak burada ben görmediğim bir şey mi, dedi. Ben de rahatsız olduğumu söyledim. …Ben giyinip çıkarken de "Cins cins insanlar. Hem işte oradan buradan bir şey kapıyorsunuz, hem de gelip söyleniyorsunuz" falan şeklinde beni uğurladı.

> …Because discrimination can be based on ethnicity and religion but in the end, this is also a feeling of being a minority. On the one hand, I felt as I am a part of the minority and felt being discriminated. They probably didn't approach the woman after me like that.

Melek summarizes how being a sexually active single woman becomes an identity that is facing discrimination much like other minorities in Turkey. This reflects the powerful roots of the culture of honor and fixation on women's virginity is in society. It is not just disapproval, but single women receive sanctions for not being a virgin, such as being denied service by a gynecologist. Sexual and reproductive health is one of the areas where they have to disclose their sexual activity; thus, these sanctions became more apparent and affect their health.

Ceyda experienced a violation of her body due to this mentality that 'she deserved the outcome and the pain' because of her choices in her sexual life. She was going through an abortion in a private clinic, and the procedure initially started with local anesthesia; however, the pain became unbearable to her, and she asked to switch to full anesthesia. The gynecologist responded with rude words, such as "Then why did you get pregnant? You should have known better to protect yourself.". Ceyda was denied full anesthesia and had to endure the pain throughout the whole procedure.

The understanding that lack of hymen can replace open consent from the patient places patients into a more vulnerable position. When health workers see sexually active single women that way, that can lead to unconsented physical interventions, such as in the case of Bahar or even sexual assault. Deniz emphasizes this possibility and explains she prefers women gynecologists because of that in her following statement:

> I preferred her because she is a woman. What I mean by a woman is not that I am uncomfortable with the examination, but it is a small city, and the man I might encounter how he would behave, how he would approach and he would see all my information; that made a bit afraid. I couldn't dare.[75]

Male gynecologists might be avoided by women with a fear of being "misunderstood" which means possible sexual harassment or assault as the man in question might take the patient being sexually active as consent to any sexual act. This was also the result of research by Esin et al., which found that between 2006 and 2011, the preference for female gynecologists nearly doubled (2014). Gonca also vocalized her fear regarding the possible sexual assault of male health workers as follows:

[75] Kadın diye onu tercih ettim o zaman. Kadından kastım, muayene olurken rahatsız olmaktan öte küçük bir şehir ve karşılaştığım erkek hekimin nasıl davranacağını, nasıl yaklaşacağını, ve bütün bilgilerimi gördüğü için beni biraz o ürküttü. O yüzden cesaret edememiştim.

> Already, there are problematic attitudes and judgment towards women. On top of that, if you are a student and not residing with your family, those attitudes can reach extremes. You are even afraid of being sexually assaulted when a gynecologist is a man and has the knowledge that you are sexually active.[76]

She points out a general problem on how society perceives the sexuality of women. Additionally, she remarks an additional disadvantage of single women; single women who do not have the protection of their family can be perceived as more defenseless and vulnerable. When this is combined with the notion that sexually active unmarried women lost their honor and no longer have control over their sexuality, patients become vulnerable to any mistreatment that can reach extremes. For Gonca, it is not only fear of being open to assault, but a second-hand experience as her friend was sexually assaulted by a health worker for the same reasons she emphasized. Gonca explained the situation:

> My friend was sexually assaulted. She went to a gynecologist. After that, during ultrasonography or X-ray screening, the technician who works there sexually assaulted her by hand while trying not to make it obvious to her, but she knew it was sexual assault. He talked to her and was testing the waters, constantly trying to talk about sexuality. But there was groping for sure because you are vulnerable there. You lay down for X-ray or ultrasonography.[77]

The understanding that sexually active single women are morally inferior and their consent is open to everyone as they already have multiple partners puts women in a vulnerable position not only in their daily lives but also in sexual health interactions, as evident in these examples. Moreover, the examination position limits women more compared to other types of examination in other health branches in terms of their ability to defend themselves, as Gonca explained. Bahar had a similar statement waiting in a laying down position on the gynecological examination table made her feel defenseless, especially in the first few visits. Thus, patients are both physically and socially vulnerable in vaginal examinations

It is not only physical vulnerability or defenselessness that is the problem when women encounter any type of violation of their body in sexual health service interactions. It is also the inability to receive justice for what has happened to them and hold perpetrators accountable. One of the obstacles is that women are worried that the fact that they are sexually active might

[76] Çünkü zaten toplumda kadınlara karşı çok sıkıntılı tutumlar, yargılar var. Bir de okuyan ve ailesinin yanında olmayan bir kadınsanız bu tutumlar çok farklı yerlere varabiliyor. Kadın doğum uzmanı bir erkekse ve sizin hali hazırda cinsel ilişkide bulunduğunuza dair bir bilgisi varsa onun sizi taciz edebileceğinden bile çok çekiniyorsunuz.

[77] Bu tacize uğrayan arkadaşım. Kadın doğum uzmanına belli bir konuyla gidiyor. Sonrasında ya ultrason ya röntgen tam hatırlamıyorum ama oradaki teknisyen fark ettirmemeye çalışıp ama daha önceden de bildiği için fark ettiği, elle taciz konuşarak da birazcık bir ağzını arama gibi mi diyeyim. Sürekli cinselliğe yönlendirme konuyu. Ama elle taciz var, çünkü siz orada savunmasızsınız. Bir röntgen ya da ultrason durumunda uzanıyorsunuz.

become public in the process of issuing a complaint. Regarding complaining, Gonca mentioned that:

> The worst part is she couldn't find anywhere to issue a complaint partly because her mother works there. If she were to complain, she would have to explain why she was there. Because there isn't much privacy there, everything is shared very quickly. There is no confidentiality. …It was a private hospital, by the way. The other reason is she is a civil servant.[78]

Lack of a complaint mechanism that guarantees the anonymity of the complainant prevents accountability of health workers. Women who have been mistreated and/or assaulted have to risk exposing their private sexual health information to ensure justice which is not a risk all women can take, as demonstrated in the case of Gonca's friend.

The result of receiving bad treatment, judgment and inattentiveness from health workers is that women can be discouraged from receiving any sexual and reproductive service at all. Not only their own experiences, but news or friends' experiences can affect their choice of whether or not they will seek sexual and reproductive services. It can take years before they can build trust with other gynecologists when the previous ones violate their trust. On that subject Beril stated that:

> After that, I started to have incredible hesitation. I never wanted to go for sexual health. I might have had a yeast infection back then, but I absolutely didn't go. It healed on its own. Years later, 1-2 years later, I had a very bad yeast infection, and I had to go.[79]

Similarly, Ceyda could not seek sexual and reproductive health service for a while which she explained as:

> After this abortion, it affected me badly. I didn't think I could face it for a long time because she treated me very badly. I didn't want to go to any sexual health expert for a long time. …I didn't go for at least 3 years, maybe 3-4 years.[80]

Melek also struggled to consult to these services after her bad experience with health staff which she vocalized as follows:

[78] İşin kötü yanı bunu şikayet edecek bir yer de bulamamış olması. Birinci sebebi aynı kurumda annesinin çalışıyor olması, bu daha sıkıntı. Yani şimdi orada şikayet edecek olsa o doktora neden gittin, neden oradaydın, bunlara açıklama getirmesi istenecek. Çünkü çok da mahremiyet yok oralarda, çok çabuk paylaşılıyor her şey. Gizlilik yok diyelim. ...O da özel bir hastane bu arada. Bir de memur olması.

[79] Ondan sonra çok büyük bir çekincem başladı benim. Asla gitmek istemiyorum, Kaç yıl sonra 1-2 yıl sonra çok kötü bir mantar enfeksiyonu geçirdim ve gitmek mecburiyetinde kaldım.

[80] Bu kürtajı yapan doktordan sonra olumsuz etkiledi. Çünkü uzun bir süre bununla yüzleşebileceğimi falan düşünmedim. Çünkü bayağı kötü davranmıştı. Herhangi bir cinsel sağlık uzmanına gitmek istemedim uzun bir süre. … Yani 3 sene falan gitmemişimdir kesin. 3-4 sene belki.

> I didn't want to go to regular check for a long time if I can help it. I didn't feel good at all because of the treatment I received. You do not want to go at all after a while, and this could have more severe consequences.[81]

Interviewees that had bad experiences, especially when that bad experience involved physical intervention, find it difficult to seek sexual and reproductive service again. Moreover, women who hear their friends' and acquaintances' experiences of bad treatment towards single women might never consult sexual and reproductive health services. For instance, Canan went to a gynecologist regularly; however, she did not reveal she is sexually active until her friends insisted that she should. The reason is that she was afraid of the attitude of health staff towards her because of the stories she heard from friends and social media. Avoiding sexual and reproductive services for a long time can have severe consequences on their sexual health.

In summary, sexually active single women are met with backlash when they want to benefit from sexual and reproductive services. Their deviant from the norm on women's sexuality results in insults, bad treatment, being denied services, or violation of their bodies. The choices that single women have been making in their sexual life are used as justification for any sexual health problem that they may have, and gynecologists frequently emphasize that they deserve that outcome. Women might be refused to be treated, examined, or informed because gynecologists do not want to heal consequences of 'immoral acts'. Moreover, sexually active single women might find themselves in a vulnerable position against the violation of their bodies due to the perception that the virgin women's body (thus, chastity and honor) being more valuable than non-virgin women and that their bodies cannot be violated. This systematic bad behavior and risks that single women experience in sexual and reproductive health can be considered as another form of control mechanism over women's sexuality. Single women who experienced discrimination, violation, and risks in sexual and reproductive health cannot effectively benefit from these services and can get discouraged, which can lead to serious consequences on their health.

5.3 Privacy and Confidentiality Issues

The patient privacy and confidentiality of private information is another topic that interviewees were concerned. I have explained in previous sections that sexually active single women are assigned a lower status, considered less honorable and respectful than virgin women; consequently, they have a higher risk of discrimination and sexual assault once their sexual activity is known by others. Thus, single women frequently hide that they are sexually active, especially from their families (Ozyegin, 2009; Scalco, 2016). Consequently, registration of

[81] Ben uzunca bir süre mecbur kalmadıkça kontrole gitmek istemedim. Karşılaştığım muameleden dolayı, kendimi hiçbir şekilde iyi hissetmedim. İnsan bir süre sonra gitmek istemeyebiliyor ve bunun daha kötü sonuçları da olabilir

their sexual health information on data systems or risk of health staff sharing their information with others become crucial for patients.

The violation of confidentiality of patients is not uncommon in sexual health and reproductive health services. Interviewees witnessed information of other patients or their friends revealed by health staff. Moreover, all health-related information of patients is registered on e-nabız and MERNIS systems. E-nabız can be accessed by family physicians and workplace doctors, which creates a risk of sexual activity status to be shared with current or future employers or family.

Disrespect towards patients' privacy is another aspect of sexual health interactions that especially single women struggle with. Assistants entering the room and observing the examination without the patient's consent have caused discomfort for patients. The reason for that is sexual and reproductive health interaction is not an easy communication for them due to fears of mistreatment and discrimination. Similarly, other patients entering the room during examination or consultation can sabotage the interaction of the patient with a gynecologist. Moreover, uncovering the patient without their consent, not closing curtains while the patient is getting dressed or undressed are the incidents that interviewees had an encounter that made them unsafe and distrusts the health staff.

All medical information and interventions of patients are recorded in electronic systems in which patients can reach through a website called e-nabız. It is not possible to hide information in this electronic system from pharmacies, any physician, or workplace physician. Interviewees believe their family members or future employees can reach their insurance documentation and e-nabız records. Therefore, they try to avoid having a procedure that can affect their career and family life in state hospitals. Regrading this issue, Canan states that:

> All treatments are recorded on e-nabız system. I didn't want to have that kind of record. When something happens, my family could find out. …Because if you go to private ones, you can decide on whether to have the record or not.[82]

Ceyda also mentioned that, "First of all, this kind of thing should remain confidential between physician and patient and should not be registered on any system; for example, I don't want to see it on e-nabız."[83]. Hande has similar concerns due to the employment of her father in which she explained as:

[82] Her tedavi şimdi e-nabız sistemiyle kayda geçiyor. İstemedim yani bende kayıt böyle bir şey görünsün bir şey olduğunda aileme de haber gidiyor falan. Ondan istemedim yani, kayda geçsin istemedim. Çünkü özelde gidersen kayda geçirip geçirmemek senin elinde.

[83] Ya bir kere bu tip şeylerin hasta ve doktor arasında mahrem kalacağını ve kayıtlarda hiçbir şekilde görünmeyeceğini, atıyorum e-nabıza girdiğimde de orada görmek istemiyorum.

> Because my father is a doctor, he can see everything. That was a big concern for me. So I always preferred to go for private clinics. … I don't want my family to find out, and because I study law, I am planning a job connected to the state, and I don't want any type of recording on this.[84]

Canan, Ceyda and Hande were worried that their sexual health information being registered to e-nabız system could reveal their information to others, especially to their family. E-nabız system is not designed for the protection of personal information. When anyone accesses the personal information of a patient on e-nabız, a notification is sent to them. However, there is no prior consent taken from the individual for accessing the system in practice. Kazanbas argues that data storage tools enable the government to collect data from surveilling over bodies and optimizing lives (2019). This optimization covers deciding on moral and immoral acts, such as pregnancies within or outside of marriage (Kazanbas, 2019). Considering the current government's position on women's sexuality and enthusiasm for standardizing the society around conservative family structure, it is possible that the data registration system for health is also utilized as a surveillance and control mechanism for detecting the ones who fall outside the norm. However, women's concern is not merely the tool itself but also distrust towards people who may access it.

Interviewees are worried about their personal information on sexual health shared by physicians. They fear that their information might be shared with their family, especially in the case of family physicians. For example, Canan did not disclose that she is sexually active to her gynecologist might share that with her mother. Begüm demonstrated her hesitancy to consult family physician in her following statement:

> I never went to a family physician (for sexual health). I think my preference is affected by the fact that I am single. …But because of the reaction, I might encounter. …Family physician knows my family, too. They talk to each other, saying, 'Ayşe got the flu, Ahmet's daughter has this and that', I heard it myself.[85]

Similarly, Begüm did not consult a family physician even if she knows that she can consult them for contraception. The reason is that she knows that they do not respect the privacy of patients and can share information on her sexual health with other physicians or her family. Moreover, Beril's friend was worried about her privacy and confidentiality of her information in which Beril explained as follows:

[84] Babam doktor olduğu için her şeyi görebiliyor. Bu benim için çok büyük bir sıkıntıydı. O yüzden muayenehaneye gitmeyi tercih ettim. … Evet ailemin duyması ve hukuk okuduğum için sonrasında devlette iş düşünüyorum ve hiçbir şekilde kayda geçsin istemiyorum.

[85] Evet, aile hekimine gitmedim hiç. Bir de bekar olmanın da etkisi illaki vardır bu tercihimde de… Ama o karşılaşabileceğim tepkiden dolayı. … Evet ailemi de tanıyor zaten aile hekimi, birbirine Ayşe de grip olmuş yok Ahmet'in kızı da bilmem olmuş diye ben bunu kendi kulaklarımla duydum.

> She was very scared. (She said) I go to the same family physicians as my mother and father. Family physicians are informed of pregnancies, and they call for monitoring. Family physicians have a good relationship with my father. What will I do? I am done if they tell him or congratulate him, what will I do?[86]

Beril's friend has a similar fear with Begüm that family physicians might share that she is pregnant with her family. In all cases, interviewees have no trust in physicians in keeping their personal information confidential.

Interviewees' distrust towards physicians in keeping their personal information is not baseless as they witnessed or experienced a violation of private information in sexual and reproductive health services. For instance, a gynecologist who was informing Beril on the necessity of an HPV test told her that a previous patient that left the room before her tested positive for HPV. After that Beril could not trust the gynecologist as she was worried that her personal information could be shared like that. Similarly, Damla witnessed a nurse asking another patient if they are married or not in the waiting hole of the hospital, which horrified her as that was a personal question that is asked to find out if they could perform a vaginal examination. Both Gökçe and Begüm felt that after they leave, health workers can gossip among each other about how they have multiple partners or are sexually active. Additionally, Family Physician 2 mentioned a violation of a patient's private information in their center:

> An engaged woman got pregnant, and a nurse asked about her to her neighbor; that is actually our fault. She didn't ask 'How is her pregnancy going?' directly but (asked) in a way that would make her pregnancy obvious. She came to the center, couldn't find me and then waited and left, fortunately. Then she complained about me to another doctor. She is right, definitely right.[87]

Similarly, it is not unusual in sexual and reproductive health services that the privacy of patients during examination is not respected. There can be more people than the patient approves in the room, doors can be unlocked, other patients might enter the room, or the patient might be uncovered without their approval. Deniz mentioned that she had to have her examination while there were 2-3 other patients in the room with her which led to her struggling to express herself. Demet stated that:

> For example, when I go for a sexual health check, I mean it is not something that happens all the time, there were some assistants or students in the room that came

[86] Çünkü aşırı korktu. Ben annemle babamlarla aynı aile hekimliğine gidiyorum. Aile hekimine düşüyormuş hamile olduğum ve beni takip için arıyorlarmış. Aile hekiminin arası babamla çok iyi. Ben ne yapacağım. Söylerse tebrik ederim falan derse ne yapacağız bittim ben falan.

[87] Nişanlı bir kız hamile kaldı. Hemşire hanım da onu, yani orda bizim yanlışlığımız oldu aslında, komşusuna sormuş. Gebeliği nasıl gidiyor diye değil de gebe olduğu anlaşılacak şekilde. Mesela o gelmiş beni bulamamış neyse ki ve bekleyip terketmiş. Sonunda başka bir doktora şikayet etmiş, Haklı, kesinlikle haklı.

> there for observation. … I noticed that I couldn't ask all of my questions when there were 4-5 people in there. I could ask if we were alone in the room with a physician.[88]

Gonca explains her experience in state hospital as follows:

> That place was also far from respecting privacy. …Doors were open during an examination. Questions were asked by yelling, and if answers cannot be heard, they would ask patients to yell etc.[89]

Additionally, Ceyda mentioned that privacy was an issue for her in state hospitals with following statement:

> And this privacy topic, for example, it is very unlikely for someone to enter the room (during the appointment) in a private hospital, but in a state hospital you do not know if another patient or an assistant will enter.[90]

There could be multiple reasons why physicians disregard personal information and do not respect the privacy of a patient's body. One possible answer is that health staff rush to complete their tasks as the time is limited for each appointment. In family physicians' cases, they might have to reach out to a large number of patients for monitoring. As a consequence of this rush with services, they might skip asking consent for inviting a patient or assistant to the examination room or uncovering the patient's body. A patient's private information might be shared with their family for convenience. Another possible reason is the lack of education on patient's rights and sexual rights in the medical faculty, which might lead to a lack of awareness on the protection of personal information. Desensitization of medical personnel to patients can be another factor in violations of privacy that personal information or patient's body are depersonalized and objectified for doctors (Abadilla, 2018). Finally, the violation of privacy in sexual health services can be part of the overall approach towards the sexuality of women. Health workers might not see anything wrong in sharing information regarding a women's sexuality with her family as her sexuality directly affects her value to her family. In order to learn the exact reason for violation of privacy in sexual and reproductive health services, further research could be required.

[88] Mesela ben muayene edildiğimde şimdi bu çok da karışabileceğimiz bir konu da değil de odada mesela öğrenci mi pratisyen mi artık bilmiyorum ama bir iki kişi daha vardı konuyla alakasız ama gözlem için gelmiş. Muayene olurken değil de bana sonuçlarımı söylerken oldu aslında mahremiyete karışan bir durum yok onlar orada işte vizite gibi öğreniyorlar. Ama ki öğrensinler buna da şey yapmak istemem ama bir yandan da orda da totalde 4-5 kişi olunca ben çok fazla sormak istediğim şeyleri de soramadığımı farkettim.

[89] Orası bir de mahremiyetten uzaktı. Zaten bir daha gitmek istemedim oraya. Kapılar açıktı kadınlar muayene olurken. Sorular bağırarak soruluyordu cevaplar duyulmadığında bağırılması isteniyordu vesaire.

[90] Ve işte bu mahremiyet konusu atıyorum özel hastanede odaya birinin girmesi çok zor ama devlet hastanesinde arkadan başka bir hasta mı girecek, asistan mı girecek

Regardless of its reasons, violation of privacy and confidentiality hinder service provision. It could be less of a problem in any other branch that health information is shared, or other people are present in the examination room. However, women already feel vulnerable and open to verbal or physical bad treatment in sexual and reproductive health. Increasing the number of people that they have to open this part of their existence is challenging when they do not know what kind of approach they will face. Consequently, respecting patients' choices of how much they reveal to which people becomes an important condition for patients. Patients respond to the violation of their privacy and confidentiality by cutting service short, preferring private hospitals over state hospitals, changing physicians avoiding a detailed communication of their sexual health needs, and avoiding asking questions. They might even neglect to receive a service such as STI testing in order to protect their private information.

An example of avoiding sexual and reproductive health services due to confidentiality concerns was when Hande had suspicions of HIV infection but could not disclose her suspicion to physicians as she was afraid that test results or even having the test done could cause problems in her career in the future. There are centers for anonymous testing and consultation for HIV in İstanbul, Ankara, İzmir, Bursa, and Mersin that are operated by municipalities, and 3 laboratories that allow anonymous testing in İstanbul that works in collaboration with Positive Living Association. However, people who find out that they are HIV positive must consult hospitals for treatment, and their information is recorded, which can be accessed by any pharmacist, physician, or workplace doctor. Similarly, there is no anonymous testing or treatment for STIs. Family physicians are informed and expected to reach out if a patient is pregnant. All these practices confirm the fear of women regarding confidentiality of their health status.

In short, the privacy of sexual health interactions and confidentiality of information is specifically crucial for patients who are sexually active single women. Lack of anonymity in sexual health services, including STI testing and treatment and utilization of data registration system that can easily be reached without patient's consent, put women at risk of being exposed to their family or current and future employers. It is not uncommon for physicians to share personal information of a patient with third persons, which might be caused by desensitization toward patients, lack of information on patient's rights and sexual rights, and the belief that personal information (especially on sexual health) of women also belongs to her family. Patients respond to their concerns regarding confidentiality and privacy by preferring private hospitals, avoiding communicating their sexual health needs in detail, cutting service short, or even neglecting to seek sexual health service altogether.

5.4 Negligence of Sexual Health of the 'Other'

The norm that women's sexuality can only take place within heterosexual marriage finds its place within general sexual health practice by the negligence of the needs of women who do not fit into this group. Even if there have been improvements in sexual health services that do not only focus on the reproductive function of married woman, the neoconservative political turning point for AKP policies became effective on policies regarding sexual and reproductive health services, especially after 2010 (Willis & Yılmaz, 2020). The rhetoric change in population and sexual health policies was not as much reflected on written policies. For instance, there is no change in the legal duration of abortion. However, services such as family planning and STI test and treatment are no longer the focus of newly introduced sexual health documents and are not included in performance criteria of physicians, distribution of contraceptives has been decreased, unmet need for abortion is high due to accessibility problems, youth counseling and health centers were closed, and the number mother and child care and family planning centers have been decreased drastically (Adalı, Çavlin, Dayan & Topgül, 2017; Willis & Yılmaz, 2020; Hacettepe University Institute of Population Studies, 2019).

Besides the structural changes in sexual health services, there are obstacles in benefitting sexual health services in practice. Sexual health concerns of single women might not be taken seriously by health staff. Interviewees struggled to benefit from services such as abortion, HPV test and treatment, information, and supply of contraception more commonly. The needs of LGBTI+ patients are also omitted, and all patients are automatically assumed to be heterosexual. Neglection of sexual health needs of women who do not conform to the conservative heterosexual family-focused ideals is ensured through policies and politics of intimate of the government. The ideological position of the government is also reflected on the practice of sexual health services by health staff. Pınar explains that prioritization with following statement:

> If you are single and you ask if there is anything wrong with your ovaries or reproductive function, they find this unnecessary, and they don't do anything. … (After getting married) You just got married, how old are you, what kind of problem you can have, that kind of approach… You will learn when the time comes. You will learn when there is a problem. First, try to get pregnant, then we will see.[91]

[91] Bekarsan devlet hastanesinde herhangi bir yumurtalığın ya da üremenle ilgili problem olup olmadığını sorman gereksiz bulunduğu ve bununla ilgili bir şey yapmazlar, benim (çıkardığım sonuç) şeyim bu yani …Zaten yeni evlenmişsin, kaç yaşındasın, zaten ne sorunun olacak da soruyorsun gibi şeyler. … Vakti gelince öğrenirsin tarzında. Bir problem olunca öğrenirsin. Önce bir çocuğu yap da bakalım, olmazsa konuşuruz gibi

Pınar's feeling that her sexual and reproductive health gains meaning when she gets married and wants to get pregnant is not an isolated case. As I demonstrated in section 5.2, single women can be denied services such as examination or consultancy on contraception. In that section, I emphasized that the reason is related to the disapproval of sexually active single women. The disapproval and stigma towards single women's sexuality directly justify negligence of sexual health of single women.

The prioritization of reproductive function of married women over single women's sexual health needs is evident in strategic documents, recent campaigns and projects of the Ministry of Health, and experiences of patients. The sexual and reproductive health policy of the government in the last decade favored maternity health, obstetric services, and in vitro fertilization over rights-based sexual health services such as contraception, sexual health education, STI prevention, and treatment. This shift in sexual and reproductive health services was pointed out by family physicians, gynecologists, and the NGO worker, as well.

I asked about current trends in sexual and reproductive health service provision and recent projects of the Ministry of Health to physicians and the NGO worker to understand the reflections of current policies on their practice. One of the important remarks stated by Family Physician 2 and the NGO worker is that the prioritization given to contraception and family planning shifted towards a pro-natalist approach. Family Physician 2 emphasizes that there is no more encouragement or monitoring on family planning services such as the application of IUDs. Moreover, the number of Maternal and Infant Health Centers have been mostly closed and they were converted to Family Health Centers. Family Physician 2 state that:

> Nobody asks me how many IUDs I planted; I have the certification for IUD. They used to ask that. They would ask a lot. Maternal and Infant Health Centers were very active. I think they closed down those centers now. This kind of application would be carried out constantly by more experienced staff in there. Their numbers were actively lowered.[92]

NGO worker has a similar claim:

> There used to be Maternal and Infant Health Centers. These centers would provide family planning services and support women and couples. Also, there was access to various contraception methods; they provided condoms, applied IUDs, and provided access to hormonal chips and pills. They told me there is great difficulty in accessing those. There is a great difference compared to previous years recently. As you know, population policies in Turkey are towards increasing the population and encouraging

[92] Yani bana mesela RİA sertifikan var senede kaç RİA taktın diyen olmuyor. Mesela eskiden bunu sorarlardı. Çok sorarlardı. Ana çocuk sağlıkları çok daha aktifti önceden. Şimdi ana çocuk sağlıklarının sayısı sanırım azaltıldı. Bu işlemler orda daha deneyimli personeller tarafından sürekli yapılıyordu. Onların sayısı aktif olarak azaltıldı.

> reproduction, because of that it is really not that easy to reach contraception, unfortunately.[93]

Another indicator that reproduction is being prioritized over family planning and other sexual health services is those performance criteria that measure the success of each physician and determine their salary includes applications such as monitoring pregnancy and infant health but not other sexual health services. Gynecologists I have interviewed did not attend great importance the performance criteria. However, both family physicians emphasized its importance on the practice of sexual and reproductive health services. Lack of accountability on physicians' side for providing sexual health services other than obstetric services can hinder the actual provision of those services, especially when the patient load for each physician is overwhelming.

In patients' experiences, decreased access to abortion, lack of information on STIs, lack of free vaccination and accessible treatment for HPV, contraception, refusal to apply IUD to patients who did not give birth, and trivialization of sexual dysfunction are examples of the negligence of sexual health needs that are not focused on the reproduction of married women. Moreover, there were cases that when a reproduction problem that can potentially decrease the fertility of the patient arose, physicians immediately suggested that the patient should get married and try to get pregnant as soon as possible. Tuğba said the following on that matter:

> After the examination (she told me), 'Your ovarian reserve is reduced, you should immediately get married. You can consider freezing your eggs.'. She made me shocked there by saying all those quickly. I am not married yet, I didn't consider having kids, I had no intention (to have kids at that moment), and without listening, she said all of those rapidly.[94]

Demet was also in a similar situation in which she explained as follows:

> Physicians acted a bit- said stuff like 'You have a chocolate cyst (endometriosis), that's very serious. If you want kids, you have to do it right away. Quit smoking.'. They made me panic a bit. For the first time, I got motivated to get myself checked fully in gynecology, but I left crying. …Yes, it is important, and I should be careful, but it is not something that requires me to get married and pregnant within a year.[95]

[93] Önceden ana çocuk sağlığı merkezleri vardı. Bu merkezlerde hem aile planlaması, buna ilişkin destek verilirdi kadınlara ve çiftlere. Hem de çeşitli gebeliği önleyici yöntemlere ulaşma imkanı oluyordu; kondom alınıyordu, işte RİA taktırılabiliyordu. Hormonal çipler ya da hormonal ilaçlara ulaşılabiliyordu. son zamanlarda bunlara erişimde çok büyük bir zorluk olduğunu söylemişti; eskiye nazaran büyük bir kontrast olduğunu söylemişti. Özellikle bekar kadınlar için bu büyük bir zorluk. Eskiden üniversitelerin içinde yer alan Medikolardan da bu kondomlara erişmek mümkün oluyordu. Ücretsiz şekilde temin edebiliyordunuz. Ama maalesef şimdi çok zor.

[94] Muayene ettikten sonra da rezervler çok azalmış hemen evlen bence falan. Yumurta dondurmayı düşünebilirsin. Çok hızlı bir süreçte beni orada dumur edip, daha evli değilim, çocuk düşünmüyorum, hiç öyle bir niyetim yok onları falan dinlemeden bir anda böyle pat küt söyledi.

[95] Doktor biraz bana şey davrandı gibi geldi işte şey falan dedi, "Çikolata kisti var bu çok önemli bir şey, çocuk yapmak istiyorsan hemen yap. Sigarayı hemen bırak vesaire. Biraz beni böyle hafif panik ettirdi ben de zaten ilk defa bir gaza gelip toplu bir kendime baktırayım kadın doğum anlamında diye gitmişim ordan ağlayarak çıktım. …

Additionally, Nazlı mentioned that gynecologist lectured her by saying, "look at your age, you should have a kid, the health of your ovarian is gone.". Tuğba, Demet and Nazlı were pressured to fulfill their reproductive function. They were all single when they heard these expressions and were advised to get married and bear children as soon as possible. Health workers assume women would like to have children and that they have to be married to get pregnant. Upon this assumption, they advise getting married and rushing for childbirth before explaining other steps for the treatment of the reproductive issue. Women that rely on expert knowledge of health workers might be pressured to do childbirth. Additionally, the information that a patient might have fertility issues is not given to them with any regard to how emotional that topic can be. Even though other interviewees did not take action towards trying for pregnancy, Tuğba was researching affordable options to freeze her eggs even if she did not know where she stands on having kids.

According to interviewees, sexual health services that fall short of women's needs were prevention and diagnosis of HPV and abortion services. HPV tests are not available in state hospitals to women younger than 30 years of age due to limits of the screening program, and vaccination for HPV is voluntary and expensive, as commonly stated by patients and physicians interviewed. HPV screening is done through Cancer Early Diagnosis Screening and Training Centers (KETEM) that covers testing women from age 30 to 65 every 5 years (Ministry of Health, 2017b). In state hospitals and clinics, HPV can be typically diagnosed through visible lesions or pathological findings on Smear tests, as one of the gynecologists interviewed explained. Additionally, women are usually not aware of the necessity of an additional HPV test or how it is spread. They either learn through their friends or by their experience when they have symptoms such as warts or findings of Smear tests indicates risk for cervical cancer. Beril stated that:

> I am 27 and I learned about the importance of HPV at the age of 26. If a gynecologist informed me about this the first time I went there, I would not have to go through this (HPV diagnosis) …They didn't inform me. I had a test one year before the HPV diagnosis. I would get vaccinated if they told me about it.[96]

Mine who was struggling with HPV infection mentioned that:

> I have been asking for tests for all sexual diseases for years, and none of them told me about HPV. I didn't even know about the existence of HPV because we didn't have sexual health training. I didn't know I had to ask additionally for the HPV test. …There

Tamam evet önemli bir şey dikkat edilmesi gereken bir şey ama bir sene içinde evlenip çocuk yapmayı da gerektirecek bir şey de olmadığını farkettim.

[96] 27 yaşındayım ve 26 yaşında öğrendim HPV'nin ne kadar ciddi olduğunu. Belki ilk kez gittiğim doktor bana bunu söyleseydi şu anda böyle bir şeyde yaşamamış olacaktım. … Bilgilendirmediler bence. Yani ben HPV teşhisi konulmadan 1 yıl önce gidip bir test yaptırmıştım. Bana aşıdan bahsetse olurdum.

> is nothing regarding informing people on HPV vaccination. We try to take care of our sexual health based on whatever we hear randomly.[97]

A gynecologist (Gynecologist 2) that interviewed pointed to the increase in HPV cases in young women, lack of information on HPV, and need for vaccination. Vaccination and, consequently, prevention of HPV and cervical cancer is left to personal awareness of women and their ability to pay for this expensive vaccine. Regarding the current situation of HPV incfection Gynecologist 1 argued that:

> Problems due to HPV have increased. Actually, people older than 13 years old should be vaccinated for HPV, but it is not a routine practice in Turkey. Making that vaccine a routine one would be the most expected improvement. …The age of first sexual intercourse has changed. When we think about genetic factors and ignorance on this subject, HPV vaccination should be routine practice to prevent cervical cancer. This vaccination has 3 doses, and its fee is not cheap at all. When it is not routine practice, women can't reach it.[98]

Morevoer, NGO worker pointed out the difficulty in getting vaccinated as follows:

> If you want to get vaccinated as a young woman, the state does not pay for these vaccines (HPV). Let's say a young woman is a student and is not working. How can they get vaccinated by sparing 750-1000 Turkish liras?[99]

Moreover, diagnosis of HPV for young women who are 20-30 of age is challenging as they don't qualify for screening program for HPV. They are put into a position where they either have to convince health workers that the test is necessary or they have to go to private hospitals and clinics. Beril mentioned that it is impossible to get tested for HPV and type of HPV in state hospitals and that, "You have to beg for it.". İlayda was told she cannot get tested for HPV unless she has symptoms even if she had suspicions. Mine mentioned that they do not perform HPV tests on women younger than 30 in state hospitals and she had to ask favors to receive the test. Lack of free and routine vaccination for HPV and obstacles in accessing the diagnosis of HPV can be linked to negligence of non-monogamous sexual experiences. There is disbelief in the possibility of STIs, including HPV and HIV spreading in Turkey as the

[97] Ben senelerdir gidip doktora bütün cinsel hastalıkları testini istiyorum dediğim de bana hiç HPV testi var denmedi. Ben HPVnin varlığından haberdar değilim. Bir cinsellik eğitimi gibi bir şeyimiz olmadığı için. Bunu ekstradan HPV testi yapılmasını istiyorum diye söylemem gerektiğini bilmiyordum. … Aşı konusunda bilgilendirmeler olsun, hiçbir şey yok. Karambole biz kendimiz sağdan soldan ne duyarsak ona göre cinsel sağlığımıza bakıyoruz.

[98] HPV ile ilgili sıkıntılar arttı. Aslında HPV aşısı 13 yaşından sonra uygulanması gerektiği halde bizde rutin değil. Bu aşının rutinleştirilmesi en çok beklenen, izlenen gelişme olurdu. … Artık cinsel ilişkiye başlama yaşı değişti. Bu konuda bilinçsizlik ve genetik hastalıklar düşünüldüğünde HPV aşısının rahim ağzı kanserini engellemek açısından rutin uygulanması gerekiyor. 3 dozu olan bir aşı bu ve ücreti de hiç ucuz değil. Rutin uygulanmadığında kadınlar erişemiyorlar.

[99] Eğer genç kadın olarak aşı olmak istiyorsanız koruyucu aşıları bunların ödemesini yapmıyor devlet. Genç bir kadın diyelim ki çalışmıyor, öğrenci; nasıl aşı olacak 750 lira 1000 lira ayırıp?

assumption is that all sexual activity takes place in the heterosexual monogamous marriage institution. However, the reality appears to be the opposite of this, for example, the number of a new diagnoses of HIV is increasing in Turkey while it is decreasing overall in the world (Soylu, 2019; Bianet, 2020). There are no public statistics on the spread of HPV or other STIs, but it can be presumed that it might be spreading faster as one gynecologist suggested due to lack of sexual health education and people becoming sexually active earlier. Consequently, a considerable portion of the population cannot have their sexual and reproductive health needs met in STI prevention and treatment.

Another service that gradually became more difficult to reach is abortion. It is legal to have abortion on demand for pregnancies up to 10 weeks since 1983 with the legislation Population Planning Law. Additionally, the abortion can take place at any point of the pregnancy when a complication occurs that affects the health of the fetus or threaten the pregnant woman's life, and if the pregnancy took place because of a crime, abortion is allowed up to 20 weeks of the pregnancy. However, there have been anti-abortion discourses that were voiced by Erdoğan and other AKP party members where they equate abortion with murder which I discussed in Chapter 2. Even the legal code and laws regarding abortion have not changed, the practice of abortion became less and less accessible, especially in state hospitals. According to Altuntaş, O'Neil, and Keskin's research on abortion services in state hospitals reveal that out of 295 hospitals; they were able to reach only 10 of them stated that abortion on demand is provided in the hospital (2020). On top of this artificial ban on abortion, single women face other obstacles where they are not permitted to have an abortion at all when married women could, or additional documents are requested of them (Altuntaş, O'Neil and Keskin, 2020; Foster et al., 2017). Because of these obstacles, single women feel the need to consult private hospitals for abortion even if the fees are expensive.

None of the physicians I have interviewed opposed abortion. Gynecologists confirmed that abortion could be performed in their hospitals. Gynecologist 1 emphasized that the political environment can affect the decision of gynecologists on providing abortion; however, in the case of prohibition, women would still consult to illegal practices to get that service. On that matter, Gynecologist 1 stated that:

> Neither opposing abortion nor supporting it changes the number of abortions. If you forbid it, you encourage it. …If politicians say, "I am totally against abortion.", the president is against it, all ministers are against it, we as gynecologists can't oppose it. There are some gynecologists who do not want to do it; they can use this.[100]

[100] Ama hiçbir zaman ne kürtaj taraftarı olmak ne kürtaj karşıtı olmak kürtaj sayısını değiştirmez. Yasaklarsanız teşvik etmiş olursunuz. … Siyasiler çıksa dese ki "Kürtaja ben tamamen karşıyım.", cumhurbaşkanı karşı, bütün

Ironically, the best way to prevent abortions is ensuring access to contraception which the government has been cutting back. Even if gynecologists I have interviewed did not specify a particular setback on abortion services, they supported the practice. According to Gynecologist 2, abortion is not just a choice but an obligation for many women which he explained as:

> Actually, abortion is not a practice we often do. However, I don't think anyone gets an abortion for the sake of it. There are certain social issues. People with problems have that demand. …17-year-old child started university and slept with a 60-year-old man immediately. She got pregnant, and the man didn't support her. …What can that child do? We need to help those people.[101]

Despite the tone of judgment towards young women who get pregnant, he emphasizes abortion is needed as some women cannot take care of a baby at the moment that they are pregnant. Evidently, it is due to social problems rather than women's agency and control over their own bodies that abortion is needed. Despite their support, Gynecologist 1 emphasized abortion is legal within 8 weeks rather than the official 10 weeks. This indicates the differences in practice when it comes to abortion and that it is affected by the political environment. 8 weeks limit to abortion was voiced by AKP but did not pass as legislation due to the efforts and reaction of feminist activists and organizations. Additionally, the NGO worker stated that they heard cases of physicians denying abortion to patients due to moral or religious reasons.

Two interviewees had abortion experiences in which Zehra did not have any problems with pain, the procedure was explained to her, she received no judgment, and the confidentiality of the operation was maintained by her gynecologist. On the other hand, Ceyda was judged for not being careful with protection and scolded for wanting to switch to full anesthesia during the procedure. Her decision to switch to full anesthesia was not respected, and she had to suffer through the operation. Other than these experiences interviewees heard of friends' experiences, or they are concerned if they will be able to receive the service in case they need to go through abortion. Begüm stated the following on her friends' abortion experience:

> The first one she went which was a private one, she was exhausted psychologically. There is that exhaustion even if you go for asking about contraception. In that case,

bakanlar karşı biz kadın doğumcu olarak karşı çıkmayız. Ama kadın doğumcular arasında da bu işi zaten yapmak istemeyen bir grup var, onlar da bunu kullanabilirler.

[101] Açıkçası kürtaj sıklıkla yaptığımız bir iş değil. Ama bence kimse keyfinden kürtaj olmuyor. Belli sosyal durumlar var.. Sorunları olan insanlar böyle taleplerde bulunuyorlar. Sosyal bir sorundur bu. Bu insanlara da yardımcı olmak gerekli. 17 yaşında bir çocuk üniversiteye başlamış, gitmiş 60 yaşında tanıştığı adamla hemen beraber olmuş. Hamile kalmış adam sahiplenmemiş. Çocuk daha üniversite 1. Sınıfta. Çocuk ne yapsın, bunun gibi insanlara yardım etmek gerekiyor.

> they directly told her they can't do it. They told her that they won't do it and scolded her.[102]

One of the interviewees, Beril's friend who got pregnant, had to go through abortion without her family finding out as she lived with them and was single at that moment. She found a private clinic that did not include abortion within the insurance archive. They also managed to hide the information that she was pregnant on e-nabız system; however, she had to pay a considerable amount to the private clinic. This story emphasizes that on top of institutional obstacles, there are also concerns regarding confidentiality for single women, as I explored in the previous section.

All abortions mentioned by interviewees took place in private clinics and hospitals. The main reason for that is very few state hospitals actually provide that service (Altuntaş, O'Neil, and Keskin, 2020). Another obstacle is that women are afraid of what kind of approach they will encounter. Abortion in private clinics and hospitals is not a cheap service; however, to avoid any judgment and bad treatment, women are willing to pay considerable fees to get an abortion. On abortion, Canan mentioned that, "What would you encounter if you went for an abortion as a single woman, it sounds horrible to me.". Additionally, NGO worker argued that:

> A woman I know had an abortion. She went to a private clinic. She went there after researching and getting recommendations. She told me that she didn't encounter any bad treatment because she is not married and having that operation done. However, she had to pay an amount that pushes her budget. She had to borrow money from friends. …If she wanted to get it done in a state hospital, it would have been much cheaper, but what kind of approach she would experience, she didn't want to take that risk.[103]

Both Canan and the NGO worker I interviewed emphasized that demanding abortion as a single woman brings an additional burden due to possible bad treatment. NGO worker's statements also support that private clinics might be an alternative to problems that might be encountered in state hospitals.

The absence of accessible abortion services is interpreted as aligned with the current neoconservative ideology of the government, which restricts women's control over their body, life and rights by interviewees. Zehra argued that:

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[102] Ama ilk gittiğinde o da özeldi zaten, il gittiğinde bayağı bir psikolojik olarak yıpranmıştı. Zaten yöntem kullanımı için gittiğimizde bile bir yıpranma oluyor. Böyle bir durumda zaten direk yapamam demiş zaten o. Yapmıyoruz deyip göndermiş ve azarlayıp göndermiş.

[103] Tanıdığım bir kadın kürtaj yaptırdı. O özel bir muayenehaneye gitti. Araştırarak tavsiye üstüne gitmişti. hiçbir şekilde evli olmadığı için ve bu işlemi yaptırdığı için kötü muameleye maruz kalmadığını söyledi bana. Ama kendi bütçesini çok zorlayacak bir miktarda ödeme yaptı. Arkadaşlarından borç para aldı. …Eğer ki devlette bunu yaptırmak isteseydi çok daha ucuz olacaktı kendisi için, ekonomik olarak çok iyi olacaktı ama acaba nasıl bir muameleyle karşılaşacaktı onun riskini almak istemedi.

> Current government is more religiously rooted government; they oppose to stuff like abortion. They have statements to encourage 3 kids (per couple). In this case, social perception is shaped based on that. Maybe, ideas of physicians are also on that side and they can say anything to you about this with the support of government.[104]

Melek stated the following on importance of abortion:

> Discussion on abortion. … Indirectly, no directly, it has an effect on people's sexual health directly. They can have illegal abortions and bleed to death, or they fear admitting to their family and commit suicide. … Opening these topics to a discussion, the fact that harming women's bodily integrity or denying women's voice on their own individual decisions is discussed this way is horrible. As far as I know, abortion is legal, but it is not legal in practice.[105]

Melek and Zehra came to the conclusion that the unofficial ban on abortion is caused by the conservative-religious ideological position of the government that encourages childbirth. The government does not respect women's choice over their own body and put their health at risk. Consequently, physicians who are more conservative find an opportunity to deny services to women whose sexuality they do not approve. I would add that physicians and hospital management who do not want to undermine the authoritarian AKP's opposition to abortion could prefer to avoid providing abortion.

Negligence of sexual and reproductive health services that are not the reproduction of married heterosexual women includes heteronormativity and erasing the needs of LGBTI+ patients. Unfortunately, the number of LGBTI+ interviewees remained limited for this research. However, Bahar, who described herself as a bisexual, experienced a heteronormative approach of health workers in sexual and reproductive health services she received. Bahar mentioned that:

> I identify as the gender I was assigned at birth, so there are people who experience bigger and worse problems than I do. I believe physicians need to receive comprehensive training on gender and trans people. … When I got a yeast infection and asked if my partner needs treatment, they told me, 'No, it is fine for guys'. The assumption that my partner is a man- then I had to explain to them and then there is a moment of silence and then they collect themselves and tell me she should receive treatment as well.[106]

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[104] Şu anki hükümet çok daha dini kökenleri olan bir hükümet, böyle kürtaj gibi şeylere karşılar yani. Üç çocuk gibi söylemleri olan bir hükümet. Böyle bir durumda hem ister istemez toplum algısı da bu yöne kayıyor. Belki de doktorların düşünceleri de o yönde ve devlet desteğiyle sana gelip bu konuyla alakalı bir şey söyleyebiliyor.

[105] Kürtaj konusunun tartışılması. …Dolaylı yok direk doğrudan insanların cinsel sağlığı üstünde doğrudan etkisi var. İnsanlar merdiven artı kürtaj yaptırıp kan kaybından ölüyorlar ya da bunu ailesine itiraf etmekten korkup intihar edenler oluyor. … Bu konuların tartışılmaya açılması bile kadının beden bütünlüğüne zarar veren ya da kadının alacağı kararlara karşı kadının söz hakkını reddeden kararların bu şekilde tartışılması çok kötü. Bildiğim kadarıyla kürtaj yasal ama uygulamada yasal değil sanırım.

[106] Ben biyolojik olarak atanan cinsiyetimi devam ettiren bir insanım, dolayısıyla benim için yaşadığım sıkıntıların çok çok başkalarını ve büyüklerini yaşayan insanlar var. Özellikle bence toplumsal cinsiyet ve trans insanlar hakkında doktorların ciddi anlamda bir bilgilendirmeden geçmesi gerektiğini düşünüyorum. …Ben mantar olduğumu bir seferde partnerimin de tedavi olması gerekiyor mu diye sorduğumda yok erkeklerde bir şey olmaz.

Bahar's partner was automatically assumed to be a man, which led to an uncomfortable interaction for her. In another case, Damla's friend was treated rudely when she was admitted to the emergency for sexual health problems. The treatment towards her was so disrespectful that she asked her friends to help her leave the hospital. In Damla's words, her friend is "a little more masculine homosexual woman," and she thinks that's why she was treated that badly. Unfortunately, I am not able to explore LGBTI+ people's experiences in more detail in this research, but those two experiences give insight into how discrimination based on sexual orientation and erasure of other sexualities can manifest itself in sexual and reproductive health services.

5.5 Sexuality as a Taboo Challenging Medical Objectivity

The subjective position of health workers on women's sexuality is contrary to the understanding of medicine as a purely objective field of science and practice. Doctor-patient interactions that involve the reflection of the doctor's own beliefs and values that are evident in the previous section violate this claim of objectivity. Moreover, even patients do not want a totally objective approach from physicians; most of the interviewees emphasized they expect attentiveness and understanding of their position from health staff in sexual and reproductive health service interactions.

Indeed, social pressures and taboos regarding sexuality and sexual health affect patients' behaviors as well. Throughout the interviews, interviewees emphasized either they might feel shy and struggle to talk about their problems to gynecologists and other health staff or that gynecologists and other health staff reflect their own judgments shaped by norms that impose monogamous, heteronormative, reproduction-focused and marital sexuality on women. On this topic, Pınar said that, "In the end, this is not ear nose throat clinic. It is a field with taboos."[107]. Gökçe mentioned that:

> Yes, I was shy about some things that I had not been going to the gynecologist. …When I first started to go, I was shy. As if there is only my sexuality in the world and the doctor only hears about it from me. But of course, that is not true; it takes time to understand this.[108]

Benim partnerimin erkek olduğu varsayımı ve bunu benim açıklamak zorunda kalmam ve bir anlık sessizlik ve toparlanıp o zaman o da ilaç alsın şeklinde devam eden konuşma.

[107] Hani bir kulak burun boğaz değil neticede. Tabuları olan bir alan.

[108] İlk gitmeye başladığımda çekindiğim oluyordu haliyle. Sanki dünyada bir tek benim cinselliğim varmış doktor da ilk defa bunu benden duyuyormuşçasına bir tavra giriyordum. Ama öyle bir şey yok tabi ki insan onu zamanla idrak ediyor ama.

Gökçe and Pınar remarks the taboo nature of the field and that they might feel shy or different in talking about sexual health compared to other branches of health. Gonca expressed herself as following:

> I had additional reservations. But I don't remember anyone helping me relax. I was struggling to express myself, but I felt as if I deserved that. If you did that, you would suffer through this. I felt that this is not perceived normal.[109]

Gonca explains that she was struggling to talk about her sexual health and go through with examination and felt as if she has to struggle for being sexually active as a single woman at that time. Consequently, women might feel ashamed or hesitant to be open with their sexuality and sexual health towards health staff, which can be fueled by health staff's uncooperative behavior. Interviewees connect this shyness and hesitancy to women's position within the society and health staff's behavior that is reflective of traditional values and attitudes towards women's sexuality in the society. Damla mentioned the following on this subject:

> It might be due to roles assigned to women. It might be due to the societal approach (to women). This brings prejudices. Certain roles are loaded on women. For example, she has to be a virgin before she gets married or married women to have to be monogamous. …Sexual orientation and your lifestyle can become problems specifically in gynecology.[110]

Canan mentioned that societal pressure as the reason who women struggle to benefit from sexual and reproductive health services. She added that this pressure on women can affect how much the patient tells to health staff and how physicians perceive the patients. Additionally, Begüm stated that:

> The common issue in all of these experiences is that physicians do not adopt a neutral attitude. My friends were examined by physicians who judged and imposed patients with values of society and their own value judgments while leaning into the existing political atmosphere.[111]

As the statements of interviewees suggest, both patients and doctors are influenced by how sexuality is constructed in Turkey. Sexuality is a taboo topic that is shameful to be talked.

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[109] Benim ekstradan çekincelerim oluyordu. Ama kimsenin rahatlattığını da hatırlamıyorum. Zorlanıyordum bir şeyleri ifade etmekte ama sanki o zorluğu hakketmişim gibi hissediyordum mesela. Tamam bunu yapıyorsan bunu çekeceksin bu olacak gibi. Bu normal karşılanmadığına dair bir hissiyatım vardı.

[110] Kadına biçilen rollerden kaynaklanıyor olabilir. Toplumsal bir bakış açısından kaynaklanıyor olabilir. Bu bir önyargı getiriyor. Belli kadın rolleri yükleniyor kadına. Mesela evlenmeden önce bakire olması gerekli gibi. …Jinekolojide özel olarak cinsel yönelimin, yaşam biçimin bunların hepsi her an sorun olabilir.

[111] Aslında hepsinin ortak noktası doktorların nötr bir tavır sergilememesi. Kendi ve toplumun değer yargılarını mevcut politik atmosfere fazlasıyla tutunarak ve karşındakini bunlar çerçevesinde yargılayarak bir muayene görmüş arkadaşlarım bu şekilde.

Women are socialized that their sexuality is shameful and that they should feel uncomfortable when talking about it even if it is for medical reasons. For this reason, women who do not conform to the norms and fall outside of the approved sexual behavior struggle even more, to talk about their own sexual health or do not seek sexual health services at all because they are ashamed. Their hesitations and fears are confirmed when health staff exposes them to discrimination and judgment for their sexual life choices that is reflective of social norms in Turkish society. Thus, what is considered a normal way to experience sexuality for women is reproduced in sexual health interactions. Gökçe explains the forbidden nature of talking about sexuality in her following statement:

> It is something that cannot be talked about, forbidden, or shameful to talk about, so people can't learn anything. It is always the case that it is something to hide both for men and women, both in their own sexuality and sexual health services that they can receive.[112]

Moreover, Bahar made a similar statement that:

> Being hesitant to disclose that you have multiple partners to doctor; 'You should be hesitant; you shouldn't have multiple partners.'. We see similar behavior in doctors because society has that understanding. Insulting women or insulting women's experiences and blaming those diseases on her.[113]

Zehra mentioned that in current political atmosphere, it feels normal that women cannot be comfortable and talk to their gynecologists freely. Bahar and Zehra emphasizes the increased pressure on women that forbids them to talk about their own sexual experiences and make them feel guilty. In line with these statements, sexuality and sexual health being taboo, difficulty and shame in talking about sexuality and sexual health and being made guilty for experiencing sexuality are not specific to health care services for women but relevant in everyday life. For this reason, women might be hesitant to receive any sexual and reproductive health service, at all. Tuğba argued that:

> First of all, I think (problems in sexual health) can be caused due to women avoiding going to the hospital. Because there are harsh taboos, we live in a weird country. As I said, I could comprehend some stuff by talking to my mom. There are some people who live this (their sexuality) without talking to anyone else.[114]

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[112] Konuşulmayan bir şey olmasından kaynaklanıyor. Konuşulmayan, konuşulmasının ayıp olduğu, yasak olduğu bir şey olduğu için insanlar daha sonra haliyle bir şey öğrenemiyorlar. Hem kendi cinsellikleri, hem alabilecekleri hizmetlerle ilgili bu alanda ve bu hep böyle hem kadınlar hem erkekler için saklanılacak bir şeymiş gibi.

[113] Doktora karşı çok partnerin olduğu zaman bunu söylemekten çekinmek, "Zaten çekinmen lazım, zaten çok partnerin olmasın", toplum genelde böyle bir anlayışta olduğu için aynı anlayışı da biz doktorlarda da görüyoruz bence. Kadını aşağılamaya ya da kadının deneyimini aşağılamaya ve bir hastalığı onun üzerine yıkmaya (yönelik).

[114] Bir kere hastanın hastaneye gitmemesinden kaynaklanıyordur bu bir. Çünkü ciddi tabular var yani çok garip bir ülkede yaşıyoruz. Hani şey, dediğim gibi ben annemle konuşarak bazı şeyleri idrak ettim. Bunu hiç kimseyle konuşmadan kendi içinde yaşayan insanlar var.

Ceyda explains the struggles of women regarding sexual health as following:

> Society is closed-minded. Women are not open to talking about their problems because they know they will be judged, and they might postpone or not consult at all for treatment. There might be some women who can't go (for sexual and reproductive health services) that they will be judged by their family; women usually can't tell their family that they are sexually active, and maybe because of that, they can't even go.[115]

According to Ceyda and Tuğba, women knowing that their sexuality is forbidden and not approved, could avoid seeking sexual and reproductive service at all.

Family and schools are the other institutions that interviewees emphasize that create the taboo nature of sexuality and burden the women with the responsibility of 'protecting themselves' and avoiding bringing shame on themselves. Gökçe mentioned the following on this subject:

> Of course, the thing (training) in high school is not informative; on the contrary, we talk about something that lasts few hours which they tell something so basic about how to use hygienic pads while taking boys out of the class and creating an environment for taboo as if they will tell something top secret to girls and embarrass them.[116]

Gonca expresses her experience regarding how sexuality is articulated during her education as follows:

> I went to boarding teacher high school. Male and female students lived in a dormitory. We found out that they were using schappe in meals given in the dining hall. …We discovered that (use of schappe) by asking around and finding out that (hormone problems) are the case with everyone. It was forbidden to hold hands. The principle would yell every day that it is forbidden to hold hands.[117]

Similarly, Damla demonstrates how schools approach sexuality in her statement as:

> Only in middle school, a school counselor came and said, 'I tell this, especially to girls, protect yourselves. You could have problems with your family. A boy will come and tell you that you're beautiful and that he loves you. I had a student who had such problems with her family. She was pregnant when I saw her n two months.' Look at this trauma. As if that will happen to all of us.[118]

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[115] Toplumun kapalı olması olabilir. Kadınların sorunlarını anlatmada ilk etapta daha kapalı olması, çünkü karşı taraftan yargılanacaklarını bildikleri için tedaviyi aksatmaları ya da tedaviye gidememeleri. Gidemeyen olabilir ailesi tarafından yargılanacağını bildiği için, kadın genelde cinsel ilişkiye girdiğini söyleyemiyor, cinsel ilişkiye girdiğini söyleyemediği için belki doktora hiç gidemiyor.

[116] Tabi lisedeki şey kesinlikle bilgilendirici değil tam tersi oradaki erkeklerin sınıftan çıkarılıp kızlara gizli bir şey anlatılacakmış gibi bir tabu ortamı yaratılıp, kızların orada utandırılıp, adet ne ped nasıl kullanılır çok basic düzeyde bir şeylerin anlatıldığı birkaç saatlik bir şeyden bahsediyoruz.

[117] Ben öğretmen lisesinde yatılı okudum. Kadın öğrenciler, erkek öğrenciler yurtlarda yaşıyorlar. Yemekhanede ciddi anlamda şap kullanıldığını öğrendik. …Bunu araştırınca ve herkeste de çıkınca bunu keşfettik. Çünkü el ele gezmek yasaktı. Her gün müdür el ele gezmeyin yasak diye bağırıyordu.

[118] Sadece ortaokuldayken bir rehberlik hocası sınıfa gelip "Özellikle kızlara diyorum, kendinize sahip çıkın. Ailenizle sorun yaşarsınız. Çocuk gelir, çok güzelsin seni çok seviyorum der. Benim böyle ailesiyle sorunları olan bir öğrencim vardı. İki ay sonra yanıma geldiğinde hamileydi." Demişti. Travmaya bakar mısınız? Hepimizin başına aynı şey gelecekmiş gibi.

Gökçe, Gonca and Damla explained the hostile and punishing behavior towards sexuality in schools and education system. Sexuality is presented as something dangerous, especially for women, and socialization of boys and girls are severed with anxieties over possible sexual interactions. Additionally, Deniz mentioned that:

> Instead of saying "Take care of yourself, or I wouldn't give you my blessing over my breast milk, those are momentary things" if my mom could say, "There are many STIs, other than AIDS; there are many diseases please protect yourself". If she told me that sentence, I would have known better. When I think about it now, I get mad at her.[119]

Deniz gave an example on how her mother tried to guilt and scare her away from sexual experiences whereas she would like her mother to inform her on how to protect her sexual health. Consequently, forbidden and taboo nature of sexuality is reproduced in education and family interactions and women are burdened with the bigger responsibility 'to protect themselves', meaning protecting their virginity.

On the contrary to interviewees' expressions, the claim of medicine as purely objective science and practice that is not affected by social norms is defended by family physicians and gynecologists I have interviewed. I asked questions on changing trends in the practice of sexual and reproductive health in Turkey and if their practice is affected by any discourse or political speech. Their common view is that medicine is a science; thus, it cannot be affected by any political trend or discourse. Only patients' views and preferences might be affected by politics which in turn affects the service provision of sexual and reproductive health. Family Physician 1 claimed that, "Discourses have an effect for sure. Not on us, but it affects citizens."[120]. Family Physicians 2 adopts a similar position in which she says, "For example, at least 3 kids… I had a patient who gave birth to their third child because of it. It affects us because it affects the patients more. …We act based on science."[121]. Gynecologist 1 added that:

> I actually think all of that individualistically. People have their own sexual life within their own generation based on their own education, learnings and their own values and they have their own priorities.[122]

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[119] Şey diyeceğine bak kendine dikkat et sütümü helal etmem sana bunlar bir anlık şeyler falan yerine karşısına beni alıp şey dese, birçok cinsel yolla bulaşan enfeksiyon var. Bu AIDS falan dışında bir sürü hastalık var lütfen kendini koru. Dese bu cümleyi bile kurmuş olması en azından bilecektim neyin ne olduğunu. Şimdi bakıyorum mesela kızıyorum ona.

[120] Söylemler etkiliyor tabi. Bizim taraftan değil ama vatandaşı etkiliyor.

[121] En az 3 tane mesela. …Yani bir çocuğu onun için yapan çok hastam oldu. Daha çok hastaları etkilediği için bizi etkiliyor. …Biz bilimle hareket ediyoruz.

[122] Aslında ben bireysel düşünürüm her şeyi, insanın kendi yaş diliminde o silsile içerisinde kendi eğitimi, aldığı şeylerle, kendi değer yargılarıyla bir cinsel yaşamı vardır zaten ve o öncelikleri farklı olur.

I believe Gynecologist 2 clearly states his poisiton by saying, "There is no politics in any point of medical practice. This is a science."[123]. When asked if discourses or speeches of politicians affect their medical practice, all physicians state that medical practice itself is an objective science that cannot be affected. They defend that patients might shape their reproductive choices based on those discourses. It is not surprising that physicians would not categorize subjective behavior in their own practice as affected by politics when their medical education takes objectivity of science as the norm (Wilson, 2000). Consequently, trends in sexual and reproductive health in recent years are explained by the change in patient behaviors by doctors. On this subject, Gynecologist 2 stated that "40-50 years ago, aunties would have 2 kids and would use protection perfectly. Now they do not know it, so there are so many miscarriages and abortions."[124]. Gynecologist 2 places a lack of awareness on family planning and reproductive choices on women, whereas family planning services have been disrupted greatly since the 2010s. Similarly, Family physician 2 and gynecologists mentioned patients' own lack of awareness on sexual and reproductive health, shyness, or concerns regarding the confidentiality of their medical information are the reasons that patients might not be able to receive needed sexual and reproductive health services. This indicates that they might not be aware of the impact doctor-patient interactions have on patients.

Interviewees' experiences as sexually active single women in sexual and reproductive health interactions in which health staff act in line with social norms on women's sexuality rather than claimed objectivity of medical practice indicate that health experts are part of those norms. To explain more clearly, health experts practice medicine not objectively as they claim, but their attitude and treatment of patients vary depending on the current politics of the intimate and the culture of honor that seeks to control and regulate women's sexuality and reproduction.

In summary, physicians working in sexual and reproductive health have a claim to be impartial to political developments. The problems patients experience regarding accessing and benefitting from services are blamed on their shyness or ignorance. It is true that patients struggle to come to terms with explicitly talking about their sexual health and sexuality due to sexuality being constructed as taboo and forbidden, especially for women in Turkey. Regardless, as this chapter and the previous chapter prove, the problems in accessing and benefitting from sexual and reproductive health services are caused by structural problems in health institutions and discrimination and oppression towards sexually active single women.

[123] Hekimliğinse hiçbir yerinde politiklik yoktur, bu bir bilim.

[124] 40 yıl 50 yıl önceki teyzeler iki çocuk yapıyor fıstık gibi de korunuyordu şimdi bilmedikleri için düşükler kürtajlar çok fazla.

5.6 Conclusion

The main argument of this chapter can be simply summarized as that the concepts such as honor, chastity, purity and the conservative politics of intimate that both aim to control women's sexuality and standardize them as modest, conservative future mothers utilize sexual and reproductive health services as another tool on control of women's sexuality. Current sexual health services that are shaped at the expense of sexually active single women and systematic response of health staff that discriminates and reproduces the norms on virginity and women's sexuality guarantees that sexually active single women and LGBTI+ people are punished for their improper sexual conduct.

CHAPTER 6

COPING STRATEGIES OF WOMEN AND WOMEN'S SOLIDARITY

Inaccessible sources of sexual health knowledge and women's encounter with obstacles in benefitting from sexual and reproductive health services require women to develop strategies and find their own solutions. In order to avoid gynecologists that act on social norms regarding the sexuality of women, women establish information networks with their friends and acquaintances in which they share their sexual health experiences along with 'bad' and 'good' gynecologists. Moreover, they share information on sexual health in order to compensate for the lack of sexual health education. Through these networks, they establish solidarity on a topic they would otherwise struggle to find help with because of the taboo nature of the topic. Issuing an official complaint or correcting the gynecologist on their choice of words are the other strategies in which women aim to improve their sexual health interaction along with future patients who are also sexually active single women. Another coping strategy is improving their knowledge of sexual health and learning terminology. These are utilized by women to overcome doctor-patient hierarchy that can dictate social norms onto patients, which results in negligence of their sexual health needs. Lastly, women who can afford prefer private hospitals to receive better sexual and reproductive health services. In the end, these strategies can help women overcome structural and social obstacles in sexual and reproductive health provision. However, employing these strategies means women have to put in work and time to research and learn or spare a considerable amount from their budget for private hospitals and clinics.

Coping mechanisms which I will mention in this chapter are gathered mainly from experiences of single women and married women who had sexual and reproductive health service experience as single women. Only strategy that is also used by married women who had sexual and reproductive health service experience after they got married was preferring private hospitals.

6.1 Women's Information Network

Most of the interviewees do not go to any random gynecologist; they gather references and research the gynecologist they will be visiting. In their research, the most crucial part is to hear

about other patients' experiences. The difference between married and single women is that married women usually research the expertise of the gynecologist, whereas single women research other single women's interaction with a gynecologist. The reason for that is single women are trying to make sure that the gynecologist that they will visit does not judge, treat badly, or discriminate against sexually active single women. Consequently, by researching and asking their friends, single women are trying to avoid the behaviors that I listed in chapter 5. Melek mentioned that if she goes to state hospitals, she chooses a gynecologist that any one of her friends can recommend. Damla, Tuğba and Demet stated that all of her friends go to each other's gynecologists and same gynecologist's names are being circulated in their friend circles. Bahar expressed that while choosing she asks her friends and acquaintances and research on internet. Begüm mentioned that:

> People who have positive experiences immediately share the name of the gynecologist with others. I think it is a very tragic situation. They find a gynecologist who acts neutrally, that acts like they are supposed to in normal conditions and say, "Friends that gynecologist did not judge me, you can consult them.".[125]

Consequently, different networks of women share information with each other on which gynecologists they can trust. Begüm points out that it is unusual to form such an information network of women just to find a gynecologist who acts as they are supposed to. Thus, women are pushed to create these networks of information to receive the service that is actually their right. I have to add that this is the strategy of socioeconomically advantaged and university-educated women. Forming those information networks mean that they can talk about sexual health with their friends. This strategy might not work among conservative circles or less educated and socioeconomically disadvantaged groups.

The process of researching and asking friends for recommendations can become constant struggles for women. İlayda and Begüm mentioned having a ready list of recommended gynecologists, in case they or their friends will need to visit urgently. İlayda said that, "I know few people (gynecologists) already. I pay attention to doctors not to be homophobic or transphobic. I check the lists of Kaos GL that list doctors that are not phobic"[126]. Similarly, Begüm stated that:

[125] Olumlu deneyim duyanlar hemen paylaşıyor şu doktor diye. Bence çok acınası da bir durum, acınası derken üzücü bir durum diyeyim. Bir doktor buluyorlar nötr davranan, aslında olması gerektiği gibi davranan, işte "arkadaşlar şu doktor beni (bekar ve cinsel olarak aktif olduğum için) yargılamadı, buna gidebilirsiniz." diye.

[126] Birkaç insan biliyorum zaten. Homofobik, transfobik doktor olmamasına dikkat ediyorum. Kaos GL paylaşıyor bazen şehirlerdeki fobik olmayan doktorları öyle listelerden bir doktor seçip kontrol edileceğim zaman ona gideyim demek.

> I still research even if I am not planning to go for an appointment immediately. I save good gynecologists in case I need them. … I wish I didn't have to spend so much time on it. I wish I could book an appointment in a state hospital, and I could get my free treatment from there.[127]

Begüm emphasizes that having a ready list of gynecologists helps her to prevent receiving any bad treatment or judgment in sexual and reproductive health interactions; however, she has to put a considerable effort just to go and receive health care service. By developing this strategy of researching and asking for a recommendation for a good gynecologist, single women can decrease the chance of receiving judgmental and discriminative behavior from health staff against sexually active single women. However, they have to put their effort and time in order to reach sexual and reproductive health services. This can be considered as another sanction for punishing sexually active single women; they are made to work to reach a service that should be their right. Gonca mentioned that:

> I couldn't go to any hospital I want now. If there is an emergency, I don't think I could trust a random institution. Because their attitude, the approach could be negative, at least that was the case earlier.[128]

Gonca expresses her concern that she could not go to a random gynecologist even in an urgent case. Thus, in case of an emergency, if single women are not able to do the work of research, they might be deprived of sexual health care, which can create serious consequences for their health.

It is not only women who recommend gynecologists to each other in person but also share positive and negative feedback on social media platforms. I have reached some of my interviewees through METU Women's Solidarity Facebook group, and they mentioned the importance of having a group in getting recommendations and sharing information with others. Beril stated that:

> The ones that won't judge me, I am not married, and I have an active sexual life. I try to go to the ones that won't judge me. I usually get help from my friends, or I received so much help from METU Women's Solidarity group.[129]

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[127] Bu arada hemen gidecek olmasam da araştırıyorum. Kaydediyorum bir sorun olursa bu doktor iyiymiş diye. …Keşke bu kadar mesai harcamasam. Randevu alıp gitsem devlet hastanesine ücretsiz, alsam tedavimi görsem dönsem çok güzel olurdu.

[128] Şu an çıkıp istediğim hastaneye girmem. Ya da çok acil bir durum olsa gittiğim yere güveneceğimi sanmıyorum. Çünkü tutumları, tavırları en azından bundan önce olumsuz olabiliyordu.

[129] Beni yargılamayacak, evli değilim ve aktif bir cinsel hayatım var. Beni yargılamayacak yerlere gitmeye çalışıyorum. Genelde arkadaşlarımdan yardım alıyorum veya işte ODTÜ'deki bu ODTÜ Kadın Dayanışmasından çok fazla yardım almıştım.

Moreover, İlayda explained that she reads other's experiences on METU Women's Solidarity group, and try to choose based on the information there. On the content of what is shared in those platforms, Begüm said that, "I hear very few good experiences, and when that is the case, they usually share it on Facebook groups and friendship circles immediately."[130]. Lastly, Gonca mentioned that:

> People share this kind of stuff a lot in METU. Because people prefer to share it relatively more comfortably with others when they have a bad experience so others will not have the same experience, if they trust themselves, they share on internet platforms or share with their own friends.[131]

It is important to notice women do share not only good experiences and their recommendations but also warn others of gynecologist that treated them badly and judged them due to their choices in their sexual life. For example, Gonca's friend who was sexually assaulted by a health worker shared this fact with her circle so that no other woman would experience what she had to endure. Thus, women share good and bad experiences and recommend gynecologists to each other through friend circles and online platforms. This collaboration can be perceived as women's solidarity on a taboo topic. Sexually active single women create those safe spaces with closed groups of women to navigate their right to receive sexual health services.

Friends and acquaintances are also important sources of information on sexual health for women. As there is no common and accessible sexual health education in Turkey, women usually find out later that they are supposed to get Smear tests regularly and information on types of STIs and prevention from STIs. Once they learn more about sexual and reproductive health, friend circles spread the information among each other. For example, if a friend gets infected with any STI because of a lack of information on condom use and the spread of STIs, she warns her friends on condom use and which tests they need to ask so that her friend would not have to experience it or receive treatment immediately. Similarly, when interviewees experience a sexual health problem, they mostly stated they research it on the internet and ask their friends. On sharing information, Gökçe mentioned that:

> When I observe something in myself or one of my friends' experience something or worry about something, we talk about those. Actually, I started to go for the Smear test when some of my friends got it done, and two of my friends had risky types (of

[130] Çok az iyi deneyim duyuyorum ve iyi deneyim duyunca zaten paylaşılıyor facebook gruplarında arkadaş çevresinde.

[131] ODTÜ'de böyle şeyler çok sıkça paylaşılabiliyor. Çünkü insanlar kötü bir deneyim yaşadıklarında başkaları yaşamasın diye bunu paylaşmayı tercih edebiliyorlar rahatlıkla daha rahatlıkla diyeyim. O yüzden çokça internet platformlarında paylaşıyorlar gerçekten kendilerine güveniyorlarsa. Ya da direkt arkadaş arasında paylaşabiliyorlar.

> HPV). …Because having that full awareness of sexuality does not happen exactly at the age of 18. After you enter the university, you gain some awareness by talking to your friends such as "Look there is a test called Smear, and you have to get that done.".[132]

Gökçe stated that she started going for regular Smear tests after her friends were infected with risky types of HPV. She points out the importance of the social circle. Of course, the social circle she mentions is a specific one. Evidently, her friends were also sexually active, open to talk about a taboo topic, and at least one of them was aware that they need to consult a gynecologist. Regarding starting the conversation of sexual health in her friend circle, Mine said that:

> I started to hear more about this after I got infected by HPV. I hear, 'Oh, you too?'. Because I tell people explicitly, I tell my friends that I experienced this, and you should definitely ask for an HPV test when you go to a doctor.[133]

Mine became a pioneer among her friends to start the conversation and warn them of HPV tests. Beril had a similar experience in which explained as:

> After I informed some of my friends on HPV, they went and got tested. I spread that information to my social circle. Fortunately, they listened to me. Some of them turned out to be positive and already started strengthening their immune system.[134]

She spread information on the importance of HPV. Similar to the solidarity for finding good gynecologists, this information sharing on sexual health is also caused by the lack of a service which is widespread sexual health education. Consequently, peer sharing and awareness level of the social circle can be a support system for women in the absence of common sexual health knowledge. All interviewees were university educated, and none of them indicated a negative approach towards the sexual activity of single women. Women who are in socioeconomic groups in which sexuality as a taboo is more prevail or access to education is more limited might be in a more disadvantageous position when this peer support system is considered.

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[132] Hem kendimle ilgili gözlemlediğim bir şey olduğunda ya da arkadaşlarım bir şey yaşadığında, bir şey olduğunda, bir şeyden endişelendiğinde kadın arkadaşlarımla konuştuğumuz şeyler oluyor genellikle. Benim aslında Smear testi yaptırmam da şeyle başlamıştı, birkaç arkadaşım yaptırdı ve iki arkadaşımda da riskli tipten çıktı. …Çünkü yani cinsellikle ilgili bilincin tam oturması 18 yaşında olmuyor yani. Üniversiteye geldikten sonra bir şeyler, arkadaşlarınla konuşa konuşa "bak Smear testi diye bir şey var bunu yapmak gerekiyor" gibi benim de bilinçlendiğim şeyler oluyordu.

[133] Ben de enfekte olup bir şeyler geçirdikten sonra daha fazla duymaya başladım. "Aa sen de mi?" gibi oldu. Çünkü ben daha fazla dışadönük bir şekilde yani insanlara anlatıyorum. Başıma bu geldi sen de doktora gittiğinde mutlaka HPV testi iste, diyerek arkadaşlarıma anlatıyorum.

[134] Ben birkaç arkadaşımı özellikle HPV konusunda bilinçlendirdikten sonra, onlar da mesela test oldular. Bayağı ufak çevreme yaydım bunu. Ve neyse ki dinlendim. Kimileri de pozitif çıktı ve bağışıklıklarını güçlendirmek için şimdiden çabalara başladılar.

In conclusion, the solidarity women established ensures information sharing on good gynecologists and sexual health information can compensate for lack of sexual education and unfair treatment of sexually active single women in sexual and reproductive health service provision. Regardless, women have to do considerable work to find a gynecologist that does not judge and discriminate who can function as a punishment for disobeying the control over their sexuality. Moreover, this solidarity and information sharing can only take place within specific circles, for instance, university educated, socioeconomically advantaged, and relatively sex-positive social circles.

6.2 Issuing a Complaint and Correcting the Language Used by Gynecologists

Another coping strategy that women I interviewed have been using is to aim for behavior change in health staff. Single women exposed to discrimination and bad treatment because health staff disapproves their choices in their sexual life might wish to contribute to changing their behavior by giving feedback on how they should treat them. Moreover, women can issue an official complaint against gynecologists who treated them unfairly. These strategies are important to note as women who are utilizing them are not only putting effort into their own sexual health but also for other women who will interact with the same health staff, as well.

Among all interviewees, only Bahar was able to issue a complaint to Presidency's Communication Centre (CIMER) against the gynecologist who judged and insulted her. Unfortunately, issuing a complaint against the gynecologist who mistreated them in every situation is not possible for women. Issuing an official complaint can mean the exposure of that patient as a sexually active single woman. Because of privacy concerns, Gonca's friend, who was sexually assaulted by a medical technician, could not issue a complaint officially. She feared that the complaint along with information on her sexual health, might show up on official records and affect her employment as a civil servant. She was also worried that her family could find out that she is sexually active. Besides, Bahar stated she did not hear any result from her complaint to CİMER. Thus, official complaints could have been a mechanism that ensures accountability of gynecologist and bring behavioral change; however, they do not seem to function, and privacy concerns discourage women in choosing this coping strategy.

In addition to issuing a complaint against gynecologists, interviewees can correct or push health staff to adopt the non-judgmental or non-assuming language. For example, Damla corrects health staff when they ask about sexual activity through marital status by saying, "Are you asking if I have a sexually active life?". Her purpose in that is so that health staff can start asking the medically and ethically correct question. I explained in the 5.1 section of Chapter 5, asking about sexual activity through marital status signifies the married women- sexually active/single women-virgin distinction that women are not allowed to challenge. By correcting

that question, Damla is telling health staff that other experiences exist. Similarly, Mine waits in silence for health staff to ask more questions after being asked her marital status to make them aware that marital status question does not serve its purpose. Both of these approaches are taking an active stand against the marginalization of sexually active single women and demanding that health staff be more inclusive. While these strategies could help to create awareness among health staff, they can also backfire. Chapter 5 demonstrates how deeply rooted the notion is that it is forbidden for single women to experience sexuality. Sexually active single women are expected to struggle and feel ashamed when they managed to seek sexual and reproductive health services. Thus, single women who are openly challenging the norm can be perceived more negatively by health staff, and the sexual and reproductive health services they will provide might be affected by that. Consequently, correcting the questions asked by health staff can contribute to the awareness on recognizing the firstly the existence, then the needs of sexually active single women; however, it can put the women who are confronting the health staff at risk of bad treatment.

Shortly, issuing an official complaint on health staff that mistreated patients and correcting the questions asked by health staff can be beneficial to create behavior change in health staff towards being more inclusive of sexually active single women. On the other hand, women have to consider the risk of exposing their personal sexual health information and being treated harshly by health staff while employing these strategies.

6.3 Improving Sexual Health Knowledge and Learning the Terminology

In response to the negligence of sexual health needs of sexually active single women, interviewees utilize increasing their knowledge in sexual health to receive better sexual health care. By increasing their knowledge, they want to appear educated to gynecologists, be able to suggest or choose treatments and tests and find their alternative solutions for sexual health issues. Similar to the obligation of single women to research 'good' gynecologists, women have to spend time and put effort into this research of sexual health.

Interviewees can learn about sexual health and the terminology of sexual health to show that they are educated on the topic and know what their sexual health needs might be. By demonstrating their knowledge, they hope gynecologists would respond to their needs that otherwise, they would ignore. Melek mentioned that:

> I prefer speaking with proper terminology. I want them to feel as, "Look when I search it on internet it says you have cancer. My health literacy is more developed than that.

> I approach this issue in more detailed and scientific way. Because of that give me what I need.".[135]

Melek utilizes using the medical terminology to seem educated and to demonstrate she knows her needs and expects those needs to be delivered. Moreover, Damla stated that:

> Now I have more information, and I read, I can go with my own suggestions. I recognize my own body. I know which medicine or application suits me, I learned all of these. Knowledge and experience are crucial. If you do not have any idea, you rely on the gynecologist; whatever gynecologist says is the solution.[136]

Damla expresses that having experience in sexual health services and learning about medicines and operations enables her to make choices and assume an active role in her interactions with gynecologists. Thus, learning about sexual health and medical terminology gives patients an advantage in being involved in decisions on their sexual health. Their involvement can help them overcome the hierarchy of the expert position of the gynecologist. Closing the gap ob that hierarchy is crucial in the sexual health interactions because the gynecologist who is the expert in that interaction incorporates social norms into the medical practice, and that hierarchy is further enhanced by lower status assigned to sexually active single women. Thus, single women have to show that they are knowledgeable in order to overcome this hierarchical relationship between the patient and the doctor and finally receive the sexual health care that they need and demand.

Responses from gynecologists demonstrate that using terminology and being knowledgeable in sexual health can result in better interaction and better sexual and reproductive health care service. Gynecologists tend to respond positively to the ability of patients to express themselves and use medical terminology. As expressed by one of the gynecologists, patients who are aware of their sexual health needs, can express themselves, and understand the language used by the gynecologists are "easier" patients for them. Gynecologist 2 stated that:

> University students can express themselves very well, and they can reach services like that. …University students ask more questions, and they have awareness of sexual health. …Income and education level affects communication. Educated women have more self-confidence, and they act more consciously and logically. Therefore, they

[135] Daha terminolojik konuşmayı tercih ediyorum. Şunu hissettirmek istiyorum bakın internete yazdım sonucu kanser çıktı yapıyoruz ya. İnternetteki tıbbi okur yazarlığım bunun ötesinde. Daha detaylı ve bilimsel yaklaşabiliyorum bu konuya bu yüzden benim almak istediğimi bana verin.

[136] Artık daha fazla bilgim var okuyorum, kendi önerilerimle gidiyorum. Kendi bedenimi tanıyorum. Hangi ilaç ne uygulama olur ne olmaz biliyorum, bunları öğrendim. Bilgi, deneyim çok önemli. Hiçbir fikriniz yoksa doktora bakıyorsunuz, doktor ne derse o oluyor.

> express themselves better, explain their problems better, and receive better treatment.[137]

Gynecologist 2 emphasizes that patients who recognize their needs and are more educated on sexual health result in better sexual health care. In the light of these statements, university-educated and socioeconomically advantaged women who are able to access and research the scientific resources have more advantage over women from less educated and lower-income groups. For instance, Gonca stated she reads articles and other resources in sexual health in English as the ones in Turkish are more limited. This is a privilege that many people do not have in Turkey. Mine, Deniz, Nazlı, and Beril specifically mentioned that they follow podcasts or posts of the experts that they find their approach close to their views and sex-positive. Hearing about these experts and understanding the language they use can be related to education level, as well. Therefore, while educated women can use their sexual health knowledge to their advantage, less educated women are deprived of this strategy in order to receive sexual health care.

Women's knowledge of sexual health and recognizing the needs of their own bodies could help them come up with their own solutions to their sexual health problems. For example, İlayda, Ayşe, Sena, and Begüm mentioned gynecologists prescribing contraceptive pills as the standard procedure for period irregularity is a common procedure as hormone irregularities or polycystic ovarian syndrome are the common reasons. Ayşe and Begüm researched period irregularity to know more about their bodies as they didn't have indicators for hormonal irregularities and decided on alternative methods that relieve stress helps them better. Ayşe stated that:

> I went to a different gynecologist for menstrual irregularity because the previous one couldn't offer a solution. … The first one suggested contraceptive pills. I didn't use it. I started using it when they prescribed it in the health center of the university. I used it for 2 months, but its effects were not good for me. …Later, I research on the internet and Youtube. I realized my case is related to diet, sleeping, and stress.[138]

Similary, Begüm mentioned that:

[137] Üniversiteli kızlar kendilerini gayet iyi ifade ediyorlar ve böylelikle hizmetlere ulaşabiliyorlar. …Üniversiteli gençler daha fazla soru soruyorlar ve konuda daha bilinçliler. … Gelir ve eğitim seviyesi iletişimi etkiliyor. Eğitimli kadının özgüveni daha yerinde oluyor, daha bilinçli ve daha mantıklı davranıyorlar. Böyle olunca da kendilerini daha iyi ifade edip, sıkıntılarını daha iyi anlatıyorlar ve daha iyi tedavi alıyorlar.

[138] Önceden adet düzensizliği için doktora gittiğimde çözüm olmadığı için farklı bir doktora gitmiştim. …İlkinde doğum kontrol hapını önermişti. Sonra kullanmamıştım. Medikodan verdiklerinde kullandım. İki ay kullandım ama etkilerini hormonal bir ilaç olduğu için çok şey yapamadım, bana iyi gelmedi yani. …Sonra internetten Youtubedan vesaire de araştırmıştım. Bendeki durumun biraz stres kaynaklı olduğunu uyku ve beslenmeyle etkilendiğini farkettim.

> I had pain problems; then later I started to seek different methods. I tried different methods such as exercise and yoga to relax physically and psychologically… Yoga helps a little, the yoga for menstruation that I found online.[139]

Sena, who also has indicators for the polycystic ovarian syndrome, found alternative methods such as yoga and ayurvedic medicine to solve her problems regarding period irregularity. Overall, women learning more about sexual health and their bodies can improve their interaction with health workers and present solutions to improve their sexual health.

On the other hand, even if women improve their sexual health knowledge, it is not guaranteed that gynecologists and other health staff will let their involvement. For example, Beril states that health staff did not include her in the decision on her sexual health, but she insisted on being involved as she had enough knowledge to know her sexual health needs. The insistence of patients on any test or operation can be perceived as meddling by gynecologists. Gynecologist 1 mentioned that:

> We don't have to argue with them on what to do regarding their situation. We don't argue; we are the ones to decide. Later, they are informed. They might want it or not want it (test or the procedure that the doctor decided to pursue), that is up to them. But they should not meddle in with our work. Now, can I publish a book if my literature skills are not good?[140]

Gynecologist 1 is probably not likely to respond well if a patient insists on a test or procedure. Consequently, women have to establish a balance in their interactions with gynecologists where they appear educated on sexual health and state their demands without undermining the expert position of the gynecologist.

6.4 Preferring Private Health Institutions

Choosing to consult private hospitals and clinics instead of state hospitals is a way for receiving better sexual and reproductive health services among interviewees. By choosing private hospitals and clinics, they can benefit from the advantages of being customer-patient which I explained in section 4.2.1 of Chapter 4, which are easier access, lower chance of being discriminated due to being sexually active, attention to patient's privacy and more attentive health staff. Moreover, services that are unofficially denied to women, such as abortion or HPV tests, are available in private health institutions. Disadvantages of these options are

[139] Ağrı problemimde olmuştu onda da artık ben farklı metotlar denemeye başladım. Spor yoga gibi fiziksel ve psikolojik olarak rahatlamanın çeşitli yollarını denedim. … Yoga biraz rahatlıyor, internetten bulduğum regl yogaları.

[140] Bizim zaten onla kendi durumuyla ilgili ne yapılacağını tartışmamıza gerek yok. Tartışmıyoruz, kararları biz veriyoruz. Ama o da sonra bilgilendirilmiş oluyor. İsteyebilir de istemeyebilir de onun tercihi. Ama işimize karışmamalı. Ben şimdi edebiyatım iyi değilse kitap çıkartabilir miyim?

expensive fees and additional operation or tests being requested for profit which are mentioned in detail in 4.2.2 of Chapter 4.

Private hospitals and clinics provide are alternatives for single women where they can reach services that are denied to them without bad treatment. Eleven of the interviewees emphasized preferring private institutions or stated they would prefer it if they could afford it. Canan and Demet mentioned that they would go to state hospitals if they could be sure of how gynecologists would treat them as they do not want to pay for a service that should be free. Patients, especially single women, are pushed to 'prefer' private hospitals and clinics if they cannot find gynecologists that do not discriminate and neglect sexually active single women. Sena prefers only private hospitals as she believes she can receive better service in private hospitals. Tuğba mentioned that, "I mean it is better (in private hospitals and clinics) because the health sector is not something we can control. The best I can do is to pay more and receive the best service I can reach."[141], in order to explain why she prefers private hospitals. İlayda stated that she has been saving money to go to a private hospital for sexual and reproductive health services to receive better health care. Seda mentioned the following:

> I never went to a state hospital. Honestly, I don't consider going. I got an ultrasonography screening once for my kidneys in the state; there are usually millions of women waiting in front of the ultrasonography room. I probably will not go because of it.[142]

Women who can afford private health institutions use that option in order to receive better sexual and reproductive health services. However, similar to İlayda's position, some women might have to save money just to receive health care services, whereas private health institutions are not possible options for women who have lower incomes. Additionally, benefitting from health care in state hospitals became more challenging during the pandemic, and interviewees who received sexual and reproductive health care during the pandemic (since March 2020) only went to private hospitals or clinics as they feared getting infected in state hospitals. Thus, inequality caused by being sexually active single women intersects with income inequality that puts those women into an even more disadvantaged position that creates a great risk for their health.

In short, choosing private health institutions over state hospitals in sexual and reproductive health can be an alternative for patients as they are less likely to encounter problems such as

[141] Daha iyi yani çok elimizde olan bir şey olmadığı için sağlık sektörü. Maksimum o biraz daha fazla para verip alabileceğim en iyi hizmeti öyle almaya çalışıyorum.

[142] Devlete hiç gitmedim. Açıkçası gitmeyi de hiç düşünmüyorum. Hani bu böbreklerimle alakalı bir ultrason için bile önünde milyonlarca hamile kadın oluyor, ultrasonun önünde devlet hastanesinde bir kere çektirdim. O yüzden muhtemelen gitmem.

discrimination and negligence of sexually active single women. However, this option is only a privilege of women who can afford to spend a considerable amount of money on sexual and reproductive health services.

6.5 Conclusion

Women, specifically single women, cannot go to any state hospital and benefit from sexual and reproductive health services. They have to come up with strategies that will support them in receiving the sexual and reproductive health care they need. The coping strategies that came up in this research were forming of information networks in which 'good' gynecologists and essential sexual health knowledge is being shared, issuing official complaints and correcting the language used by health staff, improving sexual health knowledge for better doctor-patient interaction, and preferring private health institutions. By utilizing those coping strategies, women help each other and establish solidarity on a taboo topic. They can negotiate their needs with doctors and increase their chances to receive the service they need and demand and avoid bad treatment. Nevertheless, they are made to work, spend considerable time and pay expensive fees just to receive a service that is actually their right.

CHAPTER 7

CONCLUSION

The aim of this study was mainly to explore how the experience of educated, middle-class single women's experiences of sexual and reproductive health services differ from married women's experiences. In order to understand these experiences, I provided the global and country-level sexual and reproductive policies, regulations, and newly introduced services. Later, I explored the overall perception of single women's sexuality in Turkey and the concept of honor which is utilized for the patriarchal control mechanisms of women's sexuality. I tried to demonstrate the policy shift after the 2010s in sexual and reproductive health towards pro-natalism within the context of government policies, the discourse that reflects an increasingly authoritarian conservative ideology. In this theoretical framework, I conducted interviews with 22 semi-structured in-depth interviews with educated middle-class women who had consulted to sexual and reproductive health services in Ankara. In order to see the difference between their experiences, 11 single women and 11 married women were included in interviews. Moreover, I conducted expert interviews with 2 family physicians, 2 gynecologists and 1 NGO worker that has been working in sexual and reproductive health.

This research connects the authoritarian neo-conservative ideology and the culture of honor that is obsessed with the sexual conduct of women with sexual and reproductive health service experiences of educated middle-class single women. The culture of honor in Turkey places family's honor on women's virginity and grants ownership of her sexuality only to her husband once she marries. A sexually active single woman has no place in society and is a part of the 'other' group that society and the government do not recognize. Neoconservative policies and discourses of the current government use intimate politics to declare the ideal society they wish to create. The ideal conservative family formed by heterosexual marriage with 'at least three children' is at the core of these policies in which women are the conservative self-sacrificing caregiver of all families. In line with this ideal, pronatalist politics and discourses were employed, and all practices that do not fit into the pronatalist and conservative ideology were condemned. Abortion, family planning, working women with no children, cohabitation practices of university students, and C-section surgeries were publicly declared unnatural and

unfit to conservative Turkish values. Moreover, LGBTI+ people were targeted and declared against the moral values of Turkish society.

In the context of the increasingly authoritarian and conservative politics of AKP, policies in sexual and reproductive health shifted away from their previous rights-based course. Sexual and reproductive health policies have been becoming more rights-based and inclusive thanks to democratization and the EU candidacy process and the effect of increasing funds and focus in the post-ICPD period until the end of the 2000s. In the 2010s, sexual and reproductive policies and available services shifted away from anti-natalist and rights-based services towards pronatalism and neglect of non-obstetric services such as family planning and STI prevention and treatment with the increasingly authoritarian and conservative political agenda. Moreover, Health Transformation Program and privatization of health care system had a negative impact on service provision in sexual and reproductive health services. For instance, the number of mother and child care and family planning centers drastically increased and the salaries of health staff started to be determined with performance criteria which does not include essential sexual health services. These changes reflected on the government reports and projects in this area, and services introduced in post 2010s withered away.

This shift in sexual and reproductive health policies coincides with the introduction of SDGs in global policy arena. While addressing issues in sexual and reproductive health and rights, SDGs also promote 'leaving no one behind' which means eliminating discrimination and inequalities that persist among and within countries to ensure everyone can reach those services and rights. In the case of Turkey, on top of other factors that are subjected to discrimination such as ethnicity, race or religion, being sexually active single women is a basis for discrimination which results in leaving women in that group behind when it comes to sexual and reproductive health services. It is arguable how much these issues can be addressed in global policy arena as SDGs present as non-binding policies.

In this thesis, my argument was that the culture of honor and politics of intimate was not only reflected on policies and availability of services, but it also had an impact on sexual and reproductive health interactions of patients and health staff. The interviews with patients and experts demonstrated that sexually active single women were perceived as less honorable and deserving of less respect by health staff. The norm that single women are virgins and married women are the only ones that can be sexually active was reproduced in those interactions. Sexual experiences of single women were justified by physicians' bad treatment, which can be insults, denial of services, physical violations, and even sexual assault. Sexual activeness of single women coinciding with their single status that signifies that they are not under the protection of family put them in a vulnerable position as health staff equated the absence of

hymen with consent to any physical intervention. Consequently, single women's experiences in sexual and reproductive health services become a punishment for them due to disobeying social norms and control mechanisms of their own sexuality.

The notion that women's sexuality is not as her own agency but a topic that concerns her family along with objectification and desensitization in medical practice and the monitoring of government of women's bodies lead to violation of the privacy of women's bodies and confidentiality of their personal information. Moreover, the deliberate neglection of needs of sexually active single women and LGBTI+ people in sexual and reproductive health policies reflect on the practice of this field; non-obstetric concerns of women such as painful periods or HPV infections are deemed unimportant, and services such as abortion or contraception are not provided to patients. Consequently, the reflection of the political environment and the culture onto the medical practice indicates that medical practice is not immune to the social and cultural on the contrary to the claims of practitioners.

In addition to cultural and social norms, I wanted to capture the other factors that affect single women's experiences in sexual and reproductive health services. The structure of the health system in Turkey created obstacles for women to benefit from sexual and reproductive health services. The high patient load per physician and short appointments in state hospitals exaggerated the already present objectifying approach of health staff towards patients. The impact of perceiving patients through objectifying medical gaze in sexual and reproductive health is especially problematic because patients feel more vulnerable and need a kinder approach in this field due to its taboo nature and the pressure of social norms that exclude them as the disrespected other women. I explained other differences in experiences of the patient in state and private health institutions through the customer-patient position of patients in private hospitals. Private health institutions are subjected to additional accountability, which is the satisfaction of their patients and adding extra value to their services in order to protect their reputation and maintain customer satisfaction. Consequently, the services they provide are more likely to answer to the demands of all women, including single women. Single women can meet their demands which are easier, quicker access, more attentive and non-judgmental health staff, access to services that are denied in state hospitals, and protection of the privacy of their body and confidentiality of their personal information can alternatively consult to private health institutions if they can afford those services. Therefore, structural problems in state hospitals and lack of accountability create unequal access to sexual and reproductive health services, especially among sexually active single women.

The last important output of this study is to analyze how educated and socioeconomically advantaged women respond to previously mentioned obstacles and maximize the benefit they

can get from sexual and reproductive health services. The most important outcome was that women establish information networks in which they research both sexual health information and attitudes of the gynecologist and share this information with each other. Both good, suggested gynecologists and bad, discriminative, and judgmental gynecologists are shared in those groups in order to improve one another's experiences in sexual and reproductive health services. By that, solidarity is formed on a taboo and forbidden topic. Moreover, single women strive to improve their sexual health information and learn the terminology in order to have better interactions with gynecologists. The downside of women's coping strategies is that they have to put effort and time into a subject that should be their right to access and benefit.

The outcomes of this study necessitate policy interventions in order to improve the sexual and reproductive health experiences of single women. While providing social policy recommendations for sexual and reproductive health in Turkey, I want to point out the need to be realistic. I try to demonstrate in Chapter 2 that even though the patriarchal pressure and control on women's sexuality seems to become more and more authoritarian due to policies and discourse utilization of the current government and its effect on services such as sexual and reproductive health services, the condemn of single women's sexuality and punishment of 'unchaste and dishonorable' women has always been the case in Turkey. I assume suggesting and expecting drastic changes towards feminist and rights-based policy from the government, in that case, would not be realistic. However, the power of the feminist and LGBTI+ movement in Turkey should not be undermined. Consequently, I prefer to suggest policies and applications that can be negotiated with the government or can be implemented by civil society.

Policy recommendations that would respond to the shortcomings of sexual and reproductive health services and could improve the experiences of single women would be as follows:

- delivering training on gender sensitive medical care, sexuality, rights, and communication with patients to health staff,
- establish mechanisms for accountability of health staff,
- providing age-appropriate sexual health education to the public,
- decreasing the patient load per physician in state hospitals by utilizing primary health care centers or improving the appointment system,
- improving and increasing the capacity in equipment in state hospitals, and
- introducing anonymous and confidential sexual health services.

Initiating these services and including them in sexual and reproductive policies would respond to the problematic areas in sexual and reproductive health services in Turkey that emerged as the result of this study.

The first recommendation would be to provide comprehensive training on gender sensitive medical care, sexuality, sexual rights, patient rights, and communication to health staff by prioritizing the ones that work in sexual and reproductive health. This recommendation was also voiced by women during interviews. In fact, within the scope of Turkey's reproductive health program, there was a plan on increasing the sexual and reproductive health knowledge of medicine, nursing, and midwifery students. The curriculum of this sexual and reproductive health training included anatomical and disease-focused topics as well as sexual rights, reproductive rights, the effect of gender on health, non-judgmental communication with patients on sexuality and sexual health problems, and gender-based violence (Ministry of Health, 2006). Despite the inclusion of rights and communication on the training, there is only a vague mention of sexual orientations and identities to represent the needs of LGBTI+ people. Additionally, educating only students on rights and communication skills might be inadequate in improving the current service interactions; there is also a need for in-service training. Nevertheless, the implementation of the program has not been widespread among nursing, midwifery and medicine faculties (Aşçı, Gökdemir & Çiçekoğlu, 2016).

According to the result of this study, the goals of the training towards health staff should be attitude change towards acceptation and recognition of all sexual experiences, sexual orientations and gender identities, sexual rights and patient rights, breaking the desensitization towards women's emotions and subjective experiences, improving communication skills and ensuring adoption of a rights-based approach. The literature on sexuality training delivered to health staff indicates that the main objectives of these training sessions were mostly attitude change on sexuality and addressing the religious, cultural, and social roots of the perception of sexuality (Stiernborg & Weerakoon, 1996). Comprehensive sex education can contribute to shifting from conservative attitudes on sex towards a more liberal attitude (Çok and Giray 2007). Moreover, the communication component of the training in similar education is explained to have multiple layered outcomes; the act of being listened to and informed by health staff leads to a better diagnosis, more awareness of the body on the patient's side, and humanization of patient-doctor interactions (Eleuteri, Petruccelli, Saladino & Verrastro, 2020). Consequently, training to health staff should be designed to include improvement of communication and change of attitude towards patients and sexuality.

The training of health staff on sexuality, rights, and communication might not be enough to create change as long as physicians and other health staff do not have any accountability. The

problem of accountability was mentioned by interviews, as well. Accountability is one factor that improves the quality of sexual and reproductive health services, which reflects on the difference between private and state health institutions. The existing mechanisms need to strengthen and the privacy of patient who makes the complaint should be ensured within the health system. In the case of absence of accountability within the health system, women and LGBTI+ solidarity can be encouraged to make lists of both suggested and inadvisable gynecologists. Collaboration of Kaos GL and LGBTİ Sağlığı initiative that aims to inform LGBTI+ people on sexual health and mental health produced a list of suggested gynecologists who were not discriminative or phobic towards LGBTI+ people. Those lists can be accessed by sending a mail to iletisim@lgbtisagligi.org (LGBTİ Sağlığı, 2016). This list can be developed with a joint effort of feminist and LGBTI+ organizations. Lists of gynecologists that reflect their ill approach to sexuality on their patients and treat their patients badly in any way due to their sexuality can also be shared to protect other patients.

Another essential action to be taken in order to improve sexual and reproductive service interactions is to provide comprehensive and age-appropriate sexual health education. As I mentioned in previous chapters, only formal sexual health education is the one provided in biology classes that focuses on anatomy and pregnancy. Sexual health education programs have been implemented by NGOs such as the Turkish Family Health and Planning Foundation; however, NGOs that provide rights-based sexual health and rights education have been targeted by pro-government media outlets, and collaboration with the ministry was cut especially from the 2010s (Ayar, 2019). The education programs such as the Family Education Program that include a reproductive health component heavily emphasize the importance of heterosexual marriage and family institutions and only provide information on sexual and reproductive health only to married heterosexual couples with no chance of having multiple partners (Selman, 2012). On the other hand, comprehensive sex and sexual health education should include anatomical and biological aspects of sexual and reproductive health, STIs, contraception, along with topics that will challenge social and cultural norms (UNESCO, 2018). Moreover, the training should empower its beneficiaries with communication and skills for their encounters with topics such as gender-based violence, sexual exploitation, and discrimination, and in order to maintain long-term change, the training should be delivered in different stages of life consistently. (UNESCO, 2018). Moreover, covering gender and gender identity, sexual orientation, and issues of LGBTI+ people are crucial (Çuhadaroğlu, 2017).

The sex and sexual health education would empower women and LGBTI+ people in their experiences of sexual and reproductive health and affect their overall sexual health positively. Moreover, it could help end the stigma around women's sexuality and sexuality of LGBTI+

people in Turkish society. The existing research indicates that sex education can contribute to the change in perspectives of trainees towards a more liberal and rights-based approach (Çuhadaroğlu, 2017). Most importantly, sexual health education should be incorporated into formal education to reach a big portion of the population. It's challenging to propose the introduction of comprehensive sexual health education that is inclusive of pre-marital sex and LGBTI+ people into formal education with the current direction in politics of intimate that the government employs, which I mentioned in Chapter 2. Akın and Özvarış point out the need for increased advocacy activities in order to improve policies in reproductive health and inclusion of gender issues in related policies (2005). Nevertheless, in the case advocacy efforts towards including sexual health education into formal education will fail, the NGOs and municipalities can assume the role in providing sexual health education which can be provided separately for children and adults. Evidently, introducing comprehensive sexual health education in any context would be challenging in the current familial conservative political environment.

Structural problems in sexual and reproductive health services indicate a need to restructure state hospitals. The appointments in sexual health should be longer, and the number per physician should be decreased. One way to decrease the patient load in state hospitals would be to utilizing family health centers more effectively. Family physicians can be trained on primary sexual and reproductive health care, and their provision of those services can be monitored. By these improvements, preventative sexual health services could be strengthened, which can also decrease the patient load and morbidity regarding sexual health. For example, patients who are informed on contraception and provided with condoms are less likely to be infected with STIs. Reopening and increasing the numbers of mother and child care and family planning centers and youth counseling and health centers could be another option as health staff in these centers could cater to the needs of its beneficiaries and provide more focused services. Additionally, optimization systems that include numerical and analytical methods as well as case studies and simulations can be applied to improve appointment systems (Ahmadi-Javid, Jalali & Klassen, 2017; Denton & Gupta, 2008). Evidently, advocacy efforts and the budget that the government is willing to spare for sexual and reproductive health services would be the limiting factors in the applicability of these propositions.

In order to make access to sexual and reproductive health services easier, equipment in state hospitals should be updated and increased. For example, waiting for another queue or even rescheduling for another day for ultrasonography screening can make access to service difficult as patients would have to spend a considerable amount of time in hospitals. Adding ultrasonography devices in the room where gynecological examinations are conducted can

improve access. Moreover, the inclusion of online or telephone appointments could shorten the time both patients and physicians spend on each appointment. For example, results of tests and prescriptions could be talked about over the phone or on online channels.

Lastly, the results of this research imply the necessity of anonymous and confidential sexual health services. The security of information on data registration systems such as e-nabız should be maintained. For example, access to health information of patients should not be allowed to anyone, including health staff, without the consent of the patient. Services such as STI tests and treatment, including HIV and abortion, should have the option to be accessed anonymously. These changes could be challenging to negotiate as surveillance of the sexual and reproductive health of women is one of the biopolitical and disciplinary tools that government uses (Kazanbas, 2019). Nevertheless, current anonymous STI test services of local authorities such as municipalities and civil society could be expanded with the collaboration of international organizations and/or the private sector.

Overall, this research revealed the connection of the current politics of intimate and the culture of honor with sexual and reproductive health interactions of educated and middle-class single women. The results challenged the consideration of medical practice as a purely objective area and revealed the discrimination that sexually active single women experience. Both social norms around women's sexuality and the structure of health institutions uniquely affected sexual and reproductive health experiences. Even if women came up with their own coping strategies that invoked a women's solidarity, they had to struggle due to their status as sexually active single women in order to access their rights.

This study is one of the pioneering research on single women's experiences of sexual and reproductive health in Turkey. Focusing on the experiences of single women proved relevant in Turkey due to cultural and social norms around women's sexuality. I have to add that I am surprised that a subject that has been talked about among women, mostly quietly, took so long to be researched as an academic work. Moreover, considering this subject from a social policy perspective was essential as the impact of both concrete policies in sexual and reproductive health and discourses and rhetoric around women's sexuality and gender roles on the medical practice could be analyzed. I believe this study could incite academic curiosity in consideration of different experiences in where politics of intimate and the culture of honor could be effective.

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APPENDICES

APPENDIX A: IN-DEPTH INTERVIEW QUESTIONS

Uzmanlarla Görüşmeler:

1. Cinsiyetiniz nedir?
2. Yaşınız nedir?
3. Mesleğiniz nedir?
4. Mesleğinizi kaç yıldır yapıyorsunuz?
5. Çalıştığınız kurum tipini belirtir misiniz? (Özel hastane, devlet hastanesi, tıp merkezi vb.)
6. Cinsel sağlık ve üreme sağlığı kapsamında çalıştığınız kurumda verilen hizmetler nelerdir? Çalıştığınız kurumda verilmeyen hizmetler var mı? Varsa neden verilemiyor?
7. Cinsel sağlık hizmetlerine talep var mı? Bu talep yoğunlukla hangi demografik özelliklerde kadınlardan geliyor? Kadınların hizmetlere talebini sizce hangi faktörler etkiliyor?
8. Cinsel sağlık ve üreme sağlığı ile ilgili önleyici uygulamalar, koruma yöntemleri ve aile planlama bu konuda talebi olan kadınlara anlatılıyor mu? Talebi olmayan kadınlara anlatılıyor mu?
9. CYBE test ve tedavileri, doğum kontrol yöntemleri, kürtaj gibi uygulamalara ulaşmakta güçlük çeken kadınlar var mı? Varsa ulaşamamalarının nedenlerinden bahseder misiniz?
10. Kurumunuzda cinsel sağlık ve üreme sağlığı alanında verilen hizmetler yaşa göre değişiklik gösteriyor mu? (Örneğin HPV testinin 30 yaş üstü kadınlara yapılması gibi) Başka faktörlere göre değişiklik gösteriyor mu?
11. Bakanlık ya da hastane yönetimi tarafından üreme ve cinsel sağlık alanında geliştirilmiş projelerden haberdar mısınız? Bu projelerden bahsedebilir misiniz? Bu projelerin hedef kitleleri kimlerdir? Bu projeler uygulanıyor mu? Uygulamada karşılaştığınız sorunlar var mı, bahsedebilir misiniz?
12. Cinsel sağlık ve üreme sağlığı hizmetleri uygulamaları ve olanakları ile ilgili 2000 senesinden itibaren bir farklılık gözlemlediniz mi? Gözlemleriniz nelerdir?
13. Genel olarak sağlık hizmetlerini etkileyen Sağlıkta Dönüşüm Programı, Aile Hekimliği sistemi ve performans kriterleri gibi uygulamalar cinsel sağlık ve üreme sağlığı uygulamaların cinsel sağlık ve üreme sağlığı uygulamaları üstünde herhangi bir etkisi oldu mu? Olduysa kadınların bu hizmetlere erişimine etkisi nasıl oldu?
14. Çalıştığınız kurumun cinsel sağlık ve üreme sağlığı ile ilgili olanaklarında (ödenek, malzeme, ekipman vb.) son 10 yıl içinde herhangi bir değişiklik oldu mu?
15. Yasal olarak politikaya dönüşmediği halde mesleki uygulamalarınızı etkileyen herhangi bir olgu, söylem ya da düşünce olduğunu düşünüyor musunuz? Örneğin kürtajla ilgili söylemler bu hizmetin sunumunu etkiledi mi? Nüfus artışı ile ilgili söylemler aile planlamasını, ailenin önemi ile ilgili söylemler bekar kadınların cinsel sağlık ve üreme sağlığına erişimini etkiledi mi?

16. Sizce özel sağlık kurumları ile devlet sağlık kurumları arasında cinsel sağlık ve üreme sağlığı alanında hizmet sunumunda farklılıklar var mı? Buna bağlı olarak danışanların geliri aldıkları hizmet kalitesini etkiliyor mu?
17. Kadınlar cinsel sağlık ve üreme sağlığı hizmetleri için hangi kurumları daha çok tercih ediyor?
18. Okullarda cinsel sağlık eğitimi ile ilgili bir program var mı? Siz hiç böyle bir eğitim verdiniz mi?
19. Tıp eğitiminizde cinsel sağlığın yeri nasıldı? Cinsel sağlık nasıl tanımlandı? Bireysel haklar ve özgürlükler eğitiminizin parçası mıydı?
20. Danışanlarınıza sorduğunuz standart sorular nelerdir?
21. Cinsel sağlık ve üreme sağlığı hizmetleri arasında etik bulmadığınız ya da değerlerinizle bağdaştıramadığınız uygulamalar var mı? Varsa bu uygulamaları neden etik bulmuyorsunuz?
22. Sizin için zor ya da kolay danışanlar/hastalar var mı? Danışan/hastanın zor ya da kolay olması sizin sağlık hizmeti sunmanızı etkiliyor mu? Bir danışanı/hastayı zor ya da kolay yapan özellikleri nelerdir?

Kadin Hastalar/Danışanlarla Görüşmeler:

Demografik bilgiler

1. Yaşınız nedir?
2. Cinsel yöneliminiz?
3. Mesleğiniz nedir?
4. Eğitim seviyeniz nedir?
5. Medeni durumunuz nedir?
6. Aylık gelirinizi yaklaşık olarak söyleyebilir misiniz? Kendi geliriniz yoksa hanenizin gelirini belirtir misiniz?
7. Hangi şehirde ikamet ediyorsunuz?
8. Sosyo-ekonomik durumunuzu nasıl tanımlarsınız?
9. Sağlık hizmetlerinden faydalandığınız özel veya genel sağlık sigortanız nedir?
10. En son ne zaman cinsel sağlık ya da üreme sağlığı hizmeti aldınız?

Hizmetin nereden ve hangi koşullarda alındığı

8. Hizmet alacağınız kurumu siz mi seçtiniz? Kurum seçerken kriterleriniz nelerdi?
9. Cinsel sağlık ve üreme sağlığınız için hangi kurumlardan hizmet (teşhis, tedavi, önleyici hizmet, bilgi alma) aldınız? İlk tercihiniz hangi kuruma danışmaktı?
10. Sağlık kurumuna hangi sebeple gittiniz, hangi hizmetten faydalanmak istediniz?
11. Hizmeti aldığınız doktorlar hangi branş doktorlarıydı? Size ne kadar zaman ayrıldı? Tedavi gördüyseniz takibi yapıldı mı?
12. Cinsel sağlık ve üreme sağlığı hizmetlerinden ne sıklıkta faydalanıyorsunuz? Aynı sıkıntı için doktor değiştirdiniz mi? Doktorunuzla ne sıklıkta görüştünüz?
13. Hizmeti aldığınız kurumda koşullar nasıldı? Hasta mahremiyetine özen gösterildiğini düşünüyor musunuz?

Ulaştıkları ve ulaşamadıkları hizmetler, ulaşamama nedenleri

14. Hizmete ulaşırken bir sorunla karşılaştınız mı? Karşılaştıysanız sorunlar nelerdi ve bu sorunların kaynağı size göre neydi?
15. Almak istediğiniz bir hizmeti alamadığınız ya da yapılması gereken bir işlemin yapılmadığını düşündüğünüz oldu mu? Olduysa size gerekçe olarak ne iletildi?
16. Hizmeti olması gerektiği gibi alamadığınızı düşündünüz mü? Neden böyle hissettiniz, ne farklı olsaydı hizmeti olması gerektiği gibi aldığınızı düşünürdünüz?
17. Sizce özel kurumlarla devlet kurumlar arasında verilen cinsel sağlık ve üreme sağlığı hizmetleri açısından farklılıklar var mı?

Hasta doktor ilişkisi

19. Hekiminizi siz mi seçtiniz? Siz seçtiyseniz önceden araştırma yaptınız mı? Kriterleriniz nelerdi?
20. Cinsel sağlık ve üreme sağlığı hizmeti almadan önce bu konuda başka kadınların deneyimlerinden haberdar mıydınız? Duyduğunuz deneyimler olumlu mu olumsuz muydu?
21. Alabileceğiniz hizmetlerle ilgili önyargılarınız ve çekinceleriniz var mıydı?
22. Doktor ya da sağlık görevlilere size hangi soruları sordular? Hoşunuza gitmeyen bir soru var mıydı?
23. Doktorların ya da diğer sağlık görevlilerinin size karşı olan tavrı nasıldı? İletişimde sorun yaşadınız mı? Cevabınız evet ise bu sorun sizce neden kaynaklandı?
24. Doktorların ya da diğer sağlık görevlileri ile iletişiminizin hizmet alma sürecine (muayene, teşhis, tedavi) herhangi bir etkisi oldu mu? Olduysa bu etkiyi açıklayabilir misiniz?
25. Doktorunuza ya da sağlık görevlilerine soru sormaktan ya da kendinizle ilgili tedaviyi etkileyecek bir konuyu anlatmaktan çekindiğiniz oldu mu?
26. Kendinizi kötü ya da rahatsız hissettiğiniz bir an oldu mu? Cevabınız evet ise size kendinizi ne kötü hissettirdi?
27. Size farklı bir muamele gösterildiğini ya da yargılandığınızı düşündünüz mü? Cevabınız evet ise size bunu hissettiren hangi davranışlar oldu? Bu davranışlar size ayrımcılığa uğradığınızı hissettirdi mi? Bu konuda siz ne yaptınız?
28. Hizmet alma süreci sizin dışınızda gelişen bir süreç mi oldu yoksa kararlara dahil olabildiniz mi? Tedavi hakkında fikirleriniz soruldu mu, tercihiniz alındı mı?
29. Doktorlarla ya da diğer sağlık görevlileri ile iletişiminiz hangi şartlarda daha iyi olurdu?

Baş etme yöntemleri

30. İstediğiniz hizmete ulaşamadığınızda herhangi bir alternatif kuruma ulaştınız mı, probleminizi nasıl çözdünüz?
31. Daha iyi cinsel sağlık ve üreme sağlığı hizmeti almak için izlediğiniz yollar var mıdır? Açıklayabilir misiniz?
32. Benzer hizmetleri tekrar almak istediyseniz, bir sonraki hizmet alımında neyi farklı yaptınız?

Cinsel sağlık ve üreme sağlığı konusunda bilgileri

33. Cinsel sağlık ve üreme sağlığı ile ilgili herhangi bir eğitim aldınız mı?
34. Cinsellik ve cinsel sağlık hakkındaki bilgilerinizi nereden aldınız, bir problem yaşadığınızda ilk danıştığınız kaynak nedir? Akrabalar, arkadaşlar, internet, sağlık kurumları, sivil toplum kuruluşları, örgün eğitim gibi.
35. Cinsel sağlık ve üreme sağlığı ile ilgili yeterli bilginiz olduğunu düşünüyor musunuz? Bu konuda daha fazla bilgi, eğitim almak ister miydiniz?
36. Doktorunuz ya da diğer sağlık görevlileri sizi cinsel sağlık ve üreme sağlığı hakkında bilgilendirdi mi?

Hizmetlerin nasıl geliştirilebileceği hakkında görüşleri

37. Cinsel sağlık ve üreme sağlığı için hizmet alma sırasında size benzer deneyimler yaşayan tanıdıklarınız var mı? Sizce bu alanda hizmet verilirken yaşanan sorunlar neden kaynaklanıyor?
38. Size sunulmayan hangi hizmetlerin sunulmasını isterdiniz?
39. Cinsel sağlık ve üreme sağlığı hizmetlerinden kadınların da etkili yararlanması için sizce kurumlar (akademi, devlet, sivil toplum, özel kuruluşlar) ne yapabilir? Nelerin değişmesi lazım?
40. Deneyimleriniz ile ilgili düşünce ve hisleriniz konusunda eklemek istediğiniz bir şey var mı?

APPENDIX B: APPROVAL OF THE METU HUMAN SUBJECTS ETHICS COMMITTEE

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

ORTA DOĞU TEKNİK ÜNİVERSİTESİ
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20 Şubat 2020

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Fatma Umut BEŞPINAR

Danışmanlığını yaptığınız **Ecenaz GÖZE'nin "Türkiye'de Bekâr Kadınların Cinsel Sağlık Hizmetleri ile İlgili Deneyimleri: İdeoloji, Politika Uygulamaları ve Öneriler"** başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülmüş ve **053-ODTU-2020** protokol numarası ile onaylanmıştır.

Saygılarımızla bilgilerinize sunarız.

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Başkan

Prof. Dr. Tolga CAN
Üye

Doç.Dr. Pınar KAYGAN
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Dr. Öğr. Üyesi Şerife SEVİNÇ
Üye

Dr. Öğr. Üyesi Müge GÜNDÜZ
Üye

Dr. Öğr. Üyesi Süreyya Özcan KABASAKAL
Üye

APPENDIX C: TURKISH SUMMARY / TÜRKÇE ÖZET

GİRİŞ

Tezin temel amacı Türkiye'de yaşayan eğitimli, orta sınıf bekâr kadınların cinsel sağlık ve üreme sağlığı hizmetleriyle ilgili deneyimlerini anlamaktır. Bekâr kadınların deneyimlerindeki farklılıklar Türkiye'deki namus kültürü ve mevcut muhafazakâr politika ortamı bağlamında değerlendirilmiştir. Bekâr kadınların deneyimlerinin değerlendirilmesi sonucunda politika önerilerinde bulunulmuştur.

Tez çalışması kapsamında dört temel soruya cevap aradım. Bu sorulardan ilki mevcut politikaların, düzenlemelerin ve söylemlerin Türkiye'de yaşayan eğitimli, orta sınıf bekâr kadınların cinsel sağlık ve üreme sağlığı hizmetleri ile ilgili deneyimlere olan etkilerini araştırmaktır. Daha sonra, bekârete ve kadın cinselliğine Türkiye'de verilen anlamların bekâr kadınların bu hizmetlerden faydalanırken yaşadığı deneyimlere etkisi araştırılmaktadır. Üçüncü olarak mevcut sağlık sisteminin cinsel sağlık ve üreme sağlığı hizmetlerine olan etkisi sorgulanmaktadır. Son araştırılan soru ise eğitimli, orta sınıf bekâr kadınların ihtiyaçları olan cinsel sağlık ve üreme sağlığı hizmetlerine erişmek ve faydalanmak için geliştirdiği stratejiler ve çözümler araştırılmaktadır.

Tez metninde "bekaret", "cinsellik" ve "LGBTİ+" kavramları sıklıkla geçmektedir ve bu konseptlerin tanımları anlaşılması güç olabileceği için daha ayrıntılı bir tanımlamaya ihtiyaç vardır. Bekâret hiç cinsel deneyim yaşamamış olmak ya da bozulmamış himen gibi çeşitli anlamlarda kullanılabilmektedir. Ancak bu iki durum her zaman birbirini doğrulayacak şekilde olmaz. Ben tez boyunca Türkiye'de sıklıkla kullanılan heteroseksist ve mizojinist bir şekilde kurulmuş olan bekâret kavramını kullandım. Bu bağlamda, bekâretin bu tezdeki anlamı hiç vajinal penetrasyonlu seks yaşamamış olma halidir. Cinsellik ise WHO'nun tanımındaki şekliyle kullanılmıştır. Buna göre cinsellik, cinsiyet, toplumsal cinsiyet kimliği ve rollerini, cinsel yönelimi, erotik deneyimleri, haz, duygusal yakınlık gibi deneyimleri içeren bir kavramdır. Deneyimlenmesi ve dışa vurumu da düşünceler, arzu, inançlar, ilişkiler gibi davranışlarla olabilmektedir. Son olarak, LGBTİ+ lezbiyen, gey, biseksüel, trans, interseks ve artı kelimelerinin kısaltmasıdır, ancak dominant heteroseksüel deneyimi dışında kalan aseksüellik, kuirlik gibi tüm cinsel yönelim ve cinsellikleri kapsamak için de kullanılır ve bu tezde de bu deneyimleri kapsamak için kullanılmıştır.

Bu araştırma, Türkiye'de cinsel sağlık ve üreme sağlığı hizmetlerinden yararlanmada zorluklarla karşılaşabilecek çç.Şpotansiyel olarak savunmasız bir grup olarak bekâr kadınların deneyimlerini araştıran öncü bir akademik çalışmadır. Türkiye'de bekâret veya 'cinsel uygunsuz davranış' gibi konularda kadınların cezalandırılması konusunun araştırılmış olmasına rağmen, cinsel sağlık ve üreme sağlığı etkileşimlerindeki sorunlar araştırılmamış ve kadınların onaylanmayan cinsel davranışlarının bir cezası olarak değerlendirilmemiştir. Ayrıca, Türkiye'de özellikle cinsel sağlık ve üreme sağlığı deneyimleri olmak üzere hasta-hekim etkileşimini değerlendiren sosyal bilimlere yönelik çalışmalar sınırlıdır. Ayrıca, bu çalışmada sadece politikaların değil, devletin uyguladığı söylemlerin de cinsel sağlık ve üreme sağlığı uygulamalarına doğrudan etkisi ortaya konmaktadır.

LİTERATÜR TARAMASI

Cinsel sağlık ile ilgili kavramların global politika alanında çalışılması ve geliştirilmesi nispeten yenidir. İlk olarak artan nüfusu kontrol altına alma ve HIV/AIDS salgınını önleme amacıyla geliştirilen kavramlar daha sonra kalkınma kapsamında incelenmiştir. 1994 yılında Kahire'de düzenlenen Uluslararası Nüfus ve Kalkınma Konferansı (ICPD), üreme ve cinsel sağlık ve üreme haklarının ilerlemesi için bir öncü olmuştur. Konferansın sonucu, daha önce demografik ve kalkınma sorunları olarak tartışılan konuya, cinsel ve üreme haklarını temel insan hakları olarak kabul edilmesini içeren hak temelli yaklaşımı getirmiştir. Bu konferansı takip eden Bin yıl kalkınma hedefleri cinsel ve üreme haklarını kısıtlı olarak içerse de Sürdürülebilir Kalkınma Hedefleri ve 2019'da gerçekleşen Uluslararası Nüfus ve Kalkınma Nairobi Konferansı bu hak temelli yaklaşımı sürdürmektedir.

Türkiye'deki cinsel sağlık ve üreme sağlığı politikalarını incelediğimizde, Türkiye Cumhuriyeti'nin kuruluşundan sonra, üreme sağlığına yönelik ilk yaklaşım, uzun süren savaşlar, hastalıklar ve toprak kayıplarının neden olduğu şiddetli nüfus azalması nedeniyle doğumu teşvik eden bir nüfus politikası ile karşılaşmaktayız. 1965'e kadar her türlü aile planlama ve korunma yöntemi yasaklanmış ve çocuk sayısını artırmak için teşviklerde bulunulmuştur. 1965'teki Nüfus Planlaması Hakkındaki Kanun ile aile planlama yöntemlerinin satışı ve kullanımı serbest bırakılmış, kürtaja zorunlu hallerde izin verilmiştir. 1983'teki kanun ile 10 haftaya kadar hamileliklerde isteğe bağlı kürtaj ve isteğe bağlı sterilizasyon gibi uygulamalara izin verilmiştir. Bundan sonra 2010lu yıllara kadar devletin nüfus politikalarında temel pozisyonu anti-natalist olmuştur.

Kahire'de gerçekleşen ICPD konferansının sonuçları ve Türkiye'de demokratikleşme sürecinin parçası olarak 90'lı yılların sonu ve 2000'li yılların başlarında hak temelli olarak adlandırılabilecek cinsel sağlık ve üreme sağlığı hizmetleri başlatılmıştır. Bunda konferans

sonrası yatırımlarını artıran ABD Uluslararası Kalkınma Ajansı ve Birleşmiş Milletler Nüfus Fonu gibi kurumların sağladığı fonların da etkisi vardır. Bu dönemde Ana Çocuk Sağlığı ve Aile Planlaması Merkezleri ve Gençlik danışma ve sağlık merkezleri gibi merkezler kurulmuş, ücretsiz korunma yöntemleri sağlanmış, sağlık personeli cinsel sağlık konularında eğitilmiştir. Ayrıca cinsel yolla bulaşan enfeksiyonların önlenmesi, gençlerin cinsel sağlık ve üreme sağlığı ve cinsel sağlık eğitimi gibi konularda da dokümanlar üretilmiş ve pilot da olsa uygulamalar başlatılmıştır. Bu gelişmeler 2000li yılların sonlarında sekteye uğramaya başlamış; 2010'lara gelindiğinde de birçoğu yürürlükten kaldırılmıştır.

Cinsel sağlık ve üreme sağlığı politikalarında son on yıldaki değişikliklerden bahsetmeden önce Türkiye'de kadın cinselliğinin algılanışı ve kadınlık, cinsellik, yakınlık ve aile üzerine güncel politikalardan bahsetmek gerekmektedir. Türkiye'de kadınlar Türkiye Cumhuriyeti kuruluşu süreciyle edindikleri haklar sayesinde özgürleştirilmiş gibi algılansa da Kandiyoti'nin de belirttiği gibi aslında kurtulmuş ama özgürleşmemişlerdir. Namus, iffet, ırz gibi kavramsallaştırmalar kadının toplumda gösterebileceği davranışların limitlerini belirlemektedir. Kadın toplumsal hayatta yer alsa bile cinselliğini kontrol altında tutmak ve namusunu korumak durumundadır. Kadın cinselliğinin kontrol altında tutulması hususunda namus kavramı önem taşımaktadır. Buna göre kadının uygunsuz cinsel davranışları hem kendi namusunu hem de ailesinin namusunu lekelemektedir. Kadının namusunu korumak kendi kadar ailenin erkek bireylerine de düşmektedir. Bu kavrama göre cinsel deneyim yaşayan kadın artık değişmiştir. Artık 'kız' değildir 'kadındır' ve eğer bu değişim evlilik kurumu içerisinde gerçekleşmezse namussuz ve iffetsiz kadındır. Bakire kadınlar ve evli kadınlardan daha düşük bir toplumsal statüye sahiptir ve daha az saygı duyulan bir konumdadır.

Kadınların cinselliğinin kontrolü namus, iffet gibi kavramlarla olduğu kadar devletin patriyarka ile işbirliği sayesinde de sağlanmaktadır. Namus cinayetleri ve bekaret testi gibi şiddet eylemlerinde devletin hukuk ve sağlık kolları ile işbirliği yapması bekaret ve kadınların cinselliği ile direkt bağlantılı olarak kurulan namus kavramlarını yeniden üretmektedir. Kadınlar bu koşullara rağmen kavramları yeniden üreterek cinselliklerini yaşamaktadır; ancak sıklıkla kendilerini kanıtlamak durumunda bulmakta, suçluluk ve utanç gibi duygularla baş etmek zorunda kalmaktadırlar.

Namus kültürüne ek olarak AKP döneminde gelen muhafazakarlaşma ve otoriterleşme kadınların cinselliği üzerindeki baskının artmasına neden olmuştur. Doğumu teşvik eden politikaların yeniden gündeme getirilmesi bunu destekleyen söylemler ve muhafazakar politikalarla desteklenmiştir. Örneğin, aile planlaması çalışmaları, sezaryen doğumlar ya da kürtaj hükümet yetkilileri tarafından nüfusu kurutmak üzere tasarlanmış, ülkenin geleceğini olumsuz etkileyecek olan tertipler olarak çerçevelenmiştir. Özellikle mevcut cumhurbaşkanı

Erdoğan tarafından kullanılan ‘en az üç çocuk’ söylemleriyle de yaşlanan nüfusun Türkiye'nin küresel ekonomik pazardaki rekabet gücünü önemli ölçüde etkileyeceği ifade edilmektedir. Bu söylemlerle beraber kadınların bakım yükümlülükleri, muhafazakar fedakar anne rolleri sıklıkla vurgulanmaktadır. Ailenin önemi aile içindeki güç ilişkilerine değinilmeden vurgulanmış ve bakım yükümlülüklerinin kadınlarda olduğu muhafazakar geniş aile modeli yüceltilmiştir.

Mevcut hükümetin söylemlerine ve politikalarına gömülü heteroseksüel, muhafazakâr, Müslüman ve Türk aile ideali, birden fazla 'öteki' grubu yaratmaktadır. Buna göre bu ideallere uymayan gruplar toplumun geri kalanına göre öteki olmakta ve politikaların hedeflerinden yer almamaktadırlar. Bu ideallere uymayan kadınların kimler olduğu ve özellikleri de söylemlerle sıklıkla belirtilen bir konudur. Örneğin, dönemin Başbakan Yardımcısı Bülent Arınç, kadınların toplum içinde gülmemesi, erkeklere davetkâr gözükmemek için çaba harcaması gerektiği ve genel olarak iffet sembolü olması gerektiği konusunda açıklamalarda bulunmuştu. Buna göre, ‘iffetli’ davranmayan, muhafazakâr olmayan kadınlar bu öteki grubu içinde yer almaktadır. Bunun yanında evlilik dışı cinsel ilişkinin tehlikeleri ve ayıplanmasını içeren birçok söylem de üretilmiştir. Dolayısıyla cinsel olarak aktif olan bekâr kadınlar öteki grubu içinde yer almakta ve üretilen politikalarda ihtiyaçları göz önüne alınmamaktadır.

Öteki grubuna kategorize edilen kişiler politikalara dahil edilmediği için cinsel sağlık ve üreme sağlığı hizmetleri ve politikalarında da ihtiyaçları karşılanmamaktadır. Doğumu teşvik eden politikaların önceliklendirilmesi 90’lar ve 2000’li yılların başında geliştirilen hak temelli cinsel sağlık uygulamalarından ya desteğin çekilmesine ya da tamamen uygulamadan kaldırılmasına neden olmuştur. Doğumu teşvik eden in vitro fertilizasyon, dzüenli gebe takibi gibi uygulamalar, yalnızca evli heteroseksüel çiftler için, teşvik edilirken, aile planlaması, kürtaj, sezaryen, cinsel yolla bulaşan enfeksiyonların önlenmesi, cinsel sağlık eğitimi gibi hizmetlere erişim zorlaştırılmıştır. Bu gelişmeler üretilen politika belgeleri, kurum raporları gibi belgelerin diline de evlilik ve doğumun önceliklendirilmesi ve cinsel olarak aktif bekar kadınların varlığının ve ihtiyaçlarının dile getirilmemesi olarak yansımıştır.

METODOLOJİ

Bu tezin araştırma süreci için eğitimli ve orta sınıf 11 bekar kadın ve 11 evli kadın ile yarı yapılandırılmış derinlemesine mülakatlar gerçekleştirdim. Evli kadınlarla görüşme amacım hem bekar kadınların deneyimlerinin evli kadınlardan farkını anlamak, hem de evli kadınların bekarken yaşadıkları deneyimleri de çalışmada kullanmak olmuştur. Katılımcılar eğitimli, orta-sınıf, Ankara’da cinsel sağlık ve üreme sağlığı hizmeti almış 25-30 yaş aralığındaki

kadınlar arasından seçilmiştir. Katılımcıların 19'u kendini heteroseksüel olarak tanımlarken 1 katılımcı biseksüel, 1 katılımcı da heteroseksüel ancak esnek olabilecek şekilde tanımlamıştır. 1 katılımcı ise emin olmadığını belirtmiştir.

Hizmet alan kadınların dışında, 2'si aile hekimi, 2'si kadın doğum ve hastalıkları uzmanı ve 1'i sivil toplum kuruluşu çalışanı olmak üzere 5 uzmanla görüştüm. Tüm aile hekimleri ve kadın doğum ve hastalıkları uzmanı devlete bağlı sağlık kurumlarında çalışmaktaydılar. Devlet hastanelerinden uzmanları tercih etmemin nedeni, devlet hastaneleri ve sağlık ocaklarındaki yapısal sorunların özel kurumlara göre cinsel sağlık ve üreme sağlığı hizmetlerini daha fazla aksatabileceğini ve özel kurumların göreli özgürlüğe sahip olabileceği için devlet kurumlarının devlet politikalarından daha fazla etkilenebileceğini varsaymam oldu. Bu görüşmelerle cinsel sağlık ve üreme sağlığı etkileşimlerinin doktor tarafını da öğrenmeyi amaçladım. Şu anda Ankara'da çalışan 20 yıl ve üzeri deneyimi olan aile hekimleri ve kadın doğum ve hastalıkları uzmanlarını seçtim ve uzmanlar için cinsiyet belirtmedim. Sivil toplum kuruluşu çalışanının ise alanda 5 yıllık tecrübesi vardı.

Katılımcılara ulaşmak için hem kendi sosyal çevremi hem de sosyal medya platformlarını kullanarak kolayda örneklem yöntemi ve kartopu örneklem yönteminin bir bileşimini kullandım. Verileri, Eylül 2020'den Şubat 2021'e kadar bekar ve evli kadınlarla yapılan görüşmeler ve Mart 2020'den Ekim 2020'ye kadar uzmanlarla yapılan görüşmelerden topladım. Görüşmelerin çoğunluğu pandemi koşulları nedeniyle online görüntülü görüşmeler olarak gerçekleşti ve kayıt alındı.

Bu çalışmayı feminist bakış açısı ile ve feminist metotları uygulayarak gerçekleştirdim. Buna göre araştırmacı ve aynı zamanda araştırma katılımcıları ile benzer deneyimleri paylaşan biri olarak kendi pozisyonumu araştırmadan soyutlamadım. Aynı şekilde veri analizi için kodlama metodunu kullanarak katılımcıların söylemlerini mevcut teori, araştırmacı olarak kendi bakış açım ve mevcut politikalar çerçevesinde analiz ettim.

TEMEL BULGULAR

Bu tezde benim argümanım, namus kültürü ve kadın cinselliğiyle ilgili mevcut siyaset ve söylemlerin sadece cinsel sağlık ve üreme sağlığı politikalarına ve hizmetlerin mevcudiyetine yansımadığı, aynı zamanda hastaların ve sağlık personelinin cinsel ve üreme sağlığı etkileşimleri üzerinde de etkisi olduğuydu. Hastalar ve uzmanlarla yapılan görüşmeler, cinsel açıdan aktif bekar kadınların sağlık personeli tarafından daha az namuslu ve daha az saygıyı hak eden olarak algılandığını göstermiştir. Bekâr kadınların bakire, evli kadınların cinsel

olarak aktif olabilen tek kadın olduğu normu, bu etkileşimlerde yeniden üretildi. Kadınların bekâr ve cinsel olarak aktif olmasın sonucu ortaya çıkan sağlık personeli karşısındaki hassas konumu da sağlık sisteminde yaşanan problemler ve yapısal kısıtlılıklar sebebiyle daha da vurgulanmış ve perçinlenmiştir. Özel sağlık hizmetlerinden faydalanmaya mecbur bırakılan bekâr kadınlar temel hak olan cinsel sağlık ve üreme sağlığı hizmetlerine ancak müşteri-hasta statüsüyle erişebilmekte ve faydalanabilmektedir. Bunun sonucunda da cinsel sağlık ve üreme sağlığı hizmetine erişimde eşitsizlikler yaşanmakta ve kadınlar bu hizmetler için ciddi kaynaklar ayırmaya mecbur bırakılmaktadır.

Cinsel sağlık ve üreme sağlığı hizmetlerinde her randevuya ayrılan sürenin kısıtlı olması, tıp pratiğinin nesnelleştirici yaklaşımını güçlendirmektedir. Bulgulara göre, işlemler hastanın rızası alınmadan veya uygun şekilde bilgilendirilmeden hızlı bir şekilde yapılmaktadır. Hastaların ihtiyaçları nedeniyle işlemler normalden uzun sürdüğünde, hastalar zor olmakla ve doktorların işlerini yapmalarını engellemekle suçlanmaktadır. Devlet hastanelerindeki kapasite yetersizliği sebebiyle randevulara az zaman ayırılabilmesi bu yaklaşımın tek nedeni değildir. Aynı zamanda sağlık personeli hastaları medikal bakış ile algılamaktadır; hastalar duygu ve öznellikten uzak organ ve semptomların vücut bulmuş halidir. Bu yaklaşımda, hasta soyutlaştırılmakta ve yalnızca hastalıkla ilişkisi olan dış bedene indirgenmektedir. Hasta yalnızca semptom ve organlar olarak algılandığında ise mahremiyet, utanç, bireysellik gibi faktörlerin de içine girdiği cinsel sağlık ve üreme sağlığı hizmet deneyimlerini daha derinden etkilemektedir. Medikal bakış ve hastaların nesneleştirilmesi sağlık personelinin üstünde her randevu için zaman baskısı hissettiği durumda daha da derinleşmektedir. Cinsel sağlık ve üreme sağlığı muayeneleri sırasında gereken fiziksel ve duygusal olarak rahatlama ve dikkatle dinlenme ihtiyacı gibi hastaların bireysel ihtiyaçları bu şekilde gözardı edilmektedir. Güven ilişkisi ve kaygılarının giderilmesine sosyal konumları itibariyle daha çok ihtiyaç duyan bekar kadınlar ise bundan daha da çok etkilenmektedir. Hastaların öznelliğini ve etkenliğini görmezden gelmek ve onlarla düzgün iletişim kuramamak, hastaların cinsel sağlık ve üreme sağlığı hizmetlerinden caymalarına ve teşhis ve tedavide etkisiz sonuçlara yol açmaktadır.

Sağlık sisteminin kısıtlılıklarının cinsel sağlık ve üreme sağlığı hizmetlerine yansımasına özelleşme ile gelen müşteri-hasta olma durumunun getirdiği avantaj ve dezavantajlar sayılabilir. Bulgulara göre, cinsel sağlık ve üreme sağlığı hizmetlerinden özel bir sağlık kurumunda müşteri-hasta olarak faydalanmak, devlet kurumlarında karşılaşılabilecek bazı sorunların aşılmasını sağlayabilir. Özel sağlık kurumları devlet kurumlarından farklı olarak müşteri memnuniyetini sağlamak ve diğer sağlık kurumları arasında rekabetini korumak durumundadır. Bu durum da devlette olmayan ek bir hesap verilebilirlik mekanizması oluşturmaktadır. Bu hesap verilebilirliğin en büyük katkısı ise bekâr kadınların sağlık

personeli tarafından yargılanma, dışlanma ve ayrımcılığa uğrama kaygılarını dindirmek konusundadır. Müşteri memnuniyeti sağlanmak adına sağlık personeli sosyal normları ve kendi yargılarını hastaya yansıtmayabilirler. Bunun dışında sağlık personelinin hastayla iletişimde daha ilgili olması, daha uzun randevular, hizmete daha kolay erişim, daha iyi teknolojik donanım ve ekipman ve mahremiyet ve gizlilik konularına devlet kurumlarında hizmet sunma şekline kıyasla daha çok önem verilmesi de müşteri- hasta olmanın getirdiği avantajlar olarak ortaya çıkmaktadır. Diğer taraftan yüksek ücretler ve sağlık personelinin kar sağlamak adına gerekli olmayan tıbbi işlemleri gerekli göstermesi gibi konular da müşteri-hasta olmanın olumsuz yanlarıdır. Devlette hak olarak eşit bir şekilde erişilebilmesi gereken cinsel sağlık ve üreme sağlığı hizmetlerine ancak müşteri olarak özel kurumlarda erişilmesi hem farklı gelir gruplarındaki kadınlar arasında, hem de yargılanma ve ayrımcılığa uğrama riski sebebiyle özel kurumlara danışmaya mecbur kalan bekâr kadınlar açısından eşitsizlik yaratmaktadır.

Hastaların cinsel sağlık ve üreme sağlığı hizmetlerinde karşılaştıkları ilk engel, bekar kadınların bakire, evli kadınların ise cinselliği yaşayan tek kadın olduğu varsayımıdır. Bu varsayım birçok yönden tekrarlanmakla birlikte en önemlisi hastanın medeni durumu üzerinden cinsel aktivitesinin sorulmasıdır. Bu soruyla karşılaşan cinsel olarak aktif bekâr kadınlara deneyimlerini açıklamaları istenmektedir. Bekâr kadınların ihtiyaç duydukları hizmeti almak için harcadıkları bu ek çaba ve açıklama, onlara cinsel olarak aktif olmalarının toplumun mümkün ve normal kabul ettiği bir şey olmadığını hatırlatır. Ayrıca bu bekar-bakire/evli-cinsel açıdan aktif ikilemiyle yaklaşılan bekar kadınlar, bir jinekologla güvene ve açık iletişime dayalı bir ilişki kurmak için mücadele etmektedirler. Cinsel olarak aktif oldukları için yargılanacaklarından veya ihtiyaçlarının karşılanmayacağından endişe duyabilirler. Kadınları bu iki gruba ayırdığını belli eden sağlık personeli, kadınların ihtiyaç duyduğu yargısız ve güvene dayalı iletişimi kuramaz ve hastaların hizmete devam etmemesine veya cinsel olarak aktif olma durumu ile ilgili yalan söylemesine sebep olabilir.

Bekâr kadınlar hizmet alımı sırasında cinsel olarak aktif oldukları için sağlık personeli tarafından hakaretler, kötü muamele ve ayrımcılığa maruz bırakılabilirler. Kadınların cinselliğinin kontrolünü kavramsallaştıran namus anlayışı ile hükümetin kadınların cinselliği ancak evlilik kurumu içinde yaşayabileceğini ve geleneksel cinsiyet rollerini yeniden üreten söylemleri birleştiğinde sağlık personeli de bu pozisyonu hastalara yansıtmakta sakınca görmemektedir. Bu durumda daha alt bir sosyal statü atanan cinsel olarak aktif bekâr kadınlar cinsel sağlıkları ile ilgili problemlerde suçlanmakta, cinsel hayatları sebebiyle aşağılanmaktadır. Sağlık personeli cinsel olarak aktif olan bekâr kadınlara hizmet vermeyi reddedebilmekte veya hastanın vücut dokunulmazlığını ihlal edebilecek şekilde

davranabilmektedir. Himenin yırtılmış olması ve cinsel olarak aktif olmak vajinaya müdahalelerde rıza yerine kullanılabilmekte, hasta hakları ihlal edilmektedir.

Hasta mahremiyeti ve bilgi gizliliğine saygı duyulmaması da cinsel sağlık ve üreme sağlığı hizmetlerinde yaşanan problemlerden biridir. Bilgi gizliliği devlet tarafından kullanılan MERNİS, e-nabız gibi veri kayıt sistemleri ile ihlal edilmekte ve hükümetler bu sistemleri gözetleme aracı olarak da kullanmaktadır. Ayrıca sağlık personeli de hasta mahremiyetini ve gizliliğini ihlal edebilmektedir. Dolayısıyla sosyal normların dışında kalan cinsel olarak aktif bekâr kadınlar ailesi, işvereni veya sosyal çevresiyle paylaşıldığı halde hayatını etkileyebilecek cinsel olarak aktif olma durumunun paylaşılması riskiyle karşı karşıyadır.

Bunların yanı sıra, kadın cinselliğinin ancak heteroseksüel evlilik içinde gerçekleşebileceği normu, bu gruba girmeyen kadınların ihtiyaçlarının ihmal edilmesiyle genel cinsel sağlık pratiği içinde yerini bulmaktadır. Mevcut hükümetin uyguladığı doğumu, geleneksel aile yapısını ve muhafazakarlığı teşvik eden politikalar doğum dışı cinsel sağlık hizmetlerinin geri plana itilmesine neden olmuştur. Bu durum sağlık personelinin maaşını da belirleyen performans kriterleri gibi uygulamalara yansımıştır. Aile planlaması, cinsel yolla bulaşan enfeksiyon testi ve tedavisi gibi hizmetler yeni çıkarılan cinsel sağlık belgelerinin odağında yer almamakta ve doğum kontrol haplarının dağıtımı azaltılmakta, erişilebilirlik sorunları nedeniyle karşılanamayan kürtaj ihtiyacı yüksek olmaktadır. Çalışmanın bulguları da cinsel olarak aktif olan bekar kadınların özellikle HPV, kürtaj ve korunma yöntemleri ile ilgili hizmet almakta sorun yaşadıklarını göstermektedir. LGBTİ+ hastaların ihtiyaçları da göz ardı edilmekte ve tüm hastaların otomatik olarak heteroseksüel olduğu varsayılmaktadır. Hükümetin ideolojik konumu, sağlık personelinin cinsel sağlık hizmetleri uygulamalarına da yansımaktadır.

Bütün bunlar sosyal normların tıbbi uygulamaları etkilediğini ve tıbbın iddia edildiği gibi objektif olamadığını da göstermektedir. Bu alanda yaşanan sorunlar hastaların utanmasına ya da kendini ifade edememesine bağlansa da sağlık personeli de kadınların cinselliği ile ilgili tabuları yeniden üretmektedirler.

Cinsel sağlık ve üreme sağlığı hizmetlerinde yaşanan problemlere karşı eğitimli, orta sınıf bekâr kadınlar da baş etme stratejileri oluşturmuşlardır. Bunlardan en önemlisi ise hem önerdikleri hem de sorun yaşadıkları kadın doğum ve uzmanlarının bilgilerini birbirleriyle paylaştıkları bilgi ağları oluşturmalarıdır. Cinsel olarak aktif oldukları için kötü muameleye maruz kalmamak adına birbirlerini bu konuda uyarmakta ve bilgi paylaşmaktadırlar. Bunun yanı sıra, cinsel sağlık ile ilgili önemli bilgileri de birbirleriyle paylaşmaktadırlar. Örneğin düzenli jinekolojik muayene olmanın gerekliliği okullarda ya da medya aracılığıyla paylaşılan

bir bilgi olmadığı için cinsel olarak aktif kadınlar bu konuda birbirlerini bilgilendirmektedir. Böylece yasaklı ve tabu bir konuda birbirleriyle dayanışma sağlamış olurlar. Kadınların birbirlerinin deneyimlerini geliştirmesini sağlayan bir başka strateji de cinsel olarak aktif bekâr kadınlara kötü muamele gösteren sağlık personelinin şikayet edilmesi ve kullandıkları dilin düzeltilmesidir.

Bekâr kadınlar cinsel sağlık bilgilerini geliştirmeyi ve tıbbi terminolojiyi öğrenmeyi de bir baş etme stratejisi olarak kullanmaktadır. Buna göre kadınlar cinsel sağlık bilgileri olduğunu, ihtiyaç duydukları hizmetleri bildiklerini sağlık personeline göstererek hem doktor hasta arasındaki hiyerarşiyi, hem de cinsel olarak aktif bekâr kadın olmanın yarattığı savunmasız pozisyonun olumsuz etkilerini azaltmayı amaçlar. Son olarak da özel sağlık kurumlarını devlet kurumlarına tercih etmek de baş etme yöntemleri arasında sayılabilir.

ÖNERİLER

Bu çalışmanın sonuçları, bekar kadınların cinsel sağlık ve üreme sağlığı deneyimlerini iyileştirmek için politika müdahalelerini gerektirmektedir. Türkiye'de cinsel sağlık ve üreme sağlığı için sosyal politika önerileri sunarken gerçekçi olunması gerektiğine dikkat çekmek istiyorum. Kadın cinselliği üzerindeki ataerkil baskı ve kontrol mevcut hükümetin politikaları ve söylemleri ile güçlenmiş olsa da literatür taramasında da belirttiğim gibi bekar kadınların cinselliğinin ayıplanması ve namussuz, iffetsiz olarak etiketlenmesi yeni bir durum değildir. Sonuç olarak, hükümetle müzakere edilebilecek veya sivil toplum tarafından uygulanabilecek politika ve uygulamalar önermeyi tercih ediyorum. Cinsel sağlık ve üreme sağlığı hizmetlerinin eksikliklerine cevap verecek ve bekar kadınların deneyimlerini iyileştirebilecek politika önerileri, sağlık personeline toplumsal cinsiyete duyarlı tıbbi bakım, cinsellik, haklar ve hastalarla iletişim konularında eğitim verilmesi, sağlık personelinin hesap verebilirliği için mekanizmalar oluşturmak, halka yaşa uygun cinsel sağlık eğitimi vermek, devlet hastanelerinde hekim başına düşen hasta yükünün birinci basamak sağlık ocaklarından yararlanarak veya randevu sistemini geliştirerek azaltılması, devlet hastanelerinde ekipman kapasitesinin iyileştirilmesi ve artırılması, ve anonim cinsel sağlık hizmetlerinin sunulması olarak sıralanabilir. Bu hizmetlerin başlatılması ve cinsel ve üreme politikalarına dahil edilmesi, Türkiye'de cinsel sağlık ve üreme sağlığı hizmetlerinde bu çalışma sonucunda ortaya çıkan sorunlu alanlara cevap verecektir.

Bu öneriler dahilinde, sağlık personeline yönelik eğitimin hedefleri, tüm cinsel deneyimlerin, cinsel yönelimlerin ve cinsiyet kimliklerinin, cinsel hakların ve hasta haklarının kabulü ve tanınmasına yönelik tutum değişikliği, kadınların duygularına ve öznel deneyimlerine karşı

duyarsızlaşmanın kırılması, iletişim becerilerinin geliştirilmesi ve benimsenmesinin sağlanması ve hak temelli bir yaklaşımın edinilmesi olmalıdır. Böylece bekar kadınların uğradığı kötü muamelede iyileşmeler davranış değişikliğiyle sağlanabilir. Ancak bu değişikliğin devamlılığının sağlanması için aynı zamanda ağlık personelinin hesap verilebilirliğinin de sağlanması gerekmektedir. Mevcut şikayet mekanizmaları güçlendirilmeli ve şikayet eden hastanın gizliliği sağlanmalı; hükümetin bu konuda adım atmadığı durumda da sivil toplum tarafından tavsiye edilen veya sakınılması gereken kadın doğum ve hastalıkları uzmanları listeleri oluşturularak hesap verilebilirlik sağlanabilir.

Halka sağlanacak yaygın yaşa uygun cinsel sağlık ve cinsellik eğitimi hem bu konuda yaşanan tabuların kırılmasını, hem de kadınların kendi ihtiyaçları konusunda daha bilinçli olmasını ve sağlık personeli karşısında konumunu güçlendirmesini sağlayabilir. Bu da hem hasta taraflı hem de sağlık personeli taraflı olarak cinsel sağlık etkileşimlerinin geliştirilmesine fayda sağlayabilir.

Son olarak da devlet hastanelerinde sistemsel problemlerin çözülmesine ihtiyaç vardır. Kadın doğum ve hastalıkları randevularının teknik olarak daha uzun sürmesi gerektiği için bu alanda doktor başına düşen hasta sayısı azaltılmalıdır. Bu da mevcut kaynaklarla randevu sistemleri geliştirilerek, online randevular gibi teknolojik çözümler de düşünülerek yapılabilir. Ayrıca birinci basamak sağlık hizmetlerinin cinsel sağlık hizmetleri ve personelin bu konudaki eğitimi de geliştirilerek hastanelerin hasta yükü azaltılabilir. Bunun yanında çalışmanın bulgularına göre devlet hastanelerindeki ekipman da geliştirilmeli ve bekar kadınların bilgi gizliliğinin de sağlanması için anonim test ve tedavi hizmetleri de sunulmalıdır.

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